[Classical music plays]

Hello, everyone. Thank you for joining today's "Quality Payment Program Data Submission Office Hours: MIPS Quality Data Submission." During this Office Hours session, CMS subject-matter experts will answer commonly asked questions about MIPS quality data submission. First, CMS will answer a selection of presubmitted questions. You can submit additional questions through the phone or question box, which CMS will address at the end of the webinar as time allows. And now I'll turn it over to Adam Richards, health insurance specialist from CMS. Please go ahead.

Okay, great. Thank you, and thank you all for joining us today. We're excited to have each of you here for our second Office Hours session on MIPS data submission within the Data Submission feature on qpp.cms.gov. If you were unable to attend the first session that we held back on February 14th, the recording is posted in our Quality Payment Program webinars and events section on cms.gov. We had a really interesting, very vibrant discussion. I think there's some beneficial conversation, and it really pertains to the basics of MIPS data submission, so we certainly encourage each of you to listen to that recording.

We hope to kind of build off of the energy of the first session in today's session, where our focus today is going to be a little more specific to submitting quality data in the submission feature. So, this is a little more focused on the quality performance category of data submission. So, we have assembled a very knowledgeable team of subject-matter experts to be with us today. They'll be working the chat feature to answer your questions and will also be addressing your comments, questions, concerns via the phone line. I will say that there will be times where we may need to discuss certain questions that you ask us, so please don't think that we've disconnected you. We just want to be able to provide the best guidance possible, so we may just jump offline for a minute or so.

Now, I would be remiss if I didn't take the opportunity to highlight a few key dates in the submission period over the coming weeks. We are getting closer to the March 31st deadline, but I'll kind of take a step back first. So, March 1st, which I believe is tomorrow, at this point, is the final day to submit your claims with the proper codes that were captured during the 2017 transition year to your Medicare administrative contractor for processing. March 16th represents the closing of submissions for the CMS web interface, for those larger groups who are on the line with us today. And, finally, as I mentioned earlier, MIPS data must be submitted by -- all MIPS data must be submitted by -- March 31st. As always, if you need support, please reach out to the Quality Payment Program Service Center, and we'll have that information on-screen a little bit later to have you get in contact with them. Or feel free to reach out to our network of technical-assistance organizations who are ready to help you through the submission process at absolutely no cost to you. So, of course, we also want to hear your feedback today, so feel free to use the chat feature or when you call in to let us know what's working, what's not, what can be improved. So, we're looking forward to a really good discussion today.

So, I'm going to move into the next slide to get us started. One more, please. Perfect. So, we did solicit some very basic questions, and that's where we're going to start today, just kind of talking through the high-level FAQs that you sent in to us, and then we'll go into opening up the phone lines for a little more discussion. So, I'll say that this slide

really starts off with some of the just basic submission details, so we'll go through these rather quickly, and then we'll kind of get into the more quality end of the questions you've submitted. So, really, to kick things off, and I think we have our policy experts on the line, who needs to submit MIPS data by March 31st? Do we have Tim on the line?

Hi. This is Tim.

Hey, Tim. Perfect.

Thanks for the question. So, the individuals and groups that need to submit data by the 31st are those that are easily identifiable within the lookup tool and received notification from CMS previously that they were MIPS-eligible. Those that were not identified as MIPS-eligible individuals or groups that do submit data do not need to submit information by March 31st, but they would be volunteers. So, again, who needs to submit? All who are eligible at the individual and group.

Fantastic. Thanks, Tim. And to Tim's point, you can always check your status, your final eligibility status, for 2017 by using the NPI lookup tool on qpp.cms.gov if you've not done so already. That is a great resource.

One of the next questions, and we get this a lot and we keep hearing this, is, "When I go into the Data Submission feature on the website, where is the 'submit' button? Is there a 'submit' button? Where is it? I can't find it." So, can we tackle that one?

So, the Submission U.I. application, which includes the Quality Event and Care Information or Improvement Activities categories, does not contain a "submit" button because the data that is submitted through that application is stored and represented in real time, and so any data that you are submitting through the application is already accessible in the database, and so it was already submitted.

All right. Fantastic. The third question I'm going to just reframe a little bit. So, when a commission or just a user is inside of the Submission feature and they see the different performance-category scores, are these their final scores, or are these an initial snapshot of what they will see?

