Centers for Medicare & Medicaid Services (CMS)

MIPS Group Participation 101 Webinar

Held on May 11, 2017

>> Hello and thank you for joining today's webinar on group participation in the Merit-Based Incentive Payment System. Today, Lisa Marie Gomez, health-insurance specialist in the Center for Clinical Standards and Quality at CMS, will highlight important information about the group's participation in MIPS, including individual versus group participation, group-participation requirements, performance category measures, data submission mechanisms, payment adjustments, and dates to remember. After her presentation, you will have the opportunity to ask questions. Lisa Marie will be joined by various subject-matter experts, who will be available to answer questions, as well. The subject-matter experts will answer as many questions as time allows. Any questions not answered on the phone should be directed to the QPP Service Center. You can listen to the presentation through your computer speakers and ask questions using the chat box. You can also use your phone number, provided later in the webinar, to ask questions by the phone. The slides, recording, and transcript from the webinar will be posted on the Quality Payment Program website in the next week or so. I would now like to introduce today's presenter, Lisa Marie, you may begin.

>> Thank you very much. So, as noted, we will be discussing topics relating to individual and group participation, group-participation requirements, performance category measures, data submission mechanisms and checklists, deadlines, and we'll also have a Q&A session. So, we will go on to the next slide, in relation to getting into the actual depths of information here. So, let's start with slide number 5. So, here, we're going to discuss the Quality Payment Program today. The Medicare Access and Chip Reauthorization Act of 2015, or MACRA, consolidated components of three existing programs -- the Quality Payment Reporting System, the Physician Value-Based Payment Modifier, and the Medicare Electronic Health Record, or EHR, Incentive Program for Eligible Professionals. Under the Quality Payment Program, clinicians can choose how they want to participate in the Quality Payment Program, based on their practice size, specialty location, or patient population. The Quality Payment Program has two tracks -- the Advanced Alternative Payment Models and the Merit-Based Incentive Payment System or MIPS. If a clinician or group participates in an Advanced APM, then may earn a Medicare incentive payment for participating in an innovative payment model. If a clinician or group participates in traditional Medicare, they earn a performance-based payment adjustment through MIPS. Next slide, please. So, under MIPS, there are four connected performance categories that will affect Medicare payments, which are Quality, Cost, Improvement Activities, and Advancing Care Information. MIPS moves Medicare Part B clinicians to a performance-based payment system and provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice. The MIPS reporting standards align with the Advanced APM wherever possible. Next slide, please. So, each performance category under MIPS is weighted differently. Weights assigned to each performance category is based on a 1-to-100-point scale. So, for 2017, which is a transition year, Quality has a weight of 60%, Cost has a weight of 0%, Improvement Activities has a weight of 15%, and Advancing Care Information has a weight of 25%. These are default weights, and these weights can be adjusted in certain circumstances. Next slide, please. So, you know, who participates in MIPS? So, we describe clinicians who participate in MIPS as eligible clinicians. For the first two years of MIPS, which is 2017 and 2018 MIPS Performance Period, MIPS-eligible physicians include, physician's assistants, nurse practitioners, clinical nurse specialists, certified-registered-nurse anesthetists, and any clinician group that includes one of these professionals listed above. So, physicians -- I just want to go into what a

