Hello, everyone. Thank you for joining today's MIPS Cost Performance Category for Year 2 webinar. The purpose of this webinar is to provide information about the Cost Performance Category of the Merit-based Incentive Payment System for Year 2 of the Quality Payment Program. Now, I will turn it over to Adam Richards, health insurance specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead, sir.

Great. Thank you. And greetings, everyone, and thank you all so much for joining us for today's webinar on the Merit-based Incentive Payment System Cost Performance Category for Year 2 of the Quality Payment Program. That's our current year, 2018. You know, if you're here for cost, great. If not, well, we certainly encourage you to stick around because this will be an interesting topic, and we'll be sure to have some fun along the way. You know, we've heard from many of you that additional information on this specific category is highly sought after. Therefore, we want to take the opportunity today to review various aspects of the performance category itself. Here's some practical advice on preparing for cost and engage in a bit of discussion with you all toward the end. Before we get started, I do want to make it clear that we are covering the current policies for the Cost Performance Category that were finalized for the 2018 performance period. So, this year. While we currently have proposals available for review and comment for Year 3, we will not be discussing those proposals here today. If that is something that interests you, I highly recommend reviewing our comparison fact sheets under the Quality Payment Program Resource Library on cms.gov, as well as the proposed rule itself. And with that said, let's get started with our presentation. So, I'm going to move on to slide 3 just to give a little bit of an overview, a run of the show for today. So, we have a variety of topics to review, and we have a fantastic group of Subject Matter Experts available to walk through these various components. I'm pleased to welcome Sandhya Gilkerson, our resident cost expert, Molly MacHarris, our MIPS Program lead, Dr. David Nilasena, our Chief Medical Officer out of the Dallas regional office and MIPS scoring expert, and our Acumen cost team to the call. We'll start with an overview of MIPS for Year 2. Then we'll move into an overview of the Cost Performance Category itself. We'll focus on how scoring works for the performance category. I know this is an area of interest to many of you on the line today. And then we'll have an opportunity to hear some practical advice on how to prepare for the Cost Performance Category from a very special guest, Dr. Dale Bratzler, an internist and current enterprise chief quality officer for the entire Oklahoma University Medicine campus. So, we're very excited to have Dr. Bratzler here with us today. We understand that learning about this policy is important, but we also want to give you a flavor of how someone in Dale's role, Dr. Bratzler's role, is preparing his system and practices for cost. So, it'll be a nice mix of policy and some practical advice. Of course, we'll wrap things up with a review of support options that are available to help you through the Cost Performance Category, and we'll take some questions at the end as our time allows. So, jumping over to the next slide, I won't spend a great deal of time on this slide. I'm sure those who have joined us before have seen this. You may have also seen this in many of our materials, but what I'll mention is that, again, you know, to reiterate, we are required by the Medicare Access and CHIP Reauthorization Act of 2015 to implement the Quality Payment Program. And as a part of implementing the program, we've developed two tracks from which clinicians may participate. We have the Merit-based Incentive Payment System, which we'll refer to as MIPS throughout our call today, or Advanced Alternative Payment Models for those clinicians who are