So, within the submission window, which is up until March 31st, it is essentially a snapshot of the vast representation of your scoring information based on what data is currently available within that submission, and so a typical goal is to submit your accurate and relevant information with sort of a goal of achieving or reaching the highest possible category score for each category. However, the final score representation will be available within the feedback user interface, I believe, on July 1st.

Fantastic. Thank you. And the final question to kind of round out these general questions on submission, also a question that we are seeing pop up with a little more regularity, is, "Will I have access to my data and performance scores after the March 31st deadline?" So, what will I see after that deadline?

So, after the March 31st deadline, the application will transition over into the performance-feedback stage. The user will be able to view any submissions they've made to date, and we will be providing feedback. There

will also be notification, letting the users know that there is still data that's coming in that might impact their final score. I saw a lot of questions come up asking about the All-Cause Readmission measure. That is something that we currently have tracking and will be available after the submission period. There will be details surrounding how your final score is being calculated, and it will give a little bit more detail than what you're seeing right now in the submission period. And this will continue to be the state of the application until 7/1, at which point we are hoping to have the final score and payment adjustment available, at which point you will be able to see your submission that is related to both your final score and pay measure.

All right. Fantastic. Thank you. And just a reminder -- like I said, please feel free to use the chat. I know that we have a lot of our subject-matter experts in there answering questions right now.

We're going to go on to the next slide. A little more technical in nature around the submission feature. I think what we'll do is kind of take the first two, try to pair those together, and really just talk about methods for submitting MIPS data but, more importantly, I think this is one of the top questions we get, is "How do I format those files?" or "What formats do I really need to use?" So maybe we can just start there.

Sure. So, it does get a bit complex when it comes to what options are available, but to attempt to simplify within the submission user interface, there are essentially three different types of file formats that can be submitted. One is the QPP-formatted JSON or the QPP-formatted XML, and you can also be submitting the QRDA3-formatted XML files, and that's just different file formats and structures for how that data is being represented to the user interface, and there is more information about how to structure that data and that information in those file formats on the help section of the QPP website. Additionally, there's also some relevant submission methods that can be represented with the submission method field inside of the file structure that you have available, and the most likely submission method that will be submitted through the submission U.I. are going to be electronic health record or registry submission methods, depending on where that data is originating.

Great. Thank you. I tell you, I'll come right back to you. Another question is, as clinicians, users, are signing into or logging into the submission feature and begin submitting their data, we're seeing this question, "Why is only one submission method being scored, despite uploading data from multiple submission methods?" What are they seeing in there through the different scores that are being presented?

So, I can't speak as much to the policy decision or representation on that approach. However, from the application design, if a user is to submit data for a particular entity and the category within that entity, a user can choose to potentially submit multiple submission methods if they are available. Some of those submission methods, again, could be electronic health record or registry but could also represent other submission methods, such as claims, CMS web interface, or web adaptation for items that are submitted directly on the user interface, but the business logic and policy requirements for year 1 are to essentially compartmentalize those various submission methods so that only the highest-scoring of those available submission methods are chosen on each category basis and on each entity basis.

Okay. Fantastic. Thanks. And I just want to check in with Tim. Is there anything additional from the policy side about why we're calculating one submission method despite there being uploaded data for multiple submission methods?

Yeah. So, the third question on slide 4, so one submission method scored despite multiple submission methods, is predominately the operational impact of the same selection for the same individual or group being provided in the interface so there's consistency. For the final score, the highest will be provided. So, I don't want to overstate that, but, again, when we come to the performance feedback -- and I see a lot of questions. I'll try to answer a couple. But the submission method with the highest score for that group, that TIN, taxpayer I.D. number, or NPI, National Provider Identification number, when we get to the performance feedback, the highest score for that individual or that group will be what is the final score for that end. But that's where we are at currently. The expectation will be that when we get to July 1st, that will be what is provided in the final feedback for the final score.

Okay. Fantastic. Thanks, Tim. And I'm going to jump back to you in just a second. If we can go to the next slide, please, we'll start trying to break in to some of our quality questions that you've all submitted. So, the very first bullet on slide 5, which you're seeing on-screen, asks, "If we submitted at least one claim per provider with the 'Q' code for the 'test' period," referring to kind of the pick-your-pace test option that we have, "and have received our confirmation explanation of benefits from Medicare, is anything else needed in order to avoid the 4% negative adjustment for 2017?" Tim, I don't know if you can answer that one for us.