physician means. So, a physician is a doctor of medicine, doctor of osteopathy, a doctor of dental surgery, doctor of medicine, and includes other types of doctors. But, essentially, those are the types of physicians who are required to participate in MIPS. For any of these clinician types, we also want to note that if they bill more than $30,000 a year in Medicare Part B in allowed charges and they provide care for more than 100 Medicare patients in a year, they're also required to participate. Next slide, please. So, right now, I'm going to go into, like, who is exempt from MIPS. So, there are clinician types that are not included in the definition of a MIPS-eligible clinician. And they are not required to participate in MIPS. Also, we have established three types of exclusions. So, if a MIPS-eligible clinician is eligible for one of the exclusions, they are not required to participate in MIPS. So, a clinicians who is enrolled in Medicare for the first time during a MIPS performance period are exempt from reporting on measures and activities for MIPS until the following performance period. Also, another type of exclusion are those who are qualifying APM participants. They're not considered MIPS-eligible clinicians and are not required to participate in MIPS. Also, there are another type of status, which is a partial QP status, which are those who do not report on MIPS measures and activities. They're also not required to participate in MIPS for a given performance year. Also, the last type of exclusion relates to low-volume thresholds. So, if a clinician or a group that does not exceed the low-volume threshold -- they will also be excluded from MIPS and not required to participate. So, there's a couple of dynamics I want to discuss further relative to these exclusions. So, as you can see, for the first two exclusions that relate to the newly enrolled Medicare-eligible clinicians and then those who are considered QPs or partial QPs. So, in those circumstances, we make our eligibility determinations for exclusions based at the individual level, which is the NPI level. The low-volume threshold has a unique dynamic, in that we make eligibility determinations relative to this exclusion at the individual level, which is the NPI level, and also at the group level. The reason why we've done this relative to the low-volume threshold is because we want to allow groups to have the flexibility to determine how they participate in MIPS, because groups have the option to participate at the individual level or at the group level. So, if a group is -- Let's say for a group that decides to report at the individual level. They need to see that it's more advantageous for them to do that, because more of the NPIs in their group were excluded from them because they did not meet the low-volume threshold. So it may make more sense for them to report at the individual level. However, if a group sees that -- Let's say there are very few NPIs that were excluded from MIPS as a result of this low-volume threshold, and they felt that it may be more advantageous for them to report at the group level, which is why we made those determinations at the individual level and at the group level, which is to allow groups to make those decisions. Okay, next slide, please. All right, so, now we're going to talk about non-patient-facing clinicians. So, non-patient-facing clinicians participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled to Medicare, and are not a QP or a partial QP who elects to participate in MIPS. So, in this circumstance, I just want to reiterate that even if they're considered non-patient-facing eligible clinician, you are required to participate in MIPS. I also just want to note that with non-patient-facing, we identify those non-patient-facing at the individual level and also make a determination at the group level. So, for a group to be considered non-patient-facing, they would have to have more than 75% of the NPIs billing under the group's TIN during a performance period to be identified as non-patient-facing. We define a non-patient-facing MIPS-eligible clinician as an individual MIPS-eligible clinician that bills or 100 or fewer patient-facing encounters, which includes Medicare health services, during a non-patient-facing determination period. So, those are the ways in which the different clinician types and also those who are participating in MIPS, who are required to participate in MIPS and those who are not required to participate in MIPS. So, now next slide.

>> All right, so, going on to the next slide, which is Slide 11, which is now the introduction for us getting into discussing group participation under MIPS. Okay, so, now going to Slide 12. Okay, so, as I noted earlier, groups have the option to participate in MIPS at the individual or group level. So, when you think about the individual level, we mean it's the clinicians reporting under a unique TIN, which is Tax Identification Number, and a National Provider Identifier, which I've been saying is an NPI. So, for those that are reporting at the group level, a group is identified as a single TIN with two or more eligible clinicians, which will also include at least one MIPS-eligible clinician. And they're identified by their NPIs, who have reassigned their Medicare billing rights to the TIN. Also, another mechanism for group reporting is also for an NPI entity group. That's also a mechanism for group reporting. I also just want to note that if a clinician participates as a group, they will be assessed as a group across all performance categories. Next slide, please. So, we have two requirements relative to groups participating at the group level. So, for the groups that elect to report at the group level, they must meet the definition of a group during the performance period for the MIPS payment year. Also, groups must aggregate their performance data across the TIN to have their performance assessed and scored as a group. Next slide, please. So, now we're going to provide an overview of the MIPS performance categories and measures. Next slide. All right, so, as I noted, under MIPS, there are four performance categories. So, under the Quality Payment Performance category, this replaces the Physician Quality Reporting System, which is also known as PQRS, and the Quality portion of the Physician Value-Based Payment Modifier, which is also known as VM. And this provides an easier transition due to familiarity. Next slide, please. So, for 2017, which is also the transition year, clinicians and groups have the option to decide how they want to participate in MIPS. There are three what we call Pick Your Pace options. So, the first one is the test, second is partial, and the third is full. For the quality-performance category, test means submitting a minimum amount of data for one measure set. For partial and full, it means submitting at least six quality measures, including at least one outcome measure for 90 days or for a full year. You want to note that quality measures vary by submission mechanism. And groups are encouraged to select the quality measures that are most appropriate for their practice and patient population. Next slide, please. All right, so, as I previously noted the quality-performance category has a weight of 60%, which is 60% of the total final score. The requirements for the quality-performance category are as follows. So, groups select 6 of about 271 quality measures, which is a minimum of 90 days to be eligible for a maximum payment adjustment. One must be an outcome measure or a high-priority measure, which is defined as an outcome measure, appropriate-use measure, patient experience, patient safety, efficiency measures, or care coordination. A payment adjustment is not based on the amount of data you submit or the length of time submitted. It's really based on your performance in terms of how you do on those quality measures. With that said, like, your maximum score, chance of doing well in the program if you submit more data to CMS, because, in part, you have access to more measures you can potentially submit. And some require more than 90 days of participation. So, with that, you are encouraged to submit as much data as possible, which maximizes your chance of doing well in the quality-performance category. I also just want to note that there are different requirements for groups participating via the CMS Web Interface or those in MIPS APMs. And groups may also select specialty-specific sets of measures. Also, just want to note that groups that have 16 or more clinicians and have a sufficient number of cases -- they are not required to submit the readmission measure. Now let's move on to the next slide. So, now I'll be discussing the Improvement Activities performance category within MIPS. So, the Improvement Activities performance category within MIPS assesses how much clinicians and groups participate in activities that improve clinical practice. So, examples include ongoing-care coordination, clinician and patient shared decision-making, regular implementation of patient-safety practices, and expanding practice access. Under this performance category, groups will be able to choose from many activities to demonstrate their performance. This performance category also includes incentives that help drive participation in