interested in earning additional incentives for taking on additional risk related to patient outcomes. So, this is the Quality Payment Program in general, these two tracks. Now, moving on to the MIPS track, to deep-dive a little bit and provide a little bit of background information. So, starting on slide six, so just for a bit of background. Prior to the Quality Payment Program, clinicians participated in what we refer to as the legacy programs -- the Physician Quality Reporting System, or PQRS, which dealt with quality, the Value-Based Payment Modifier, which dealt with the measurement of quality and cost, and the Medicare EHR Incentive Program for Eligible Professionals, which really focused on the use of Certified EHR Technology. Those three programs have now ended, and we have combined elements of all of those previous programs into what is known as MIPS. So, for those of you who participate in the legacy programs, you will see quite a few similarities under MIPS, which is certainly advantageous knowledge, as you're all working through the Year 2 requirements. So, just for reference, you know, the Quality Performance Category is similar to PQRS, Cost to the Value-based Modifier, and what we're now calling our Promoting Interoperability Performance Category, the EHR Incentive Program, and we'll talk a little bit more about that name change in a bit. Jumping to the next slide. As you'll see on screen, MIPS is comprised of four performance categories in 2018, which, again, is our current performance period. Now, this is different from the 2017 performance period because we are counting the Cost Performance Category as a part of a clinician's MIPS final score this year. So, that is something to note, and that's why we're all here today, to kind of talk about this very important inclusion of the Cost Performance Category. You'll note that each of these four performance categories has an assigned number of points, or weight. All of the performance categories add up to 100 final points, and that's important because under MIPS, we will assign a final score to each eligible clinician, and that final score can range from 0 to 100 points. Additionally, the final score, depending on how it relates to what we call a performance threshold, will determine whether clinicians will be receiving a positive, negative, or neutral payment adjustment. And as a reminder, for those keeping track, the performance threshold for Year 2 -- again, our current performance period -- is 15 points. Moving onto the next slide -- this is where I wanted to talk a little bit about the name change around Promoting Interoperability. So, CMS recently released, and I think this was back in April, the Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System proposed rule. Of course, those were certainly very important proposed changes, but I'm bringing this to your attention because we are addressing the Meaningful Use element that cuts across many of our programs here at CMS. And we're really rethinking the concept of meaningful use to focus on interoperability. And what that means is, you know, we want to make the program, the Meaningful Use Program more flexible and less burdensome, emphasize measures that require the exchange of information between patients and providers. And we also want to get to a state where all clinicians are using the 2015 edition of CEHRT by next year, 2019, as well as the built-in API, or the Application Programming Interface, functionality to improve the flow of information between providers and patients. So, all of that is to basically say that we are changing the name of Meaningful Use to Promoting Interoperability. So, as you saw on the previous slide, we've changed the name over. Advancing Care Information, or what was known as the Advancing Care Information Performance Category under MIPS, will now be referred to as Promoting Interoperability. So, please do note that. You'll see this change in all of our educational resources around the Quality Payment Program. You'll see it on our website, qpp.cms.gov. But, it is relatively minor. It is a name change only. So, that's also important to call out. The requirements under Promoting Interoperability Performance

Category for 2018 remain exactly the same. This is nothing more than a name change. So, just wanted to call that out so as we're working through our slides and certainly our, you know, we have our future webinars, you understand that that is Promoting Interoperability. Okay, jumping into some of the participation basics for MIPS, and I'll move through these relatively quickly. On slide 10, just a bit of a recap. So, for Year 2, we did not change the clinician types. Year 2 still have the MIPS eligible clinicians still include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. I do want to mention -- you'll see on some of these slides we say change or no change. Ultimately, this just shows whether we maintain similar policies from Year 1, 2017, or we change them ever so slightly. You know, ultimately, our goal was to continue with the gradual implementation of the program into Year 2 to allow clinicians to, you know, continue familiarizing themselves with the system, the basic requirements, et cetera. So, as you can see on this slide, there was no change to our MIPS eligible clinician types. On the next slide, I will note that as it relates to the low-volume threshold and, you know, determinations for clinicians, we have changed the low-volume threshold. It now includes MIPS eligible clinicians billing more than $90,000 a year and allow charges for covered professional services under the Medicare Physician-Fee Schedule and -- and this is the important part -- and furnishing covered professional services to more than 200 Medicare beneficiaries a year. The "and" piece of this is very important. Clinicians need to exceed both of those criteria. I also want to call out something that's important for Year 2 that began with Year 2, and you'll continue to see this with our future performance years. Earlier this year, the Bipartisan Budget Act was passed. So, in order to be compliant with the Bipartisan Budget Act, which helps, you know, gives us some additional authority to continue our gradual implementation, we had to adjust the low-volume threshold. So, beginning for Year 2, 2018, low-volume determinations will only be made on covered professional services under the Physician-Fee Schedule. This is different from 2017, where the low-volume threshold determinations were made on all Medicare Part B allowed charges. So, I do just want to call that out for you all. Moving on to slide 12... We did not change anything related to our exemptions. Again, clinicians are exempt if they are newly enrolled in Medicare, if they are below the low-volume threshold. So, if they do not exceed any of those the two criteria I mentioned earlier, or if they are significantly participating in Advanced APMs, by which they become qualifying APM participants. So, the exclusions remain the same. Jumping onto the next slide... We did increase the performance period for MIPS. So, as you can see, for Quality, it is 12 months, for Cost, again, this is 12 months. This is the most important one, and I think this is the one why we're all here again today speaking. Cost is 12 months, and we've retained Improvement Activities in the Promoting Interoperability Performance Categories at 90 days. So, please just note those time frames for the 2018, our current performance year. And then, finally, on slide 14, just wanted to give you a sense of what the performance period or basically the timeline for Year 2 what it looks like. Again, we are in the performance period right now, where clinicians are seeing patients, collecting data. We will move into the submission period beginning January 1st of next year, 2019, and clinicians will have the opportunity to submit their data to us. Again, we'll have a feedback period, which is actually what we're doing right now for the first year. We're in the performance feedback period, so I encourage you all to take a look at your performance feedback if you have not done so already. There's a wealth of information there, so please do take a look. And then of course the corresponding payment adjustment year for the 2018 performance period is 2020. So, that was just a brief overview of the Quality Payment Program, of

MIPS. Now, we're going to jump into the meat of our discussion. So, at this point, I'm going to turn it over to Sandhya Gilkerson to start the discussion on the Cost Performance Category. Sandy?

