[Classical music playing]

Hello, and thank you for joining us today for the overview of MIPS for Small, Rural, and Underserved Practices webinar. Today, representatives from the Centers for Medicare and Medicaid Services will present an overview of the Quality Payment Program, including Merit-Based Incentive Payment Systems, as well as a brief summary of the proposed MIPS requirements included in the Quality Payment Program Year Two proposed rule. CMS will also discuss flexibilities and resources for small practices. You can listen to the 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 phone. Dr. Elena Rios, president and C.E.O. of the National Hispanic Medical Association, will provide an introduction for today's webinar, and turn it over to Adam Richards, health-insurance specialist at CMS, and Dr. Ashby Wolfe, Chief Medical Officer of Region 9 at CMS. Dr. Rios, you may now begin.

Okay. Thank you very much. It's a pleasure to be here. I am very happy to co-host this event with the Centers for Medicare and Medicaid Services. And Jeanette and all her team in the Communications office, thank you very much for the marketing out to our doctors and other health professionals. And my message is simple. If you can turn the slide, please. One is, we are a leadership organization with a mission to empower those who take care of Hispanic patients, especially the Hispanic physicians, nurses, dentists who we work with. But all of those who are not Hispanic we understand how of all the doctors in the country, only 5% are Hispanic. We know how important it is to empower and to have cultural competence information and leadership information. So we established our organization to be able to do this. We also developed a foundation to have a scholarship program for students that are interested in serving the Hispanic population. We serve as a resource to the federal government -- White House, Congress, and Executive Branch. We provide leadership development, and we provide networking opportunities. Next slide. And this particular webinar is going to share with everybody today, from the experts at CMS, the importance that we believe are priorities for the transition that we are now living in that will change a fee-for-service system in this country to a quality, value-based system. We are focused on what it means to have quality care for the Latino patients from your perspective. You decide your measures, the quality measures that you are going to select that you will develop from your own teams. If you're a small group practice, your teams of nurses, your billers, the insurance companies you work with, the pharma companies you work with. You're going to have to have a team approach. You're going to have to have cultural competence within your measures, and cultural competence within your systems of presentation to your patients, whether it's oral communications, websites, forms that you use. And you're going to have to understand that, if you're in a clinic with boards of directors in your leadership, you're going to have to explain to them the importance of cultural competence to move forward in a quality manner. And then, lastly, I think the major, major transition for especially the younger generations who want to look for jobs in our safety-net opportunities for jobs, it's going to be all about data analytics. Data analytics to develop, "What is the quality definition?" Whether you're looking at

population health for a whole underserved area, or what we'd call the safety net, or if you're just looking at a patient-to-physician interaction and satisfaction, what does that mean to analyze satisfaction from a patient? So, we are a participant in Transforming Clinical Practice Initiative, which is one of the initiatives with the greatest amount of money put forward by the federal government to help small practices like yourselves get involved with the transforming of your practice to become a quality practice. We will be having more speakers, such as the speakers you will hear from today, at our fall regional forum from September to November this year, and then our NHMA annual conference, which is in Washington, D.C., in March. And for any information about our organization, our website is www.NHMAMD.org. We do have a website page on the Transforming Clinical Practice Initiative where you can sign up and get connected to CMS through NHMA so that we get credit on how many doctors we're referring to the program. You'd have free counseling and assessments of your practice. Whether you're a private-practice doctor in a clinic or a rural hospital, or you're in the academic world, you can have an assessment on how you can better transform the way you practice to a quality practice that makes sense for the Latino patients in this country. So thank you very much for what you do. Thank you.

Great. And thank you so much, Dr. Rios. And a special thank you to the National Hispanic Medical Association for being here with us today to learn about the Quality Payment Program. And, really, a thank you to all for your interest in today's discussion. It's always a privilege to have the opportunity to talk widely about the Quality Payment Program. And as such, we have assembled a nice overview of some aspects of the program that we're hoping that will help each of you as you progress through the 2017 transition year, which is really the first year of the Quality Payment Program. Our focus today is predominantly on the Merit-Based Incentive Payment System, which we'll refer to as MIPS as we go throughout our slides today. But we'll also mix in information on our Technical Assistance Initiative, as well as discuss at a very, very high level the recently-released proposed rule for year two of the Quality Payment Program. So let's get started. Let's move to the next slide, please. General disclaimers. One more slide. Great. Thank you. And this is just some general housekeeping before we really get into the meat of our discussion. As we noted earlier, there will be a Q&A session if time allows at the end. I did want to make a note, however, that we will just be doing a very, very high level overview of the proposed rule for year two of the Quality Payment Program, therefore we do need to protect the rule-making process, and certainly comply with the Administrative Procedures Act. So if there are any comments or feedback or recommendations for the proposed rule for year two, we ask that you share those comments with us through the formal process, as outlined under the Federal Register. And we'll talk a little bit about that process later on. We do have some step-by-step instructions for you, as well as where to go for resources. So we will talk about that in just a little bit. Next slide, please. So, we do have a robust discussion planned today. And this is just a general rundown of some of the topics that we intend on covering. We'll start with a nice overview of the Quality Payment Program. Just a basic understanding to really set the context for our discussion about MIPS. We'll talk more about the Merit-Based Incentive