certified patient-centered medical homes and APMs. Groups will be able to choose from activities listed under the Improvement Activities inventory, which includes over 90 activities. The inventory for the first year of MIPS is currently listed on the Quality Payment Program website. The inventory contains activities that are divided into these nine subcategories that you see here on this slide. All right, next slide, please. So, as you can see and as noted for the transition year, groups can participate at pick their own pace, which can be at the test, partial, or full. So, for test, this means groups can submit one Improvement Activity, and the activity can have a high weight or a medium weight. For the partial and full participation, this means choosing one of the following combinations, which is two high-weighted activities, one high-weighted activity and two medium-weighted activities, or at least four medium-weighted activities. For partial, a group would submit data on Improvement Activities for 90 days. For a full, a group would submit data on Improvement Activities for a full calendar year. Next slide, please. For activities, groups attest to completing between two and up to four Improvement Activities for a minimum of 90 days. Groups of 15 or fewer clinicians in rural or health-professional-shortage areas attest to completing up to two activities for a minimum of 90 days. Activities -- I just want to note that activities do not change for each submission mechanism under this performance category. Next slide, please. As previously noted, the Improvement Activities has a weight of 15% of the total final score. So, for groups with more than 15 clinicians, each clinician is weighted either medium or high. To get the maximum score of 40 points for the Improvement Activities score, a group may select any of these combinations. And I had just actually previously identified those, which would be two high-weighted activities, one high-weighted activity and two medium-weighted activities, or up to four medium-weighted activities. Each medium-weighted activity is worth 10 points of the total Improvement Activity performance-category score. And each high-weighted activity is worth 20 points in total performance-category score. So, groups with 15 or fewer clinicians, non-patient-facing eligible clinicians, and all clinicians located in rural areas or health-professional-shortage areas -- again, each activity is weighted either medium or high. And to achieve the maximum 40 points for the Improvement Activities score, a group may select either of these combinations -- one high-weighted activity or two medium-weighted activities. For these clinicians, each medium-weighted activity is worth 20 points of the total Improvement Activity performance-category score. And a high-weighted activity is worth 40 points of the total category score. These clinicians may select two medium-weighted activities or one high activity to receive a total of 40 points of this total performance-category score. For certified patient-centered-medical-home participants, they can get full credit for the Improvement Activities performance category if they are practicing in a certified patient-centered medical home, including medical home models or a comparable specialty practice. For multi-practice groups, if one group is certified as a patient-centered medical home, the entire group under the same TIN can still get full credit. Next slide, please. So, the way the score for the Improvement Activities is calculated is based on total number of points scored for completed activities, divided by the total maximum score of 40 points. So, that's how we calculate the Improvement Activities performance score. All right, next slide, please. Now we're going to go on to discussing the Advancing Care Information performance category. So, the Advancing Care Information performance category replaces the Medicare EHR incentive program for eligible professionals. It does not replace the Medicare-eligible EHR incentive program. The Medicare EHR incentive program continues on as a separate program. In 2017, there are two measures for reporting. The Advancing Care Information Objectives and Measures, which are based on Stage 3, and the 2017 Advancing Care Information Transition Objectives and Measures, which are based on modified Stage 2. These measure sets are based on the edition of a group-certified EHR technology. In order for a group to report any of the measures under the Advancing Care Information performance category, they must use certified EHR technology. Groups can report the Advancing Care Information Objectives and Measures if they have EHR technology certified to the 2015 edition or a combination of technologies for the 2014 and 2015