Thanks, Adam. Hi. I'm Sandhya Gilkerson. I'm the lead on the MIPS Cost Measure Development Project in CCSQ. And I'm a health insurance specialist from the Center of Clinical Standards and Quality here at CMS. So, today I'm going to talk briefly about the 2018 MIPS Cost Measures. Next slide, please. So, as Adam spoke earlier to Cost category, in 2017, we did not score the Cost category. The maximum score was zero. But for 2018 performance year, the Cost category will be assigned a score of 10. So, which basically means that participants can get a maximum score of 10% in the Cost category. Next slide, please. So, essentially, the goal here is to align Cost measures with quality of care assessment so we can achieve better patient outcomes and efficient spending. Next slide, please. So, CMS evaluates Cost for clinicians by using National Provider Identification Numbers and Tax Identification Numbers. For 2018 performance year, the two Cost measures are Medicare Spending Per Beneficiary and Total Per Capita Cost. Moving on to the next slide. For MSPB measure -- the MSPB clinician measure assesses the cost of services provided to a Medicare fee-for-service beneficiary during an MSPB episode. This episode is triggered by an IPPS hospital admission, also called an index admission. The MSPB episode extends from three days prior to an index admission to 30 days after hospital discharge. And this episode includes all Medicare Part A and Part B claims during this period. Next slide, please. MSPB Attribution. Attribution is the process of determining which clinician or clinicians are responsible for an episode. So, for MSPB attribution, for MSPB, each episode is attributed to the clinician who pays the majority of the Part B of Physician Supplier services in terms of the dollar amount during the index admission for that episode. If two or more clinicians bill the same amount during the index admission, then that episode is attributed to the clinician who provided services most recently. We know that for clinicians participating individually, the episodes are attributed at the unit TIN/NPI level. And for clinicians participating as groups, a single score is assigned to the group based on the combined data. Next slide, please. MSPB: Case Minimum. Case minimum is the minimum number of episodes a TIN must be attributed to receive a report on that measure. In case of MSPB, clinicians must have at least 35 MSPB clinician episodes to receive a score on the MSPB measure. Clinicians that have fewer than 35 episodes and clinicians that don't bill for in-hospital stays will not be scored on the MSPB measure. Next slide, please. The second Cost measure for MIPS 2018 Performance Period is Total Per Capita Cost, TPCC. This measure includes all Medicare Part A and Part B costs during the performance period. It's an average of payment standardized, risk-adjusted per capita costs across all attributed beneficiaries. For this measure, we attribute the measure a beneficiary based on which TIN NPI provided the most primary care services. Next slide, please. So, for TPCC Attribution -- the attribution for TPCC is a two-step process. In the first step, a beneficiary is attributed to a TIN NPI if the beneficiary received more primary care services from either primary care physicians, nurse practitioners, physician assistants, and clinical nurse specialists in that TIN than in any other TIN. But, if the beneficiary did not receive a primary care service from either PCP, NP, PAs or CNS during the performance period, then the beneficiary is attributed to the TIN within which the beneficiary received the most primary care services from a non-primary care specialist. Next slide, please. And if a beneficiary did not receive any primary care service from PCP, NP, PA, or CNS, or non-primary care physician, then the beneficiary is not attributed. And if two TINs tie for the largest share of beneficiaries' primary care services, then that

beneficiary is attributed to the TIN that provided primary care services most recently. Next slide. So, for TPCC, clinicians and groups must have at least 20 different episodes attributed to be scored on the MSPB measure and receive a report. I would like to remind that both MSPB and TPCC are claims-based Cost measures, and clinicians don't need to submit any special data or report. That's pretty much the basic information for MSPB and TPCC Cost measures for the 2018 Performance Period. With that, I'll turn it over to Molly MacHarris from the Center of Clinical Standards and Quality here at CMS. Molly?