Payment System -- specifically an overview of the participation requirements. We'll talk about some of the submission methods, individual versus group reporting. We'll talk about the performance categories under MIPS, and even get into some of the scoring at a very, very high level, and a little bit on the payment adjustments that clinicians can expect in 2019. We'll then move on to talk about technical assistance. Before technical assistance, we'll also give you some tips for really getting started for the 2017 transition year. Then we'll talk about the support that is available to all clinicians who are included and are participating. And then we'll move into talking a little bit about the proposed rule for year two. And hopefully, like I said, if time allows at the end, we'll take some questions. So let's move on and jump into our discussion. Great. Thank you. So, the Quality Payment Program, at a high level, really consists of two tracks for clinicians -- the Merit-Based Incentive Payment System, which we will discuss today, and Advanced Alternative Payment Models -- also known as APMs -- which we will not get too deep into. But there are a number of great resources available on qpp.cms.gov that are specific to Alternative Payment Models and Advanced Alternative Payment Models that I encourage each of you to review. We also have some upcoming webinars on the proposed changes to year two that are very specific to Advanced Alternative Payment Models, so we encourage you to take a look at those upcoming events and register if interested. One thing that I will say is that when we began developing this program, we took the opportunity to listen to you in settings similar to what we're in today. And we wanted to understand how each of you practice, how your practice is structured, and really the makeup of your patient population, as well. This way, we could develop a program with your help that really is patient-centered, patient focused, it helps to reduce burden, like I said, and it really puts the patient first. So if we move on to the next slide, as you can see, we have three foundational elements here, or what we like to call the bedrock of the Quality Payment Program. Of course, our intentions are to certainly bolster that high-quality and patient-centered care, so that's really the top of our bedrock here. And we are making sure that the patient is always put first, and that we're improving patient outcomes. And with any good program, we'll keep what has been working, but we will also continue to elicit feedback from clinicians, stakeholders, our partners, and others out in the field as a means of continuous program improvement. And that's where you see the useful feedback feeding into the continuous improvement to really complete the cycle, and that's how we will continue to develop the Quality Payment Program. And I think it's very important that everyone knows that the 2017 transition year represents the first step in the evolution of the program. And as such, we're still listening, and we're looking for ways to improve, to streamline the program, and really to reduce burden for clinicians. Next slide, please. As you can see, on this slide, these are our top considerations for the Quality Payment Program. If you've been with us on previous webinars, some of these may look familiar to you. Very quickly, very concisely, we're really looking to improve beneficiary outcomes, reduce burden on clinicians -- and I think we really attempted to emphasize this with our proposals for year two -- increase adoption of advanced APMs to move from volume to value, maximize participation in the program, improve data-information sharing, ensure operational excellence, and one that we're really working on throughout the remainder of this year, and certainly into year two of the program,

is delivering information-technology systems that really meet the needs of users. So, if we move on to the next slide, please. So now we're going to jump into our discussion on the Merit-Based Incentive Payment System. And, so, really, what is the Merit-Based Incentive Payment System, and what does MIPS do? So, if we go to the next slide, you'll see that MIPS consolidates three of the programs that you may all be familiar with, including the Physician Quality Reporting System, or PQRS, the Physician Value Modifier, and the Medicare EHR Incentive Program for Eligible Professionals. In essence, MIPS keeps the focus on quality and cost and the use of Certified EHR Technology without having three separate programs that essentially do the same thing and potentially add burden. I do want to take a moment, because I think that it is important to point out, to remind everyone that the Medicare EHR Incentive Program for hospitals and the Medicaid EHR Incentive Program will remain in place. And also, just so you are aware, the second graphic that you see on-screen is really just an example of how the PQRS program will phase out over the next two years, and how the legacy programs will phase out in general. We will talk about this in just a few minutes, because there are some nuances that I want to make sure everyone understands as we move forward. So, the next slide, please. So, there are four performance categories, as you can see on-screen, that comprise MIPS, and each have a different weight for the 2017 transition year. So, quality is weighted at 60%. Cost will be 0% for the transition year. Clinicians will not necessarily be assessed on cost for 2017. Improvement activities is worth 15% of the final score for MIPS. And advancing-care information is 25%. I do think it's important to note that the improvement-activities performance category is really the only new performance category for clinicians. So, if we move on to the next slide, I think this graphic will help depict what I mean. So, outlined on this screen, when we talk about quality under MIPS, it's very similar to PQRS. Cost is similar to the resource used or the cost-measurement side of the Value Modifier Program, of course with some elements of PQRS quality data mixed in. And the advancing-care information performance category is similar to the Meaningful Use Program, as it focuses on the usage of electronic health records. But just remember -- and I think this is important -- I use the term "similar" in this context as the performance categories are not necessarily identical to the former legacy programs. They just contain some elements. But there's enough there that I think there's some similarities that many of you will see as you begin participating, or if you are participating have already noticed. So, if we move on to the next slide. I mentioned that the legacy programs would phase out over time and be replaced by a single reporting program. We generally receive a number of questions wondering, "What will happen to expected payment adjustments from these programs?" And as you can see on-screen, the bottom line is that you will still receive your expected adjustments. And I encourage you to please take note of the time lines for these programs. I won't go through all of these, but they are outlined on-screen. And we will be posting these slides, so, of course, you always have these for reference. But please do take note of the three programs for the legacy systems. So, if we move on to the next slide. Breaking away from MIPS for just a second, I want to talk about a special nuance for the Medicare EHR Incentive Program that I think is important for each of you to understand. 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 EPs, those eligible professionals, who are first-time participants in 2017 have until October 1, 2017 -- I encourage you to circle this or write this down -- to avoid the 2018 payment adjustments. We note that 2017 is also the first year of the Merit-Based Incentive Payment System, which we're talking to you about today, which carries similar EHR reporting requirements to those of the Medicare EHR Incentive Program for Eligible Professionals. So, we've also received the question, "What is a first-time participant?" That's a very good question. So, we define first-time participants as those being eligible to previously attest but never did. So this is really the first year they are participating to try to demonstrate Meaningful Use. Also of note, eligible professionals that are brand-new to Medicare are automatically exempt from the EHR Incentive Program and do not need to file this hardship. So, as you see, as we move on to the second bullet point, which I think is very important, for first-time Medicare EHR Incentive Program participants in 2017, we at CMS are offering a one-time significant hardship exception for the Medicare EHR Incentive Program 2018 payment adjustment. Really to provide eligible professionals with ample time to collaborate with their EHR vendors, and to adjust to the new reporting requirements in the advancing-care information performance category under MIPS. And we'll talk about that category in a little bit. Really, our goal is to help those first-time participants successfully participate in MIPS for the 2017 transition year. And if we move on to the second screen, the next screen, a first-time participant, a first-time eligible professional may apply for this one-time significant hardship exception from the 2018 payment adjustment if -- all those criteria are listed on-screen. I won't go through them. I will just say please note the "ands" in between the bullet points. So these kind of work on top of each other. So, if an eligible professional meets these criteria for this one-time exception to the 2018 EHR Incentive Program payment adjustment, they will need to submit the 2017 Eligible Professionals Transitioning to MIPS Hardship application no later than October 1, 2017. Again, please note that. We note that this is only available for first-time eligible professionals in the EHR Incentive Program. So if you have previously participated in this program, you are not eligible for this one-time hardship exception. And just to make this easier, you can either click on this link or copy and paste this link into your browser. This will take you directly to that hardship exception. Moving on to the next slide. Moving back to MIPS, really. On-screen is really the typical performance and payment cycle. As you can see, we are currently under way in the 2017 performance year. And an important milestone still a few months away but on the horizon is the closing of the performance period and opening of the data-submission window. And this occurs January 1, 2018. That's when the submission window will open. Of course, all data must be submitted by March 31, 2017 to count for a payment adjustment in 2019. I just want to add that there is still plenty of time to begin participating. There are a number of participation options available to clinicians, which Dr. Wolfe will discuss shortly. But please, please, please know that it is not too late, and that we are all here to help you either get started or support those of you who are currently participating and working with your patients and capturing performance data for 2017. So, with that said, I will turn it over to my colleague, Dr. Ashby Wolfe, for a discussion on the MIPS program requirements. Ashby.