Yeah. So, I am not the expert in the feedback that will come on the explanation of benefits, but if they do have verification from the MAC that processed their claim that they have it processed, recorded, before the last date of claim submission, they would have completed what we originally describe as the pick-your-pace test case. They would have avoided the negative 4% adjustment. And the adjustment is applied in 2019, not 2018.

Okay. All right. Thank you, Tim. We're going to keep charging right along here. Moving on to our second question -- second and third question, really. So, can you explain how clinicians who submitted quality performance data via claims will see their scores in the Data Submission feature, and is there anything else that clinicians need to do when it comes to claims submission in this feature?

So, if you are a group or individual and your claims data is available, you can navigate to QPP to the entity that you are interested in and navigate to the quality category page, and at the top of the page, there will be available at least one tab or a series of tabs, and one of those, if you have claims data available, will be represented as claims, and by selecting that tab, you can view more information about the claims data that is available and some of the preliminary scoring information relating to that data.

Okay. Fantastic. And to just build off of that -- and I think, really, the next two questions, I think, will kind of be in the same realm -- but "How often will my claims' measure score for the quality performance category be updated in the submission feature?" Can Tim answer that?

Yeah. I'm sorry. Which one are we on? I'm trying to answer --

Sure. We're on the third bullet on slide 5.

Yeah. So, the question here is what is the frequency of the claims score category update feature? So, the frequency of the score will be final when we have completed the last run of claims within our scoring system, so once we have that final performance, which is assessed off of that last date of claims, the claims refresh for general knowledge within CMS refreshes every week, but our run-out period carries through, so if the expectation is you are submitting a claim today or tomorrow, when would you expect to see that reflected in our user interface or it is not reflected in the user interface, the answer would be next month.

Okay. Fantastic. And I think you actually kind of answered our first question on slide 6, as we move forward, because the answer was wrapped up for those two questions, so if we can move on to slide 6. And I believe we've also answered the second question, too, so the deadline for submitting claims to my Medicare Administrative Contractor is tomorrow, 3/1, so please make sure that you get those claims with the proper codes onto the 2017 performance year over to your MACs if you have not done so already. I'll also throw this question out, one that we have seen come up over the last week or so, but "Am I able to submit my quality performance category data through a method other than claims, and so I still have time to submit that data?" So I'll throw that over to our policy team.

Yeah. This is Tim again. So, there are other ways, if the billing vendor that you work with or the claims-processing CMS forms that you had have been unable to provide, at this point, do you still have time to submit? And the answer is yes. However, to do so, you would not be using a claims submission. You would need to work with a third-party entity, and those are identified within the program as registries or Qualified Clinical Data Registries or EHR vendors, so these are the organizational inputs that would allow for, other than claims submissions, essentially for the last 29 to 30 days, depending on which day, talking about today or tomorrow. But you would still have a month to provide data in a quality performance category in the event that you did not submit via claims.

Okay. Thanks, Tim, and just stay with us for a second as we move on to slide 7. I looked forward a little bit to our next two questions. So, for the quality performance category -- and we are on slide 7, that first question at the top, for those following with us right now. So, for the quality performance category, can providers get extra points by submitting additional measures that are outcome measures or high priority? And if they can, should a provider submit data on the required six measures, including one that is an outcome measure, and then add other measures that are high-priority or outcome measures to maximize the points?

Yeah. This is Tim again. So, the quality performance category does allow for bonus points. They are capped at the number of measures within the category, so, for the purpose of the high-priority bonus, we'd be able to get up to six bonus points with six measures. And they can come from multiple means of measures provided, right? So, the program expects, looks for, scoring logic for that outcome or high-priority measure which is required to get that first measure performance locked. And then if there are other measures beyond that to include measures 2, 3, 4, 5, assuming the

first one is an outcome measure, measures 2 through 5 could be outcome measures and including beyond our first six measures, they can submit in other measures that would get them bonus points for the quality category. And, again, you have the maximum amount. The max here is 6 points for the category for individual clinicians.

Perfect. Thanks, Tim. And I'm just going to move right along to that second question. I don't know if there's any advice that we can provide to this particular specialist, endocrinologist, who does not have a quality measure category for their specialty -- I'm thinking this is representing the specialty-measures set and has to submit data as a primary care physician. Is there any solution or exclusion without receiving a penalty?