Thanks, Sandy, and thanks, everyone, for being here today. I just wanted to cover a couple items with you all. So, as Sandy went over for the second year of MIPS, we are assessing clinicians' performance on two Cost measures -- the Medicare Spending Per Beneficiary and the Total Per Capita Cost Measure. So, for these two measures, in scenarios where clinicians or a group of clinicians do not meet the case minimum, essentially what would happen there is that if we are unable to calculate either one of the measures or both of the measures, if we are only able to calculate one of the measures, we would assess your Cost Performance on that given measure. If we are not able to calculate either of the two measures, the Medicare Spending Per Beneficiary or the Total Per Capita Cost measure, we would redistribute the weight of the Cost Performance Category to the Quality Performance Category with Cost contributing zero points towards the clinician's final score and Quality then counting for 60 points. Let's move on to slide 27, which is just a brief example of what this would look like. So, we have a scenario where we have 20 episodes attributed to you, the clinician, for the Medicare Spending Per Beneficiary measure and 20 for the Total Per Capita Cost measure. So, which, if any of these, would we include? We would only include the Total Per Capita Cost measure because, as Sandy mentioned, this would fall below the case minimum that's required for scoring under the Medicare Spending Per Beneficiary measure. So, the entire 10 points associated with the Cost Performance Category in this scenario would be based off of the Total Per Capita Cost measure. And let's move on to slide 28. So, just as a brief reminder for folks, for our Year 1 rule, we did finalize a set of episode-based measures in last year's rulemaking. So, for the second year of the program we removed those episode-based measures because the feedback that we received from stakeholders really across the board was that while those episode-based measures that have been developed were helpful, they didn't include enough frontline clinician support and involvement in the actual measure development process. So, we really went back to the drawing board and created a new process for episode-measure development. Those episode measures, just so folks are aware, we have proposed eight of those measures in our Year 3 policies. So, for those of you who have read the proposed rule, you'll see that that is reflected there. But, focusing on the second year of the program, again, for the 2018 performance year, there are no episode-based measures that would contribute towards a clinician's final score. So, that's it for me. So, I'm going to go ahead and turn the rest of the presentation over to Dr. David Nilasena. David?

Yeah, thanks, Molly. And I'll just be doing the next few slides, and then I think we have some more stuff after me. So, I'll be talking about how we're going to score the Cost category in 2018 for MIPS. And as was mentioned earlier in the call, for Year 1 we did not score Cost. It didn't contribute to your final score. But for Year 2, since it's 10% of your final score, we do have to figure out how to score it. The good news for the Cost category is that it's relatively simple compared to the other categories. We only have two measures to deal with. We don't have any bonus points. We don't have end-

to-end electronic transmission. We don't have to worry about selecting, you know, which measure is highest. So, we basically just look at the two measures that have been discussed, and we score those. The first thing to understand about how we're scoring the Cost measures is that we will be using data from the 2018 performance year. So, we're going to use the data that is submitted for 2018, and we'll be creating benchmarks using that same data. So, there's no historical benchmarks that are used for scoring. Each of the two measures will be assigned a score from 1 to 10 achievement points, based on performance relative to benchmarks. And keep in mind that these measures have been risk-adjusted, both of them, as was mentioned earlier by Sandhya, to take into account the complexity of patients and to better account for things that are beyond the position and clinic's control. So, those are built into the measure and also are built into the benchmarks that we'll be using to score them. So, we'll be assigning 1 to 10 points for each of the measures, and then we will add up the two measures and divide by the available number of points, which would normally be 20. And that gives you your Cost performance score. So, onto the next slide. This slide just gives an example of how the scoring might work. So, in this case, we have the TPCC measure, which got 8.2 achievement points out of 10, and the MSPB measure got 6.4 points out of 10. So, we would add up those achievement points to get 14.6. We would divide by the total which was available, which was 20, and that accounts for 73% of the available points. We then multiply that by the 10% weight for the category, and that gets you 7.3 points toward your final score. Now, as Molly just mentioned, in the case where one or more of the measures does not meet the case minimum, then those measures would not contribute to your category score. So, in this particular example, let's say that the TPCC measure didn't meet the case minimum. Then your entire score would be made up of the MSPB Measure, or 6.4 points. And vice versa -- if the MSPB measure didn't meet the case minimum and only the TPCC measure did, then your category score would be 8.2 In the case where neither of the measures met the case minimum, as Molly mentioned, the entire category would be reweighted to zero, and those points would be assigned to the Quality category. Next slide. Now, for the data that we use for the Cost measures, we will be using data for Calendar Year 2018. So, those are Medicare A and B claims with date of service between January 1st and December 31st of 2018. As a reminder, you don't need to submit any additional data for these Cost measures. We derive it from the Medicare claims that you are already billing as you're taking care of your patients. And so, there's no additional reporting burden associated with this. But you will hear from Dr. Bratzler in just a few minutes about things you might consider as you're doing your coding that may help you in your score in this category. So, with that, I think I will turn it back over to Adam, who will introduce Dr. Bratzler.