Thank you so much, Adam. And it's a pleasure to be with you all today. Thank you for joining us. As was mentioned, I am the Chief Medical Officer for Region 9 in CMS, and I also am a practicing family physician, continuing to see patients as part of my work with the agency. So, this information that we're going to be sharing, hopefully, is very practical for you whether you are a clinician or a practice manager to help understand the basics of participating in the MIPS pathway of the Quality Payment Program. So we're really going to build off of what Adam just shared, and break things down a little bit so that you can understand. So, here on the slide that you see in front of you, Slide 21, this slide provides information about who actually is included in this MIPS pathway. For the performance year, this year, 2017, clinicians participating in MIPS are those who are billing more than $30,000 a year in Medicare Part B allowed charges and providing care for more than 100 Medicare patients in that same year. And these clinicians are those types that you see on the bottom of this slide -- physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. So if you are one of these eligible clinicians and you meet the criteria at the top of this slide, you would be considered eligible to participate in MIPS. Now, on Slide 22, there is a very particular definition that Medicare has for "physicians." These include not only doctors of medicine and doctors of osteopathy, but also dentists and podiatrists and optometrists and, with respect to certain treatments, chiropractors. So, again, this is the Medicare definition of physician for those who are eligible. Now, let's change to the next slide. On slide 23, there's an example of what this really means. Let's talk about Dr. "A," who is a physician, and so therefore one of the eligible types of clinicians for MIPS. Dr. "A" in this example billed $100,000 in Medicare Part B allowed charges in one year, and saw 110 Medicare patients. Therefore, Dr. "A" meets both of these volume criteria" and is included and expected to participate in MIPS this year. So, the key point is that the given clinician must meet both the billing and patient volume criteria in order to participate. On our next slide, if you are like Dr. "A" and therefore included in MIPS, we are recommending that you actively participate this year in MIPS to possibly earn a positive payment adjustment to your Medicare Part B reimbursement in 2019. Not participating will result in a negative 4% downward adjustment to your reimbursement under Medicare Part B in 2019. Let's move to the next slide, and talk a little bit about who might be exempt or not included from MIPS. There are some exceptions, and those include, in the middle square here in Slide 22, those who do not meet the volume threshold that I was just mentioning. So, clinicians who bill less than or equal to $30,000 in Medicare Part B allowed charges or see 100 or fewer Medicare Part B patients -- if they meet either of those criteria, they do not meet the volume threshold, and therefore would be exempt from MIPS this year. There are also some clinicians that are just starting as Medicare-enrolled providers. These are folks, of course, who may be newly graduated from a training program, or for whatever reason have never enrolled as a Medicare provider in the past. These folks, if they're enrolled for the first time during this performance period, they are exempt until the following performance year. That allows these clinicians to get up and running with their practice, but also learn some of the expectations before they are required to participate. Finally, on the

right-hand side of the slide, there is a box related to Advanced Alternative Payment models, which is the second pathway of the Quality Payment Program that Adam mentioned previously. There are some clinicians who are participating in Advanced Alternative Payment models and seeing a significant number of their Medicare patients through those models. Those clinicians are exempt from participating in MIPS because they are already doing a lot of the work of MIPS in their Alternative Payment model. We're not going to talk about those particular clinicians today, but we do have a number of resources for clinicians who are participating in those kinds of models to understand what the expectations are. So, moving to the next slide, I do want to come back to this volume-threshold issue. And we'll illustrate it with Dr. "B," who is also one of the five eligible clinician types. He's either a physician, physician assistant, nurse practitioner, nurse anesthetist, or clinician nurse specialist. And Dr. "B" billed $100,000 in Medicare Part B charges in a given year. But Dr. "B" only saw 80 Medicare patients. Dr. "B" does not meet one of these two criteria, and therefore Dr. "B" is exempt from MIPS. So, let's move to the next slide. If you are like Dr. "B," and if you are exempt, you may actually choose to voluntarily submit data to CMS as part of MIPS in order to simply prepare for future participation. However, if you are voluntarily participating, you're not require to participate, you will not qualify for any payment adjustments based on your 2017 performance. But we do believe that voluntarily participating will help you prepare for future years if you become eligible. So let's move to the next slide. And based on the eligibility criteria that I just discussed, there are some important special considerations and flexibilities that we're going to review in the next few slides. So, on Slide 29, if we flip to the next slide, you'll see that there are particular considerations for clinicians who participate or practice in rural health centers and federally-qualified health centers. Clinicians who are billing under either their rural health clinic or FQHC payment methodologies are actually not directly billing Medicare Part "B." Therefore, they are not subject to the MIPS payment adjustments. However, there are clinicians who practice in a number of different settings, and may not be exclusively practicing within either a rural health clinic or an FQHC. They very well might be practicing additionally in a hospital, where they might be dealing Part "B." So, for clinicians, the takeaway here is that this program is clinician-specific, and clinicians who do bill Medicare Part "B," regardless of where they're practicing, may be required to participate in MIPS, and might be subject to the payment adjustment. So we strongly recommend that clinicians and practice managers take a look at how they're billing, and understand where they may or may not be eligible. On the next slide, we're going to talk specifically about clinicians in other specific facilities, namely critical-access hospitals. For clinicians who are practicing in these kinds of facilities, there are a few different ways that they bill. And for clinicians who are in box one here on Slide 30, they are practicing in method one. That means that the MIPS payment adjustment would apply to payments made and charged under Medicare Part "B." It would only apply to the MIPS-eligible clinicians. Any payment adjustment under MIPS would not apply to the facility payment that is directed towards the critical-access hospital itself. But there is a second methodology in billing critical-access hospitals, and for clinicians who are practicing in method two, where they have assigned their billing rights to the critical-access hospital, the MIPS payment