Yes. I don't know if we have any folks on the measures team on here or a specific request from any clinician-specialty type. The solution -- I would strongly recommend clinicians and anyone advising a clinician here is they're looking for understanding how to avoid the negative payment adjustment -- that is, the negative 4%. They are not finding a quality measure that they are able or can fully document and submit to CMS. There are two other categories that allow for submissions that would provide an opportunity to avoid the negative payment adjustment. For example, a clinician who is unable to find a measure available or applicable to his or her practice would still be looking at the improvement activities. There are several very broad improvement activities which do apply to most clinicians that see patients because they receive patients or see patients that come from other doctors, and the improvement activity is closing the referral loop. That is a common practice, the standard of care, and is something that even specialists, even subspecialists -- their patients come from somewhere, so they do get a referral to see the patient. So, closing the referral loop is, again, a standard of care that we believe is very achievable for even a very highly specialized subspecialist.

Okay. Thank you so much, Tim. Appreciate the guidance. So, we've made it through kind of the top questions that you have sent us that we solicited prior to today's event, so now can we go on to the next slide, please? I do want to present the dial-in information. Again, we know a lot of questions are coming in through the Q&A right now. We do have a lot of our subject-matter experts in there working through your questions. But we do want to engage in a nice conversation with all of you, as well, so if you'd like to dial in, we do have the information on-screen. Moderator, I don't know if you can just give everyone the information again.

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 on your telephone keypad to ask a question. If you're dialing in, you will need to dial 1-877-388-2064. Again, that's 1-877-388-2064. If prompted, please enter I.D. number 5480378. Again, that's 5480378.

Fantastic. Thank you. So, in the meantime, while you're all dialing in, I just want to just remind everyone that we will host a recording of this event on our Quality Payment Program Events and Webinars page on cms.gov. We will have the link for that. In just a bit, we'll post that for you, just so you know where to go. That recording will be available in just about a week or two, so always keep checking back if you wanted to follow up on any of these questions. We'll also certainly send out that information, and I highly encourage each of you, if you have not done so already, to sign up for our Quality Payment Program listserv. That's where we always send out a

lot of great information as it relates to program, any updates we have with our education outreach, our educational resources, or even any updates that we make to the Quality Payment Program submission feature. So, it is really a great resource. If you go to qpp.cms.gov, you can sign up for the listserv. I believe it's at the bottom of the screen, so you'll be able to get registered. So, at this time, I'm going to turn it back over. Do we have any callers on the line?

We do. Our first question is from Eden Essex.

Hi. Thank you. If somebody has a zero in the numerator and they have no denominator exceptions, should they be getting 3 points? I'm with a QCDR vendor, and the API is giving 3 points, and we thought that that would give zero points.

So, as long as you have a denominator greater than zero, a numerator of zero will result in a 3%, or 3 points, and it's a 0% performance rate.

So they'll get 3 points even though they have a 0% performance rate? Is that just for 2017, or will that go into 2018, as well?

That one we may have to follow up on, just to check through into year 2. We do not have our Advancing Care Information subject-matter experts on the line with us today, but that is something that we can certainly check into and follow up on.

Okay. This was for the quality category, though. I'm sorry if I didn't stipulate that. For the quality category, if you have a zero in the numerator and no denominator exceptions, would you still get 3 points? The API is giving us that.

Yes. Tim, I don't know, if you're still on, if you have any input for Year 2, and for API, that would not be correct. If you have a zero in the numerator, you will not be meeting the requirements and you will receive a score of zero for that measure.

That's correct. Yeah, that's correct. This is Tim. That's correct.

Okay. And can I talk with somebody offline? Because we work with a vendor that reports the number to QCDRs, and they've tested the API, and a zero in the numerator is giving 3 points right now.

Yeah, this is Tim. If you can send us a Service Center ticket with the measure number in your header, we can flag that and send that to the right team. So, if you can send us the QCDR measure number in your header for the Service Center ticket.

Okay.

Thank you.

Thank you.

And to our Ketchum team, who's supporting this call today, if we can, just let's capture that caller's information. That way we can pair the ticket with the caller and make sure we get it to resolution.

Absolutely. No problem.

Okay. Thank you. Okay. We'll take the next caller at this time, please.

Our next question is from Sandy Swallow.

Hi. Thank you. I got on just a little bit late, so I wanted to know if you could revisit your talking points if someone was reporting as a group and then they also reported for quality in their claims as individual. If the claims score is higher than the group score, then that individual, eligible clinician, will get that score for their quality category. Do I understand that correctly?

Yes.