Sure. Thank you, Dr. Nilasena. Thank you, Sandy and Molly, for going through this information. Again, folks will have some time at the end to ask questions. So, if we haven't gotten to your question in the chat, hang in there with us. We'll certainly have a Q&A session a little later on. But at this time, we're going to shift gears ever so slightly to talk a little less about the policy itself around the Cost Performance Category, as well as the performance category requirements, and discuss some of our more practical tips for preparing to participate in the Cost this year, maybe even beyond preparing, you know, really starting to participate in the Cost Performance Category and really understand it. So, with that, it's my pleasure to, once again, introduce Dr. Dale Bratzler. So, I'm going to move on to the next slide because I think this is a better introductory slide. Dr. Bratzler, again, internist and current enterprise Chief Quality Officer for the entire Oklahoma University Medicine campus. He is a professor in the colleges of

Medicine and Public Health at OU. Has served for the past six years as the Chief Quality Officer for the Oklahoma University Physicians, the faculty practice of the OU College of Medicine. He is, among many other things, responsible for PQRS, Meaningful Use, participating in the Transforming Clinical Practice Initiative, which we'll talk a little bit later, as one of our technical assistance organizations, and, really, more recently, you know, overseeing MIPS and participation in the CPC+ implementation. So, and I say among other things because Dr. Bratzler is also currently one of our Quality Payment Program clinician champions. So, he has been instrumental in helping us to really make this program palatable to clinicians. So, it is my pleasure to introduce Dr. Bratzler to go through some just basic tips for preparing for Cost. Dr. Bratzler?

Yes, thank you, Adam. It's really a pleasure to be here. So, if we could go to the next slide. So, we've heard now from several speakers that participation in the Cost component of MIPS is actually pretty easy. You see your patients, you submit your claims, just as you always have. Dr. Nilasena just highlighted that from a scoring standpoint, it will be relatively easy for CMS, since there are only two metrics that actually need to be calculated to come up with a score for the Cost component of MIPS. So, what's the tough part? Well, the tough part, I think, is actually controlling cost of care, because you're basically being held accountable for the overall cost of care for the beneficiaries that are attributed to your practice. So, remember that Medicare claims are being used to analyze your Cost performance, but that includes all Part A and Part B claims, which means that when your patient is hospitalized or receiving other services that represent either Part A or Part B services during that episode of care, then you're actually being held responsible for those costs. So, it starts making you think about the overall cost of care for patients that goes well beyond what you're doing in your office practice. And I will tell you here at OU, we've been looking at this data for some time, and when we look at our data, the biggest drivers of cost for our patients include hospitalization. As you know, many of them may be preventable or unnecessary. Use of the Emergency Department. Readmissions are very costly when they occur. And, also, one that some people don't think about -- but use of post-acute care services. Now, there may be some cost in ambulatory care that vary between practices -- use of hospital-based facilities versus outpatient-based facilities, how your spending patterns on things like imaging or laboratory. All of those are important, but when I look at the big drivers of cost for our practice, it's principally use of hospital services or post-acute care services. So, you don't have to submit any additional data, but I think the bigger challenge with this particular category in MIPS is that you actually have to work now to start thinking about how you control cost of care. Next slide. The other important point, and one that we're focused a lot on right now, is that, as Dr. Nilasena and others have pointed out, the Cost metrics are risk-adjusted. So, there's an expectation that if you're taking care of more complexly ill patients that have more comorbid conditions, that it will cost more to take care of that particular patient. So, CMS recognizes that. Well, how do they do the risk adjustment? The risk adjustment is based on what you code on the claim that you submit to Medicare for payment. So, if there's going to be accurate comparisons of the complexity of illness or the severity of illness of your patients compared to somebody else, it means that your claims data has to reflect the severity of illness of your patients. And so, what that means is you need to be specific in your coding. Not only do the doctors have to document the severity of illness of the patient and the comorbid conditions that a patient has, but whoever is doing your coding and submitting the claims needs to make sure that they put that specificity in the bill that