adjustment may apply to these method-two payments. Finally, there are some clinicians who are practicing in method two, but they have not assigned their billing rights to the critical-access hospital. In that case, the payment adjustments under MIPS would apply in similar fashion to box one. Now, there are some subtleties here. And so if you are a practice or a clinician who is practicing within a critical-access hospital, we would definitely recommend that you take a look at which method you're using to bill, and if you have questions that you contact us. And we have our contact information at the end of this presentation to answer some of those practice-specific questions. Let's move to the next slide and talk about another special consideration for clinicians who are hospital-based. Now, we define hospital-based MIPS-eligible clinicians as clinicians who provide 75% or more of their covered professional services in a place of service that is either an inpatient hospital, which is place-of-service code 21, an on-campus outpatient hospital, which is place-of-service code 22, or emergency room, which is place-of-service code 23. And of course these are based on claims. Of course, the hospital clinicians are subject to MIPS if they are deemed eligible and they exceed the volume thresholds we were discussing previously. But there are some flexibilities for these hospital-based clinicians where they do qualify for some re-weighting of particular performance categories. And we're going to talk specifically about that in a few slides. On Slide 32, there are also some additional considerations for clinicians who are deemed non-patient facing. These are, of course, clinicians that may include pathologists, certain types of anesthesiologists or radiologists. These folks are not exempt from MIPS, but they have more flexibility in what they are required to do if they meet these volume thresholds. With respect to this designation an individual clinician is considered non-patient facing if they have fewer than 100 patient-facing encounters in the performance period. So, let's go ahead and move to the next slide. And at this point, we've reviewed much of who's eligible to participate in the MIPS pathway of the Quality Payment Program this year. But let's move on to what options clinicians have to participate in this program. So, you'll see on Slide 34, we have a wide variety of ways that clinicians can participate, and we call this picking your pace for participation in MIPS for this transitional year, where we're transitioning away from the legacy programs of PQRS and Medicare Meaningful Use that Adam mentioned, and we're transitioning into the Quality Payment Program and MIPS. Now, for clinicians who are participating in MIPS this year, there are three different ways that they can participate. They can choose to test the new program by simply submitting some minimal amount of data. They can also choose to participate for part of the year or for the full calendar year this year. Not participating at all will result in the negative 4% payment adjustment that I mentioned earlier. Now, you'll also see here on Slide 34 that, on the left-hand side, there is a column related to Advanced Alternative Payment models. There are some practices that may choose and be eligible to participate in the Advanced Alternative Payment model pathway, but that's not what we're going to be addressing today. So, again, if you are one of those clinicians that think that you might be participating in an Advanced Alternative Payment model, we would definitely recommend that you contact us so we can walk you through your options and provide you the resources that we have available on our website. But getting back to pick your pace. Let's move to Slide 35, and

we're going to go through each of these options for what clinicians can do this year to participate in MIPS. So, clinicians might choose to simply test this new program and submit a minimum amount of their 2017 data to CMS. In doing so, if you test the system this year, you will avoid any negative payment adjustment in 2019. And it will give you an opportunity to gain familiarity with MIPS and with the Quality Payment Program. What does this "minimum amount of data" actually mean? It means submitting one quality measure or one improvement activity or either four or five required advancing-care information measures. And that four or five depends on which Certified EHR edition you're using. We are going to go through each of these performance categories in detail. But, again, the minimum amount of data is shown here on this slide. That will allow you to test the program this year and avoid a negative payment adjustment. Now let's move to Slide 36, where we're going to talk about the other two options -- either partially or fully participating in the program this year. There isn't any set difference, really, between participating for part of the year or a full year. But I would call out to you that "part of year" means participating for at least 90 days, where you submit at least 90 days of data from your performance this year. And again, this 90-day window can start any time between the first of the year and October 2nd. October 2, 2017 is the start of the last 90-day period in this calendar year. By participating for part of the year you may earn a positive payment adjustment to your 2019 Medicare Part B reimbursement. If you choose to participate for the full year, you would submit a full year's worth of data. And, again, you would have the opportunity to earn a positive payment adjustment. We do recommend that practices participate to the fullest extend that they are able in order to gain familiarity with the program and prepare for future years. So, moving on to the next slide. We've covered some of the expectations and flexibilities for participating in MIPS this year, but let's review specifically what options practices have for sending in this data to CMS. So, Slide 38 provides some options. Eligible clinicians have two options for participating in MIPS. They can participate individually, meaning the clinicians reports under a unique tax identifier and a unique national-provider identifier. Alternatively, they can participate as a group, meaning that two or more clinicians with a unique national-provider identifier have reassigned their billing rights to a single tax-identification number. And if clinicians choose to participate in this manner as a group, they are assessed as a group across all four MIPS performance categories that Adam mentioned earlier. Let's move to Slide 39. And it provides a little bit more practical information about what this really looks like. So, again, as an example, this slide really reviews the options for clinicians to participate, either as an individual or as a group. We see the difference between Dr. "A," Dr. "B," and a nurse practitioner who are participating individually. Some are exempt based on their volume threshold, and others are included in MIPS this year. You can see that on the left-hand side of Slide 39. However, if Dr. "A," Dr. "B," and their nurse practitioner decide to participate as a group altogether, they would all be included in MIPS since we analyze their eligibility at the level of the tax-identification number. So you can see their exemption status and their inclusion status is different depending on how they choose to participate. Let's go ahead and move to the next slide. And with respect to sending in your data to CMS, there are many different submission methods. For those of you who have

been participating in PQRS, Medicare Meaningful Use, or the Value Modifier Program in the past, you will probably recognize some of these submission methods, as many of them are similar. There are many different ways to send in your Quality Improvement activity and advancing-care information data to us, and we wanted to provide flexibility given the fact that a lot of practices have used multiple different submission methods in the past. Your options really vary depending on how you choose to participate -- either as an individual or as a group. And just take note that across all three performance categories, there are some submission methods that are consistent across all categories. These include the Qualified Clinical Data Registry option, the Qualified Registry, or via EHR. Let's go ahead and move to the next slide, which is really move for your information. I'm not going to read this slide in its entirety, but it is one that provides additional detail and definitions of each submission method and how it works. So feel free to review this with your practice as you decided how you would like to submit performance data. Let's go ahead and move to the next slide. And at this point, in summary, we've reviewed which clinicians are included in the performance here of MIPS this year. We've discussed the various ways that clinicians can participate by picking their pace of participation, and we've discussed how clinicians can submit their performance data to CMS. So now let's actually review what data we're talking about. We're going to step into reviewing each of the performance categories of MIPS. And this, again, is actually the data that clinicians and practices are capturing and submitting as part of this program. So, here on Slide 40, you will see the MIPS quality performance category. And as Adam mentioned earlier, there are four performance categories, and we're going to go through each of them in turn. Quality represents 60% of a clinician's or a group's final score in MIPS in 2017. And again, that final score is determining your reimbursement under Medicare Part B in 2019. Now, quality really deals with the quality of care. There are process measures. There are also outcome measures as part of this category. And there are over 270 quality measures that are available for clinicians to choose from. Now, these measures didn't come out of thin air. These have been developed in collaboration with stakeholder organizations like the National Quality Forum, clinician societies including primary care, and specialty medical societies, as well as a number of other societies that are measure-development organizations and have been working in the quality-measurement space for many, may years. So these are quality measures that may actually look familiar to you. And many, actually, are also currently in use in the PQRS and Medicare Meaningful Use Program. So these are not measure that are coming out of the blue, but there might be some that are more pertinent to your clinical practice now, as we've really worked hard to focus on developing measures that both look at process and outcome of care. So, for clinicians to participate in this category, they should select six individual measures, and one must be an outcome measure or high-priority measure. Again, we're focusing on both outcome and process in the MIPS program. Clinicians may also select, actually, a set of quality measures. And we have made again some similarities in this category related to PQRS to provide an easier transition for those who have some familiarity with reporting. So, let's move to the next slide, because depending on how you're going to participate in 2017, you may not necessarily need to report six quality measures. If you're only going to test the system this year, you need to