So, just to be clear, as well, that interesting area where there is a group and an individual submission, there is no combining of methods, so there would be a submission for individual and a submission for group. The only way that the NPI would actually be used as the submission would be if the overall submission is higher than the group's. So, it takes into consideration the other two categories, as well.

So, would that individual need to go in and submit as an individual for ACI with their ACI data and the improvement? Would they need to submit for all three categories as an individual and as a group?

If they're looking to use their claims information as their quality submission, they would need to submit for all three categories. Otherwise, the group score, most likely by default if the group is reporting all three categories, is going to be higher.

Okay. That was the clarification I wanted. So, in other words, if they just submitted as a group for quality and as an individual claims for quality, only the group IA and group ACIs, and that individual's score for that claims is not going to count for them, correct?

Yeah, that's correct.

Okay. Okay. Thank you. That helps to clarify that.

Great. Thank you. Thank you for that question. We'll go on to the next caller, please.

Again, if you would like to ask an audio question, please press star, then the number 1 on your telephone keypad. Again, that's star, then the number 1.

And do we have anyone on the line?

Please hold for the next question. Please press star, then the number 1 if you have a question. Our next question is from Julie Lundberg.

Hi. Thanks for the call today. I sent this in earlier today with a video recording so you could see what our experience is, but let me try to describe it. Do you have any advice for us? So, we're assisting several practices in their MIPS applications, and we have successfully uploaded our QRDA III files for several practices, but on two separate occasions for two

different practices, we were on the "upload physician data" screen. It shows our filename. It shows "status complete" with a nice green check. And we navigate to the next screen, which is the main dashboard, which shows you your quality category, and it says there's no data uploaded. They called while they were experiencing this, and we're being told it's a problem on our end. We're testing, our engineers have tested, with every tool available to us with Cypress, with the API, and we believe our file is good. We need to know what we can do differently. We've tried several browsers. Not sure what else to do.

So, I'll try to answer to my current knowledge. There's a few things that could probably cause this, but the most likely culprit is that your data's probably fine, but what takes place with the authentication and the submission model for how it works is that as you navigate through the dashboard, you have the option of reporting as a group versus as an individual, and sometimes as an individual, there are a number of connected clinicians and things of that sort, and what we see happen frequently based on that authentication model is that sometimes users will submit data within the user interface for one entity, and that file is actually being submitted for another entity, which would be in sort of a different compartmentalized user interface. So, the best advice we can give is to double-check the TIN or TIN/NPI combination within the file with what is represented in the left-hand navigation sidebar on the user interface and just make sure that those are completely matching up, because if you're receiving a message that the file was successful, then we did get your data and it is being stored at the database level, but it might be represented on another user interface instance of where you would navigate to for that TIN or TIN/NPI combination.

Julie, does that help?

You know, the tricky part is the person who had the EIDM account to do all this work is someone that is the one person that has that, and that's not the person who has the technical expertise to work on problems like this, so we need to regroup with those folks. But, yeah, we'll certainly try this. So, I'm looking at the TIN on their page, and I need to make sure that TIN is in our file. And it's not, but let's make sure of that.

Or make sure, if you're submitting, if it's an individual file, that you are navigating down to the individual level, because you could be on the group dashboard and submitting an individual file, and that also will not render on that page. You'll need to navigate down to the individual NPI.

Yeah. We're doing group reporting. The screenshot I'm looking at shows, under Group Reporting Quality Measures, no file. All right. We're going to test the patience of our client and try to get them to do this with us again, and, hopefully, we're going to be successful the next time. We'll validate that we've got the same TIN in both, and I'm sure we do. And you'll respond to the case we logged, as well, I hope? We've got this happening with two different practices, so is there a way to get your technical folks on a call with our technical folks to make sure that...

Julie, do you have tickets open with the Service Center, by any chance?

Yes, I do. We've got two, I think. I'm sorry. We've plagued you with two of them.

Right here.

Okay. If we can capture those tickets for you, we'll be able to closely analyze the issues. That way we can dig into it a little bit more. So, if you can, Ketchum team, can you reach out to Julie? Or, Julie, just send a private message to our moderators if you have those Service Center tickets. If not, we can try to capture that from you at some point. Okay. All right. Well, thanks for calling in, Julie. We'll connect with you to get this all sorted out. At this time, let's move on to our next caller. Do we have another caller on the line?

Our next question is from Chastity Barnum.

Hello?

Go ahead with your question.

I'm sorry. I just have a question...that if we have...