goes to Medicare because that will affect your risk score. CMS uses something called "hierarchical condition categories." You don't need to understand that necessarily, but when we look at our practice, one of the things we're focused on right now is getting our doctors to avoid using things like unspecified codes when they submit a claim or uncomplicated codes when the patient obviously has multiple comorbid conditions. An example might be a diabetic patient that has a GFR at approximately 55 or Stage III kidney disease, chronic kidney disease. Adding the specificity of the nephropathy that the patient has with their diabetes substantially increases the risk score for that particular patient. But if you don't include it or if you just code it claim for an unspecified or an uncomplicated diabetes code, then your patient doesn't look nearly as sick, and it won't be reflected in the risk adjustment of your Cost metric. So, in our practice, we have two big focuses now, as we think about Cost. The first is making sure that we adequately document patients' risk and their comorbid conditions, the complexity of their care, and the second thing is focusing on use of hospital services, including the Emergency Department and also post-acute care services. Next slide. Finally, I actually have some pretty good resources that CMS has provided to me to start looking at our Cost data. So, even though in 2017 Cost was not a component of the MIPS program, if you look at your final 2017 performance feedback report for MIPS, the last few pages of the report actually include Cost data from 2017 on the two measures that you'll be held accountable for in 2018. So, on my report, which I have on my desk in front of me right now, it has Medicare Spending Per Beneficiary and our current score on that metric, and it has the Total Per Capita Cost metric, and our current score for that based on our claims in 2017. So, I can already predict that if we don't change anything what our score might be for 2018. And it's useful information. But the other sources of data that CMS has provided that have been helpful include the episode-based Cost Measure Field Test Report. It came out towards the end of last year and had, in our report, I think there were about 10 different episodes of care that CMS was testing and provided a report to your practice that might show you what your episode-based costs of care for some common Medicare conditions were. Prior to MIPS the Quality and Resource Use Report files that came out also had data on both per capita costs for all attributed beneficiaries and Medicare Spending Per Beneficiary. So, we actually have been using that report now for several years to start looking at our overall cost of care. We also, we're a participant in an Alternate Payment Program, CPC+, that provides routine data on our use of inpatient services and Emergency Department services. And then we have not been participating in Bundled Payment Programs in the past, but are looking at participating in Bundled Payments for Care Improvement Advanced. And by applying for that, it provided useful data to us and our use of services, particularly post-acute care, where we find substantial variation and opportunities to reduce overall spending for our patients. So, you've been getting some data for several years, particularly if you've been receiving your QRURs or other reports that might be very helpful. And the final thing that I would point out, is that some private payers provide routine data on cost of care. So, in my market, Blue Cross Blue Shield is fairly prominent, and they've provided information at the various clinic levels on use of imaging services, laboratory, hospitalizations, ER use, and other metrics that are very helpful in us being able to look at our overall cost of care. Next slide. And I think I'll turn it back over to Adam.

Great. Thank you so much, Dr. Bratzler. Certainly appreciate you joining us today and providing that practical advice to help folks get started. And just so everyone on the line knows, Dr. Bratzler, as well as our subject matter experts, will stay with us through the end of the call so when we do get to

the Q&A portion, if you do have a question for him, please feel free to ask. I do just want to take a moment to talk about some of those resources that are available that we highly encourage you to review. So, we certainly, on the Quality Payment Program Library on cms.gov, and we do have hyperlinks to all of these resources on the slide. There is the 2018 MIPS Cost Measures, as well as our fact sheets on the Cost Performance Category, both available on our Quality Payment Program Resource Library. Of course, as always, if you have questions related to Cost, you can certainly reach out to the Quality Payment Program Service Center via the information that is on the slide. I do want to also re-emphasize a point that Dr. Bratzler made around performance feedback, and I'm seeing a lot of questions in the Q&A about where you can find your performance feedback. And I think this is a good time to just kind of reset. So, 2017 performance feedback is available on qpp.cms.gov. You just need to sign into the platform using your EIDM accounts credentials, and you will have access to performance feedback. So, that's where you will find your performance feedback reports. Again, I highly encourage you to review those reports, not just from the Cost components, which we did provide feedback on for 2017, but also taking a look at the other performance categories, where you may have been submitted data for 2017. So, certainly Cost, Improvement Activities, and Promoting Interoperability, which was Advancing Care Information in 2017. So, all of that is available on qpp.cms.gov. Please, definitely take a look at those reports. There's a wealth of information in there to really help you get started and prepare for Year 2 if you're included and need to participate. But also as a part of the performance feedback, we do have a targeted review period that's open. So, if there are any issues with the payment adjustments you received, you do have the opportunity to file a targeted review, and that period is open until October 1st. So, the sooner you get in to check out your feedback reports, the better. And that's how I'm going to end this slide. So, let's move on. I know we're getting closer to the top of the hour, and I do want to have some time for Q&A. I just want to talk about some of the help and support that we have available. So, if we jump to the next slide. Of course, we have, and we will continue to offer our technical assistance throughout the 2018 performance period. This is robust support to help you with all aspects of the Quality Payment Program. But that also does include support on the Cost Performance Category. So, please reach out to any one of these networks. For those in small practices, we do have customized support available to you through the Small, Underserved, and Rural Support Initiative. That's the top, righthand quadrant. For those in larger practices, of course you can reach out to our Quality Innovation Networks and Quality Improvement Organizations. And for those who are interested in, you know, or who are participating in MIPS and are interested in making that transition to an Alternative Payment Model, maybe even an Advanced Alternative Payment Model, highly recommend taking a look at the Transforming Clinical Practice Initiative. They have do have Practice Transformation Networks that are certainly very eager to come in and help if you are interested in that transition. And, of course, we have the Quality Payment Program Service Center. Our website, qpp.cms.gov -- highly recommend taking a look at those resources if you need the help. And, of course, it is always free. So, moving on to our next slide. I think this is going to bring us to -- oh, well, an announcement before we get to our Q&A session. I sometimes surprise myself. So, we are interested in eliciting your feedback on the Quality Payment Program, on ways that we can continue to improve this program. So, this is just a brief announcement. If you are interested in providing feedback to CMS and helping us to improve the overall user experience, we're looking to collaborate with you. So, really looking at all aspects related to qpp.cms.gov, our products, our services, our educational materials, the website content -- you name it. If it has