submit one quality measure. If you are going to participate for part of the year -- that's at least 90 days -- or the full year, you need to be submitting at least six quality measures. Now, we have this list of measures on our website, and we even have a shopping list where you can search the measures by keyword, by clinical practice type, specialty, and even by data-submission methods. So we strongly recommend that people go to our website and take a look at this particular page to get familiar with what quality measures might be most pertinent to your clinical practice. Let's go ahead and move to Slide 45, and we'll talk about the second of the four performance categories in MIPS -- that of cost. Now, as Adam mentioned earlier, this is one of the performance categories this year, but we are not going to count it for or against a clinician's final score this year. So cost will have no bearing on a clinician's reimbursement in 2019. However, the MACRA legislation does require us to look at cost in future years, and so this year CMS is going to be providing feedback to clinicians and practices on how they performed in this category this year so that clinicians can get familiar with what their cost in their practice looks like. Again, this is similar in some ways to the legacy program the Value-Based Modifier. And for clinicians who have previously participated in PQRS and the Value Modifier, we would recommend that you take a look at your quality and resource-use report, or QRUR, which provides feedback on those legacy programs, and it may provide you some information about how things look now in preparation for your participation in MIPS this year. Let's go ahead and move to Slide 46, and we will talk about the third performance category in MIPS, which is improvement activities. Now, as Adam mentioned earlier, this is a new category. We have not had a category like this in our legacy program. And I like to think of this category as, in some ways, giving credit where credit is due. A lot of us, as clinicians, do things to improve our patients' experience in care and their outcomes in care on a daily basis. We may be reorganizing our appointment schedule in order to accommodate same-day or urgent-care needs. We may be working with a care coordinator or a care manager in order to really help manage our most complex patients. We may be using a checklist in order to prepare a patient for a procedure, and we're using that checklist to make sure that patients are prepped the same way every time to ensure adequate patient safety. All of these and more are activities that you can get credit for in MIPS through the improvement-activities category. And you'll see here on Slide 46 that there are over 90 different activities in nine different categories that you can choose from. So, we would, again, highly recommend that folks take a look at our website, because, again, you can search these improvement activities to find which activities match up with your clinical practice and your scope of practice. It's very possible that you're already doing something that's on this list of 90 activities, and clinicians have the flexibility to choose what they would like to submit as part of their participation in this category. Now, you'll note here on Slide 46 that one of these categories is participation in an Alternative Payment Model. And let's move to Slide 47 to talk a little bit more specifically about what that means. There is special consideration within this performance category for clinicians who are participating in patient-centered medical homes, comparable specialty practices, or Alternative Payment Models that are designated as a medical-home model. Those practices will automatically get full credit in this category. Additionally, there are some more flexible requirements for reporting for

those smaller practices with 15 or fewer clinicians, or if clinicians are in a rural or health-professional-shortage area. You have to simply provide information about two improvement activities. Other groups, larger groups, must report four activities. So there is some flexibility there for practices that are smaller in size. Again, on the bottom of Slide 47, you'll see that there also are some special considerations for participants in certain other alternative payment models, such as the Medicare Shared Savings Program Track 1 and the Oncology Care Model. These clinicians will automatically receive points in this category based on their participation in this Alternative Payment Model. Let's go ahead and move to the next slide to provide some additional context for what this category means depending on how you pick your pace. For clinicians who are choosing to test the system this year, that means you can simply pick one improvement activity and attest to that activity, that you have been doing that activity for 90 days. If you'd like to go ahead and try to participate more fully and go for a possible positive payment adjustment based on your performance this year, you can attest to a variety of combinations of improvement activities. And that's show here on the right-hand side of Slide 48. Again, for a full list of improvement activities and options, you can go to our website, which is listed here on the bottom of the slide -- qpp.cms.gov. Now let's go ahead and move to discussing the final performance category in MIPS -- that of advancing-care information. Now, unlike the improvement-activities performance category, which is a new category, clinicians and practices may be more familiar with the components of advancing-care information as it is similar to the Medicare EHR Incentive Payment Program, more commonly known as Medicare Meaningful Use. So, on Slide 49, you'll see that advancing-care information represents 25% of a clinician's final score in MIPS this year. And the goal is to really promote patient engagement, as well as the use of Electronic Health Record technology. But there are some important differences between advancing-care information and the legacy program of Medicare Meaningful Use. For example, this performance category is not exclusive to physicians. In the Medicare Meaningful Use Program, only physicians were required to participate. But in the advancing-care information category of MIPS, it applies to all eligible clinicians participating in the MIPS program, either as an individual or a group. Additionally, advancing-care information eliminates the all-or-nothing reporting criteria that was a part of Medicare Meaningful Use. And instead what we've done is replacing that requirement with a greater degree of flexibility so that clinicians can choose the measures that fit their scope of practice and their patient population. At the bottom of Slide 49, here, you will see there are two measure sets that clinicians can choose from depending on their Certified EHR edition. We have the Advancing Care Information Objectives and Measures, which is pertinent to the 2015 edition of Certified Electronic Health Record Technology. We also have a transition-measures set, which is pertinent to those using a 2014 edition of Certified Electronic Health Record Technology. So, moving to Slide 50, you will see this is laid out more visually for you so that you can better understand which measure set you might want to choose to report. So, again, you must use Certified EHR Technology to report in this category, and depending on which edition you're using you can use the various options here. The transition-measures set on the right-hand side was really developed to help those with certified technology that is 2014-edition to participate. So, let's move to Slide 51 to remind