editions that support these measures. In 2017, groups can alternatively report the 2017 Advancing Care Information Transition Objectives and Measures if they have EHR technology certified to the 2015 edition or EHR technology certified to the 2014 edition, or a combination of technologies certified to the 2014 and 2015 editions. Next slide, please. So, for the transition year, there are three pick your options -- just test, partial, and full. For the test option, it means to submit four or five base-score measures, which are based on the 2014 or 2015 edition. Groups need to fulfill the requirements of all of these score measures in order to receive a 50% base score. If these requirements are not met, they get a zero in the overall Advancing Care Information performance-category score. For the partial and full options, this means submitting more information and reporting for a partial year of a minimum of 90 days or for a full year. Next slide, please. So, for scoring purposes, the Advancing Care Information performance category, as I noted, is weighted at 25% of the total score. In order to achieve this 25%, there are three components that make up the Advancing Care Information performance-category score. So, one is the base score, which is required and is worth 50%, plus the performance score, which is optional and is worth up to 90%, plus a bonus score, which is optional and worth up to 15%. Groups may earn a maximum score of up to 155%, but any score above 100% will be capped at 100%. This structure was really created to ensure that clinicians have flexibility to focus on measures that are the most relevant to them and their practices. I just also want to note that the total Advancing Care Information-performance-category score will then be multiplied by 25% of the Advancing Care Information performance-category weight, which results in the overall MIPS final score. But, ultimately, as I noted, the Advancing Care Information is worth a weight of 25%. And, as I noted, for each of the three components that make up the Advancing Care Information performance category, the base score, the performance score, and bonus score each has their own percentage relative to the overall 25%. All right, next slide, please. So, for a base score, a group can report either the Advancing Care Information Objectives and Measures or the 2017 Advancing Care Information Transition Objectives and Measures, which is based on the edition of a group-certified EHR technology. The Advancing Care Information Objectives and Measures have five measures, while the 2017 Advancing Care Information Transition Objectives and Measures have four measures. And the base score is worth 50%. All right, next slide, please. So, groups need to fulfill the requirements of all the base-score measures in order to receive the 50% base score. If these requirements are not met, they will get a zero in the overall Advancing Care performance category. So, in order to receive the 50% base score, groups must submit a yes for the security-risk-analysis measure, and for all the other measures, the requirement is to perform the action for one patient. The patient can be different patients, and they do not have to be the same patient for each measure. Groups need to fulfill the required base-score measures for a minimum of 90 days to earn credit for the Advancing Care Information performance category. Next slide, please. So, the second component of the Advancing Care Information performance category score pertains to the performance score. So, once a group fulfills the base-score requirements, a group has the option to fulfill performance-score requirements, which can increase a group's score. For the Advancing Care Information Objectives and Measures, a group has the option to report up to nine of the performance-score measures. For the 2017 Advancing Care Information Transition Objectives and Measures, a group has the option to report up to seven of the performance-score measures. The performance score, as I previously noted, is worth up to 90%. The performance score is calculated by using the numerators and denominators submitted for measures, included in the performance score or for one measure by the "yes" or "no" answer submitted. For each measure, with a numerator and denominator, the performance score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2017 transition measures, which are worth up to 20 percentage points. Next slide, please. So, as you see, the box on the left contains nine performance categories. I mean, nine performance score measures for the Advancing Care Information Objectives and Measures. And the box on the right