Sorry. Chastity, we're having trouble hearing you.

Okay. Can you hear me now?

Yes. Thank you.

Okay. So, we have 16 providers, and of those 16 providers, we're only reporting one in MIPS because we're in the CPC+ module for the APM for the other 15 providers. Do we still have to report anything on MIPS for the 15 providers that are in CPC+?

Do we have anyone --

We submitted for CPC+, but I just wanted to make sure I'm not supposed to follow anything for the MIPS process for them.

So, this is Chris. I don't think we have anyone from the CPC+ program represented here. I can tell you what I know. CPC+ is one of the APM models that does participate in the MIPS program, so the quality submissions that I believe you were referencing, either doing via AccessPatient or via QRDA III submissions, are not used for MIPS, and that's solely for the purpose of the CPC+ model team scoring. However, within MIPS, you would have to submit API at the group-practice level for all the individuals that are within that CPC practice I.D.

So, regardless, we do have to report that?

For the MIPS component of scoring, yes.

Okay. And then for the one physician, which is a surgeon, of our practice, we were not able to get with -- I'm believing a registry is the third-party component which you're talking about? Is that what you're -- Like, if we had someone in a registry submitting our data for us, is that the third-party entity that you guys are talking about?

Is this in reference to earlier?

Mm-hmm.

Okay. Yeah, a third-party submitter would be a registry. Did you have additional questions with that?

...to get that set up in time, so we were told by our vendor that we would just test this year to avoid the negative payment adjustment, but I'm confused as I've been on the website and the dashboard to report. What exactly am I supposed to report for just testing mechanisms to avoid the negative payment adjustment, seeing as how we're not reporting any measures?

So, to avoid the negative payment adjustment, you either have to submit one quality measure, one improvement activity, or meet the base measures for Advancing Care Information. If there is no submission and you have a score of zero, you will receive a negative payment adjustment for year 1. And is your question still in regards to CPC+?

No, no, no. This is MIPS for the one provider that is not in CPC+.

All right. Gotcha.

Yeah. So, what you're saying is I would report one quality, one improvement, or just the base, or I have to do one, one, and the base?

It's just "or."

Yep. "Or."

Okay. Okay. Wonderful. Those are my questions. Thank you very much.

Thank you. We're going to keep charging right along. Do we have another caller on the line?

Our next question is from Ravi Bhathal.

Yes. My question is what are we supposed to report for the improvement activities? Because there is no template or there is no information forwarded to us. What are we supposed to report for those measures which are identified under improvement activities? That's my first question, and second question is how many measures we are supposed to select for the improvement activities to report?

So, we're not really able to give direct advice on which improvement activities are most relevant to your practice or how many to submit. However, as you navigate to the improvement activities category page, either through reporting as a group or reporting as an individual, you have a few options for submitting that data. One, you can submit directly on the user interface. As you navigate there, you'll see the list of the 92 available improvement activities for the 2017 submission year, and you can choose your performance period, where the performance period was active for your group or practice, and then upon selecting that, you can choose any of the 92 available improvement activities by simply checking the box there next to the activity name, and that will submit or attest for that activity. You also have the capability of uploading a file or having a file uploaded on your behalf by, say, a registry or QCDR. And the file structure would just have to be as we described before and would contain submission data for your TIN or TIN/NPI combination with the improvement activity that you would like to submit. And there's a bit more information on the structure of how to build or develop those files by going to the qpp.cms.gov page, going all the

way down to the bottom for "help and support," and then there's a number of resources available there, but, also, the developer tools, which can give some more information about how to structure that data. So, long story short, you can attest directly on the user interface or submit a file with that data.

Okay.

Does that help?

I'm still not sure what to report for those specific, and I can give an example that we had selected that we actually are taking more Medicare patients. And we enroll with some Medicare plans included on here to say that, "Hey, we are accepting more Medicare patients." But I don't know how to communicate that. Is what we are supposed to communicate under that measure, saying that, "Hey, we are taking more Medicare patients? We are accepting?"

Okay.

So, hi. I think I know what you're looking for. This is Ashley. I think what you're looking for is the criteria for the individual activities so that you understand what is required for each activity. So, on the resource library on the website, under the MIPS general section for 2017, there's a document labeled "MIPS Data Validation Criteria." If you open that, it's a workbook, but it has a sheet in there that lays out the criteria for each individual activity for improvement activities. It also has the criteria for the other categories, as well. But I think that's what you're looking for so that you understand what we're looking for per activity.