ourselves what this means if you choose to either test, partially participate, or fully participate this year. So, if you choose to test the system this year, you need to submit the four or five required measures in the advancing-care information measures set, again depending on what Certified Electronic Health Record Technology edition you are using, either 2014 or 2015. If you're going to participate more fully, either for 90 days or for the full calendar year, you need to do more than just the required measures. And so we have information about the expanded opportunities to submit performance measures and actually gain bonus points in this category on our website. Let's go ahead and move to the next slide. And we'll pull all of this information together to discuss what this really looks like. But first, I want to provide some additional information about flexibility in the advancing-care information category. You will see here on Slide 52 that there are two different boxes related to clinicians who may not have total control over their EHR. And there are some important flexibilities here pertinent to hospital-based, non-patient facing, or non-physician clinicians who are participating in MIPS this year. If that's you, box number one applies to you. In this case, clinicians will have their performance in advancing-care information automatically re-weighted to 0% of their final score. Again, that will happen if you're a hospital-based, a non-patient facing clinician, or a non-physician clinician since you were never required to participate in Medicare Meaningful Use in the past. So, again, the category will be re-weighted to 0% of your final score, and the 25% that used to represent this category will go into quality. So, quality for these physicians will be 85% of their final score, and advancing care information will be 0%. Now, in box two, here, on the right-hand side of your slide, there are also clinicians who may not be the type in box one that would automatically get a re-weighting, but clinicians can apply to have this category re-weighted to zero and have that 25% be a scientific quality category if they have a particular reason for hardship, and those reasons are listed here on the right-hand of Slide 52. Number one -- insufficient Internet connectivity. We do know that there are areas of the country where there is inconsistent access to broadband Internet, and so that is one way that clinicians could apply to have their performance category score re-weighted to zero. A second reason may be extreme and uncontrollable circumstances. A third could be lack of control over the availability of a Certified Electronic Health Record Technology. So, again, there are some flexibilities here to account for the fact that we are still in the process of implementing Electronic Health Record Technology across the country. And we do have more information about this and how you might participate in these flexibilities on our website. Let's go ahead and move to the next slide, and transition into really pulling all of this information together, and see how these performance categories together affect a clinician's final score. So, on Slide 54, if we can flip to the next slide, when calculating the final score, CMS is taking information from each of the performance categories I just described, and we are bringing them all together and multiplying the score for each performance category. The final score from your MIPS performance this year, 2017, will determine your practice's reimbursement under Medicare Part B in 2019. So, again, out of 100, a clinician's final score would determine their reimbursement under Medicare Part B. Now let's move to the next slide to break down this final score and see where things fall. So, as we mentioned, if you do not participate at all in

MIPS this year, you will earn zero points, which means that you will be subject to a negative payment adjustment of 4% for your reimbursement in 2019. If you participate at the minimum level, if you choose to test the system, you will earn three points, which will allow you to avoid any payment adjustments in 2019. But if you choose to do more than the minimum, you have the potential to earn greater than three points, and depending on how many points of your final score you earn, you will be eligible for positive payment adjustments. I do want to call your attention to those who are considered exceptional performers. If you earn greater than 70 points in your final score, you may be eligible for what we're calling an exceptional performance bonus, which would be a minimum of an additional .5% payment adjustment, an increase to your 2019 Part B reimbursement. Let's go ahead and move to Slide 56. And in reviewing all of this information, it can be overwhelming. We do understand this is a big change for many practices who may have just been getting used to the legacy programs of PQRS and Medicare Meaningful Use. So, as a result, in the next few slides, I'd like to take you through a few steps that are key to getting started in MIPS. And here on Slide 57, we do really recommend clinicians start by determining their participation status. This spring, CMS sent letters to clinicians to identify for them who is included in MIPS and who is exempt. These letters were sent at the level of the tax I.D. number rather than to individual clinicians. So, it's most important for clinicians to check in with the representative of their practice to see where that letter went. And as this slide shows, these letters were mailed starting in April, but we do believe that some clinicians are only just receiving their letters now. On Slide 58, you'll actually see a screen shot of what this clinician participation letter looks like. And the most important information was designed to come first, providing information about why clinicians are getting this letter and what they need to do. On the following slide, Slide 59, this is the second portion of the participation letter, which also details what to do if the clinician or practice is participating in an Alternative Payment Model. Which, again, as I've been mentioning, is the other pathway in the Quality Payment Program. For clinicians who may fall into this category, we highly recommend that they verify their status with whatever Alternative Payment Model they are participating in. But of course, if you do have questions, you are always welcome to contact us. This clinician participation letter does have the contact information at the end of the second page. And, again, we're going to provide that contact information at the end of this presentation, as well. On Slide 60, there's also an important attachment that came along with the clinician participation letter which explains specifically which clinicians are included in MIPS and who should actively participate. And this attachment identifies who is included and who is exempt. It lists each clinician by national provider identifier associated with the tax I.D. Let's go ahead and move to the next slide. And for clinicians who may not have seen this letter or would like to verify the information that was in the letter, you can track your participation status online by going to qpp.cms.gov. And right on that homepage you can enter an NPI number and click "Check Now," and it will provide information about that National Provider Identifier status combined with its associated tax I.D. numbers. Let's move to the next slide. And this checklist is really meant to serve as guidance to clinicians who are looking to get started and prepare for participating in MIPS this year. Regardless of your level of experience

in past reporting programs, we believe that clinicians will be successful in participating this year. And again, this checklist is really meant as a guide to help clinicians get started. It's not meant to be prescriptive, and there are certainly additional resources that we have available, which we will describe in the next few slides. But we do want to call out that it is important to consider your practice's readiness, and your practice's ability to report. Picking your pace, as we've discussed, is an important part of preparing. And choosing what your submission method may be, and whether or not you'd like to use your EHR, if you have one, to report that information. And with that, I will go ahead and turn it back to Adam to talk a little bit about our technical assistance program, and how you can get help with choosing what measures you would like to use to participate in this program and some other details. So, Adam, I'll turn it back over to you.