something to do with qpp.cms.gov, we certainly want to hear from you. So, these feedback sessions, as you can see on screen, typically range from 30 to 60 minutes. They can be done over the phone, via video conference, through e-mail. We have a number of different options to accommodate those who are interested in providing feedback to us. And if you do participate, it also -- you can claim some Improvement Activity credit for Year 2 under MIPS. So, these links will take you to an e-mail that will get you connected with our user research experience team, so it's a great opportunity. There's no strings attached. So, if you are interested in helping us out, please follow up with us. Now, if we move on to the next slide, I believe this will start our Q&A session. So, I'm going to turn it over to the moderator just to provide some guidance on how you can call in to talk to us. And then I'll rejoin you in just a minute. So, over to the moderator.

We are now going to start the Q&A portion of the webinar. You can ask a question via chat or phone. To ask a question via phone, please dial 1-866-452-7887. Again, the number is 1-866-452-7887. If prompted, provide ID number 5778128. Again, the number is 5778128. Once you have joined the call, please press *1 to join the Q&A.

Okay, great, thank you. So, we're going to give everyone about 30 seconds to dial in. We have some great questions coming into the Q&A. I know our teams are working through some of those questions and trying to provide answers. Just a couple of ground rules for Q&A. Try your best to limit to one question so we can try to get through as many folks as possible. Just a reminder -- we're trying to keep this very focused on our Year 2 Cost Performance Category policies and requirements. So, please, if you can, you know, focus on the requirements for Year 2. I will also say that this is very MIPS focused performance category webinar. Unfortunately, we don't have a number of our SMEs, our subject matter experts, from the APM side of the house. So, we won't be able to answer too many of those questions. But we're going to try to do our best. So, with that said, let's take our first caller.

We have our first question from Jeff Fawcett.

Hi. Can you hear me?

Yes, we can. Welcome.

Terrific. Thank you. I am wondering if CMS has done a study, and this is prompted by the information in the 2019 proposed MPFS rules, but has done a study to determine how many eligible clinicians are anticipated to meet the case minimums for both the MSPB and TPCC measures, or, vice versa, how many ECs would not meet the case minimum for either one of those measures?

Yeah, hi. This is Molly MacHarris with CMS. I know we have done those analyses. I believe that information was contained within the proposed rule. I can try to pull it up real quick to see if I can find it before the Q&A session ends, unless any of my other CMS colleagues on the phone have those statistics handy. Okay. So, I can try to pull that up, and if I find the answer before the call ends, I will give it verbally. If not, I'll make sure that that answer goes out to our communications team so they can share that information with you all after the fact. Thank you.

Thank you.

Thanks, Molly. Okay. Let's keep chugging along. Do we have another caller?

Your next question is from Randi Terry.

Hi. I kind of have two questions. I'll try to make them quick. The first one is, the QRUR reports were available for 2016, but when we called in to see if they would be available for the 2017 data and on, they said they wouldn't. But those QR reports gave us what we needed to improve. And the Cost data and the QPP website really doesn't give us very much data. And then the second part of that is we don't get any Cost data for anybody who was in a MIPS APM. We have a whole bunch of people that were a MIPS APM and decided to go away from that and submit their data alone. But there's no Cost data for them. So, any thoughts on those two?