So, I'm sorry to, again, keep on going back. So, we understand those criteria, but then how do we report it? We, like, put it in some Word document and then upload it, or how do we --

So, yeah. So, related to this, I think what you're looking for is that these are just basically Boolean responses, so either you did them or you did not do them.

Yeah.

So, there's no additional criteria. If you're reporting that on the website, you basically are going to say, "Yes, I did this activity," in which case it will be attested to that Improvement Activity, and you will receive points for that specific activity.

But you do keep your records, you do keep your documentation for recordkeeping, just in case there's an audit of some sort down the road. You do need to keep that documentation handy.

Got it. I think that answers my question. I appreciate it.

All right. Thank you. So, we are getting closer to the top of the hour, but I do want to keep moving forward. Do we have any others on the line?

Our next question is from Debbie Gitner.

Thank you. I am from an EHR vendor. One of our clients submitted claims in December with the quality code, but there was a glitch, there was a problem, and the quality code never made it to Medicare. The EOBs came back, and they just showed the office visit and whatever else was done. Is it too late for her to send those codes electronically now, or does she need to do a corrected claim, or is she just in trouble? [Chuckles]

Yeah, this is Tim. So, unfortunately, no one on this call can review how to adjudicate claims that didn't get full resolution with the Medicare Administrative Contractor. If there was no other submission or a claim with a quality data code on it, again, that has to be in final within the MAC and within the shared systems where the data repository shows the quality data code. The last day for that would be tomorrow. So, the other options would be what was previously discussed from other questions. There are other ways to submit to the program.

Sure. I understand. Yeah, yeah. Okay. Thank you very much. I appreciate it.

Yep.

Yep. Thanks.

Just before we take the next caller, since most folks do have this information now, I do want to go on to the next slide, just as a reminder of where you can find the recording, where we'll post this in the future, as well as all of our education-outreach sources relative to the Quality Payment Program and then, of course, I do want to call your attention to a number of training videos that we've created around data submission to the MIPS submission feature on qpp.cms.gov. Those are also available, and I highly recommend taking a look at those if you have not done so already. And then, of course, if you do need support, please, please feel free to contact the Quality Payment Program Service Center. The information is on screen. And we also have our no cost technical assistance that's available in the field right now.

We do have just a few minutes left, so I think we'll take one last caller before we wrap up today. Do we have anyone on the line?

Our next question is from Lisa Sagwitz.

Hi. I have two questions I've been trying to find the answers to. One is specific to an Improvement Activity, IA_PSPA_5, which is annual registration in the prescription drug monitoring program. For group reporting, do all of the physicians need to be involved in the PDMP, or if some of them are, would that satisfy for the entire group?

Yeah, this is Tim. I can answer that one for you. The requirement is for at least one individual within the group to have been actively performing the Improvement Activity for the group to receive credit for conducting the Improvement Activity.

Thank you. And then my other question -- if a provider is in two different ACOs, so they're APM Track 1, two different TIN numbers, would each of those scores be separate, or could, potentially, there be an overriding of one with the other with that provider being in two different groups?

So, I can give you a brief overview of that, but it really depends on the QP status of the individual who you're seeking about. If, in one of the ACOs, they're considered a QP, then that score is what would be considered for each and every association for that practitioner. If they are not a QP, then they would have individual scores with each TIN/NPI association.

Thank you.

Okay. Thank you, Lisa. So, we are at the top of the hour. I know that you've all had a lot of great questions, and we've been monitoring the chat, and I know that a number of our experts are still in there, working to answer those questions, so feel free to keep sending your questions in until we close today. We will kind of take a look at these questions, try to develop some additional resources around the top trending questions, and make sure we provide some guidance where possible. I do want to certainly thank our experts here today for taking the time to speak with you all. We certainly thank each and every one of you for being on the call today and providing us with these great questions. This really helps us to continue to improve the program, certainly by seeing where the questions are coming from. We do have some additional events planned that are forthcoming, and we will also have some additional guides that we'll release in the next few weeks, but, again, I do want to reiterate those dates of March 1st for submitting your claims with the proper quality codes, which is tomorrow, March 16th for CMS web interface users as the deadline, and then, certainly, maybe the most important one, March 31st to have all of your MIPS data submitted to the Quality Payment Program. With that, I do want to thank each and every one of you again, and we will talk to you all again soon. Thank you.

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