Great. Thank you so much. And before we jump into the technical assitance component, I've been trying to monitor the chat as we've been going along, and there's one question that I saw trending for a little while, so I did want to address that very quickly before we move off of the actual criteria for MIPS. So, the question really is, "What's the difference between 90-day reporting versus a full year's worth of data?" And, very simply, there's really nothing built into the program that would give a MIPS-eligible clinician a lower score payment adjustment based only on reporting data for a 90-day period. So, we, CMS, we're evaluating the overall performance on the data that is submitted, regardless of whether the time frame is 90 or 200-plus days. Full-year participation is generally a better way to earn the maximum MIPS payment adjustment because it provides clinicians with more measures to select from and the opportunity for bonus points. And reporting for a full year also helps to enhance the reliability of those data being reported. However, a MIPS-eligible clinician could earn a high final score at 90 days, or at the partial pace, and still receive a positive payment adjustment, or even the maximum payment adjustment. So I just wanted to kind of tackle that question -- because I did see it coming up quite a bit in the chat -- before we moved on. So, this next section, we're kind of in the home stretch now. I want to talk a little bit about the technical assistance, and really the support that is available for clinicians who are included in the program and need to actively participate in the 2017 transition year. So, as you can see on-screen, this is a nice little organizer of all the various types of support that we have available. I'm just going to spend a few minutes trying to break this down a little bit. So, in the bottom, right-hand quadrant of the screen, I think that's one of the best starting points -- just kind of the general technical support that's available. So, that includes the Quality Payment Program -- so qpp.cms.gov. There's a lot of great resources out there. Certainly under the "About" and "Resource" section, we have a number of great educational resources. There's also links to all of our previous webinars so that you can take a look at some of the other focus areas that we've had on the Quality Payment Program throughout the year. Of course, if you have questions, please feel free to contact the Quality Payment Program at the number you see on-screen, or send us an e-mail at qpp@cms.hss.gov. For those of you who may be participating in an Alternative Payment Model or an Advanced Alternative Payment Model, the Center for Medicare and Medicaid Innovation have the

APM learning systems. So that will provide support for those who are in those various models. For those who are participating in MIPS in 2017, we do have three branches of technical assistance that we'll offer you. I'm going to go counterclockwise, so starting with small practices. So, those practices with 15 or fewer clinicians. We have the Small, Underserved, and Rural Support program, so they're available to assist those smaller practices. And then for larger practices, practices with greater than 15 clinicians, we have our very, very experienced Quality Innovation Networks and Quality Improvement Organizations. And I will say, all of these branches are made up of experienced and professional organizations that have a deep history with CMS on our various reporting programs, our Quality Improvement initiatives. These organizations have worked with us for a number of years. They truly understand the requirements, and they're out there and they're able to assist you. Finally, the Transforming Clinical Practice Initiative really, for those clinicians, those practices that are participating in MIPS but are interested in ultimately moving toward an Alternative Payment Model, that are interested in large-scale practice transformation, for the Transforming Clinical Practice Initiative, clinicians would enroll with a Practice Transformation Network. We have 29 of them throughout the nation. So, you enroll with a Practice Transformation Network. And I just want to note that there is a bit of a time and data commitment, so please take that into consideration as you're kind of looking through the available options. For more information, there's a great resource guide on qpp.cms.gov. We've included the link on this slide. It really outlines everything that's available, as well as provides direct contact information to all of these branches of technical assistance. So if we could move on to Slide 65, please. So, breaking down technical assistance a little bit more. Technical assistance essentially depends on how you as a clinician participate in the Quality Payment Program. Again, as we mentioned with the APM Learning Systems, clinicians who are participating in Advanced APM and earn qualifying APM-participant status, they'll receive support through the APM learning systems, generally, through model inboxes. Again, clinicians participating in MIPS may receive support through TCPI via the Practice Transformation Network. We do have the other two branches, as well. Again, please note that we've established them based on practice size. So, again, Quality Innovation Network, Quality Improvement Organizations are for larger practices, those with more than 15 clinicians. And the Small, Underserved, and Rural Support are for practices with 15 or fewer clinicians. We also have a nice program in place whereby clinicians who may be a part of an APM but also potentially may be required to participate in MIPS for the 2017 transition year, they are also eligible to receive technical assistance through either the QIN-QIO's or the Small, Underserved, and Rural Support. Again, that is depending on practice size. So any APM-related, Advanced APM-related answers can go, and they'll be answered through the APM learning systems, and then the other branches will take care of your MIPS-related questions. I do want to mention a few other things on this slide about technical assistance. We have employed an integrated approach with kind of high-level shared goals. So we have shared goals for technical assistance, and those include consistent exceptional customer service, so all of our technical assistance organizations are well-versed in customer service. We also have a "no wrong door" approach. And I think this is important to really talk about because, since there are a number

of resources available, you may not necessarily know where to start. But reaching out to any one of these branches of technical assistance will be fine, because even if it's not the best fit for you based on your long-term goals, maybe how you want to participate this year, or even your practice size, our technical assistance organizations are working together to get clinicians where they need to go. They'll certainly help you triage your question at first, get you on the right path, but then they're also going to make sure that you are placed in good hands, and that you're with the right form of technical assistance. Also, another significant goal from CMS was that we are attempting to ensure that 100% of clinicians that are included in the Quality Payment Program have access to this technical assistance. So, again, no matter where you go, no matter what you're looking for, you will have access to some form of technical assistance. And just one additional note: we've had a few questions on the time frame for this form of assistance, and I would be remiss if I didn't remind everyone that this is no-cost technical assistance to clinicians. This is no-cost. Free. So we encourage you to take advantage of it as soon as possible. All of our organizations are out there, they're working, and they're waiting to hear from you. And they may even be reaching out to you within the coming days and weeks and months. But so for 2017, our technical assistance is available to clinicians throughout the entire year. In many cases, as you will soon see, our Technical Assistance Initiative for the Quality Payment Program will extend into future years, as well. Of course, at the end of the year, we'll see what's working, what's not, and we'll adjust accordingly, but our plan is to continue offering technical assistance for the Quality Payment Program throughout the entire year, and certainly into future program years, as well. So if you need the assistance, it will be there for you. Moving on to the next slide. Just a quick run through of our Small, Undeserved, and Rural Support Initiative. This was launched a few months ago. It is a five-year technical assistance program that was authorized under the Medicare Access and CHIP Reauthorization Act, many of you know that as MACRA. Again, it's designed for small practices -- those with 15 or fewer clinicians -- and that includes practices that are in rural locations and health-professional-shortage areas, and certainly medically-underserved areas. As you can see on the screen -- I won't go through all of the support that's available -- but our organizations are ready to come to help you out however you need, whether that's one-on-one support, or maybe it's just a phone call or an e-mail. But again, the support is available immediately, and it is free to clinicians in small practices. And, of course, that extends to, really, all practices. And I encourage you, as you see these slides and you begin to explore this form of technical assistance, please help us spread the word. We'd like to get as many clinicians the assistance that they need. So, if we can go to the next slide, please. Again, sticking with the theme of Small, Underserved, and Rural Support, this is a coverage map. We have 11 organizations. They are experienced. They are professional. Many have worked with us before on a number of programs. But these are the areas that they cover throughout the nation. As you can see, it is well-covered. So if you see your state on there and you're in that state, just locate your technical assistance organization, and they'll be more than happy to get you started and work with you. Of course, if you just need general information or just some help getting connected, you can reach out to our central support contractor, qppsurs@impaqint.com. They'll also help you