So, I'll start, and I certainly encourage others to jump in here. So, certainly hear you on, you know, having additional information as a part of the performance feedback. As you know, as I think Sandhya or Molly touched on earlier, for Year 1 we were just providing some basic feedback for the Cost Performance Category. So, we are certainly looking to Year 2 to add, you know, elements that may be useful to you, information that you think is beneficial, that will certainly help with preparing for future years and, you know, participating in this category during a performance period. So, we certainly encourage this type of feedback. So, again, this kind of comes back to our feedback opportunities. You know, this is great information that we, you know, can certainly take back and consider as we continue to build out these reports over time. I do know that I think one of the elements that you mentioned is something that we are looking at for Year 2. You know, adding additional beneficiary level data is something that we are looking at for Year 2, working through all the different elements, the operation elements right now. But we certainly welcome you to, you know, provide us with additional feedback for our user testing sessions on how we can continue to build out the reports. The other aspect of that, the MIPS, providing cost information for those who are MIPS APMs, that's something that I can -- again, unfortunately, we don't have our certain SMEs online today, but that's something that I can certainly take back to the team just as a piece of feedback for future years.

May not have qualified last year, but they do this year, and there's no Cost data. So, that's really tough to advise our providers.

Sure. No, completely understandable. And, again, that's something that we can certainly take back.

Thank you.

Okay. Charge along. We'll take -- I know we're getting closer to top of the hour. Let's try to get another question in, if we could, please.

Your next question is from Rene Auria.

Hello. Can you hear me?

Yes, we can.

Yeah, I have question for you. It seems like a lot of physician practices admit to hospitalists so they're not rounding anymore, billing for any of the Medicare Part B services. So, they're not going to be included in that measure. It just seems like, therefore, many of the practices are just going

to be measured on the TPCC measure. Was that really the intent, or was it, kind of, that wasn't what was originally planned, because they were kind of looking at episode-based measures? And now we have something that wasn't really as intended?

So, Adam, this is Dale.

Sure.

So, your assumption there is incorrect, though. So, for, let's say, a primary care physician who has a group of attributed Medicare patients who see them and refers those patients to a hospitalist for care, you're still held accountable for the episode-based cost of care for that patient, even though you didn't take care of them in the hospital. So, a lot of our primary care physicians here in our practice, that patient may be admitted to either a hospitalist or to a subspecialist. But Medicare, CMS rolls up all of the Medicare Part A and Part B charges for that attributed patient, that patient that's attributed to your practice, and you're held accountable for those overall costs of care, whether you're providing it in the hospital or not.

So, how are they linking the charges back -- how are they making the connection to the patient that's in the hospital that has no charges from the primary care physician back to the primary care physician?

Well, they couldn't if you've never had a primary care charge for that patient. In our practice, we have about Medicare somewhere around 9,000 Medicare patients that CMS has attributed to our practice because they receive their primary care services in our practice. So, those are the patients that CMS will be holding us accountable for, for the Total Per Capita Cost metric and the Medicare Spending Per Beneficiary.

So, even though the definition says you did not bill for Part B during the hospital stay, they're just talking about any Part B charges during the hospital stay, not specific to the primary care physician.

That's correct. It's basically all of the cost of care for your patient that's attributed to your practice.

All right, thank you.

Yes, thank you. And thank you, Dr. Bratzler, for certainly jumping in. Always appreciate your insights. Well, folks, we are at the top of the hour. I just want to make a few quick announcements here. I do want to remind you all to sign up for the Quality Payment Program listserv at qpp.cms.gov. This is a fantastic way of staying connected with the Quality Payment Program and getting all of our up-to-date resources, as well as announcements about upcoming events. I flagged this for you, and I encourage you all to join because as we continue developing resources to help you all understand the Cost Performance Category for the, you know, current performance year and then eventually into future performance years, we will put that information out through the QPP listserv. So, all you have to do is go to qpp.cms.gov, scroll to the bottom of the page, and enter your e-mail, and you'll get all of those updates and announcements. Two other items I do want to flag for you all. We have two additional Year 2 MIPS performance category webinars on the horizon. So, next Wednesday, August 1st, from 1:00 to 2:00 p.m., we will be talking about the Improvement Activities Performance Category, and then Monday, August 6th, from 1:00 to 2:00 p.m., we're going to be talking about

the Quality Performance Category. Both for Year 2 of the program, so they should be both very interesting and have a lot of great information for you. With that said, I do once again want to thank all of our speakers, our subject matter experts, Dr. Dale Bratzler, also, for being with us today and thank all of you for joining us today. We'll talk to you all again soon.

Thank you. This concludes today's webinar.