get connected to the right technical assistance organization. So, one more slide, please. And I did want to call attention to this as many of you begin exploring qpp.cms.gov. We do have a new page dedicated to small and rural practices. That page contains contact information for our Small, Underserved, and Rural Support technical assistance organizations, and it also highlights the available options for small practices, especially those in rural and underserved locations. As you can see on-screen, there is an interactive map on that page. Again, all you have to do is select your state and the information for your local technical assistance organization will pop up. So, we're going to move on to the last few slides today. And this is really talking at a very, very high level about the proposed rule. So, before we transition to the question-and-answer, we'll take a minute just to talk through this. This is really more for everyone's awareness, that we have issued a proposed rule. It is important to remember, however that we are currently in the midst of the first performance year. And I certainly encourage everyone on this call who is included, who is participating to really remain focused on 2017. So if we go to the next slide. For Year 2, which is 2018, we are proposing a few changes to the MIPS side of the program. So, some examples include -- we have proposed to raise the low-volume threshold, implement virtual groups as a participation option, add additional flexibilities for small practices, including bonus points and a new hardship exception. We've proposed to adjust performance threshold, add some other bonus points aside from small practices, adjust some of the scoring methodology, and much more. This is certainly not an exhaustive list, and we have several areas of the proposed rule on which we are seeking public comment, so we encourage you to review the proposed-rule materials, including the rule itself and the accompanying fact sheet, both of which are available on qpp.cms.gov. Of course we want to hear from all of you. Your feedback was extremely valuable in helping us to shape the program for 2017, so we want to hear your thoughts and recommendations on our proposals moving forward. You have the opportunity to comment over the next few weeks. The comment period for the proposed rule does close on August 21, 2017, which is a Monday, I believe, so please circle that on your calendar. And again, you must submit comments through the official submission process for them to be considered. That process is outlined below. Of course, for additional information, please go to qpp.cms.gov. And also we have our various lines of communication. Our technical assistance organizations are also available to help. Okay. So, that should wrap up that section. We're going to move on to Q&A. I know we don't have a lot of time remaining, but to ask a question please use the below phone number. Again, as you're dialing in, or if we take questions from the chat, I just want to remind everyone that we won't necessarily comment on the proposed rule. We're happy to answer questions on the 2017 transition year, and really on all the information that you just learned. Again, we do have to protect the rule-making process. So, please, if you're interested, submit your comments through the official submission process for the proposed rule. With that, I think we're going to go into the Q&A. And I didn't know if there were any questions we'd want to pull from our chat box. I know we've had a pretty good discussion going on over in the chat box, as well if we have anything on the line. But we can move into that right now.

Stephanie, are there any questions on the phone line? Okay. We can start with a couple questions in the chat box. The first question -- "For testing only, I was told that you only have to report one measure one time for one patient. Is this correct?"

So, for testing, for the quality performance category, it could be as little as one patient one time. Of course, for the improvement activities performance category, it would be attesting to one improvement activity, and typically those activities will generally be around the 90-day time frame, just so everyone is aware. And then, of course, for the advancing care information performance category, it would be the four or five base measures, depending on your edition of Certified EHR Technology.

Adam, this is Ashby. I'd like to add to that. Because one of the things that I think is important for practices to keep in mind is that you may choose to do as little as reporting on one quality measure related to one patient one time, but while that will allow you to test, and technically allow you to earn three points, it won't really give a practice a lot of practical information or experience in the program this year. And as Adam mentioned, we are continuing to move forward with our proposals for what next year's MIPS will look like, and so our suggestion would be that practices really look at not only getting familiar with the program this year, but really participating to the extent possible in order to gain familiarity with the program and actually obtain useful feedback that could become part of a practice's own quality improvement processes.

Thanks, Ashby and Adam. The next question -- "Is a CRNA working only in a Critical Access Hospital exempt from MIPS?"

So, this is Ashby. Thank you for that question. And as we spoke to earlier, eligible clinician types include certified registered nurse anesthetists. Now, depending on your practice setting, there may be some subtleties to whether or not that clinician is eligible, particularly if they are choosing to participate as an individual. However, the underlying point that I want to make in response to that question is that MIPS and the Quality Payment Program at large is a clinician-specific program. It's not a facility-specific program. So, regardless of where you practice, if you are one of the five eligible clinician types this year and you bill Medicare Part B, it is worth checking in with the representative of your practice group to see whether or not you're required to participate. And again, you can also look up your participation status through our website at qpp.cms.gov.

Thanks, Ashby. Deirdre, do you want to open the phone line for any questions?

We do have a question from Karen Pope.

Okay.

Karen, your line is open. Please go ahead.

Okay. We have a physician that has retired in July, and he had reached 100% of the MIPS quality measures, or whatever you want to call it, and

he will be participating part time at a different facility from us. Do we need to go ahead and report at least 90 days for him so that he doesn't have any penalty in 2019?

So, this is Ashby. I would say that for practice-specific questions like these, a lot of them we recommend either e-mailing us or calling our service center, because sometimes there are subtleties where we can't actually answer the specific question you have or follow up on a question in a forum like this. So, as you can see on slide 72, there is the e-mail address qpp@cms.hhs.gov, as well as the phone number. However, in general, if clinicians are participating in MIPS as a group, we would recommend that practices report data based on whatever performance period they're going to use. So if you're going to use a 90-day or more time period to participate in the program this year, we would definitely recommend including all MIPS-eligible clinicians in the data that you submit. And we can certainly help you in terms of providing technical assistance with respect to how you're going to submit that data and which measures you're choosing. So, again, I think for that practice-specific question, we'd be happy to follow up with you, and certainly you're welcome to send us an e-mail so that we can dive into the details.

Okay. Thank you so much.

Great. Thank you. That's all the time that we have for today. I do want to thank, again, Dr. Rios, Dr. Ashby Wolfe for being here with us today. Please be on the lookout for additional education and learning opportunities in the near future. Thank you. Thank you, thank you, thank you so much, and we hope to speak with you again soon.

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