contains the seven performance-score measures for the 2017 Advancing Care Information Transition Objectives and Measures. In these boxes, you will see an asterisk next to some of these measures. And these measures are base-score measures that can also contribute towards the performance score. So, groups have the option to select the performance-score measures they want to submit. Groups can choose as many or as few performance-score measures to submit. Next slide, please. So, the third component of the Advancing Care Information performance-category score pertains to bonus score. There are two ways in which a group can obtain a bonus score. If a group reports "yes" to one or more additional public-health and clinical data registries beyond the Immunization Registry Reporting measure, a group would earn a 5% bonus. For example, if a group has EHR technology certified to the 2014 edition, a group could report to a specialized registry. If a group has EHR technology certified to the 2015 edition, a group could report using electronic case reporting. As you may notice, there are numbers 14 and 15 there in parentheses, and these signify either the 2014 or 2015 edition. I also just want to note that whether a group does one or more additional public-health and clinical data registries, the bonus is limited to 5%. So, the other way a group could earn bonus points is if a group reports "yes" to the completion of at least one of the specified Improvement Activities using CEHRT, which would result in a 10% bonus. Next slide, please. So, these Improvement Activities listed here are part of a larger set of Improvement Activities, but these are special in that they require the use of certified EHR technology. So, if a group performed one of these actions and reported it to us, we would give them an additional 10 percentage points towards their Advancing Care Information performance-category score. So, whether the activity is weighted as high or medium, a group would earn an additional 10% towards their Advancing Care Information performance-category score. Next slide, please. So, as I described earlier, the Advancing Care Information is a compilation of a base score, which is worth 50%, a performance score, which is worth 90%, and a bonus score, which is worth up to 15% and which provides an accumulation the final score for the Advancing Care Information, which is worth 25% of the total MIPS final score. Next slide, please. And now we're going to get into the submission mechanisms for groups. Next slide. So next we'll get into the data submission mechanisms. Groups have the option to choose different submission mechanisms for each performance category, and that would be in relation to Quality, Improvement Activities, and Advancing Care Information performance categories. There is no reporting requirement for the cost performance category in 2017. Next slide, please. So, the data submission mechanisms available for groups. For the Quality performance category, groups have the option to use QCDR, qualified registry, EHR, administrative claims, CMS Web Interface. And the CMS Web Interface is only available to groups of 25 or more. And groups also have the option to administer the Consumer Assessment of Health Providers and Systems, which is the CAHPS for MIPS Survey. For the Improvement Activities, the submission mechanisms available to groups are the QCDR, qualified registry, EHR, the CMS Web Interface -- and, again, only for groups of 25 or more eligible clinicians -- and they also have the option for attestation. For the Advancing Care Information, the submission mechanisms for groups include QCDR, qualified registry, EHR, attestation, and CMS Web Interface. And, again, the web interface is only available to groups of 25 or more eligible clinicians. All right, next slide, please. So, this slide just further outlines, you know, the various submission mechanisms and in more detail. And this information is also available on our website, in terms of the various submission mechanisms and what's entailed, relative to the submission mechanisms and requirements for those submission mechanisms. Next slide, please. So, now I just want to go into, you know, approved qualified registries and QCDRs. So, groups who use qualified registries and QCDRs must choose from the list approved by CMS to ensure the entity meets CMS submission standards and criteria. Approved lists of qualified registries and QCDRs are available on the CMS Quality Payment Program website, which is available at qpp.cms.gov. Next slide, please. So, for the QCDR, there is a submission-mechanism checklist. And this checklist can be used for the Quality performance category, the Improvement Activities performance category, and the Advancing

Care Information performance category. But, essentially, this checklist provides groups with elements that they would need to make sure that they're meeting in order to be able to report via QCDR. Next slide, please. So, for a qualified registry, you know, we all have to provide a submission-mechanism checklist. We encourage groups to look into the checklist so that they can send the data via qualified registry. Again, a qualified registry can be used for the Quality, Improvement Activities, and Advancing Care Information performance-categories. And, again, this information is available on our website. But this is the checklist here. All right, next slide, please. For electronic health records, the submission-mechanism checklist -- again, we encourage folks to go to our website to get information relative to what groups need to do in order to report via EHR. And, again, this submission mechanism is available for the Quality, Improvement Activities, and Advancing Care Information performance-categories. Next slide, please. So, attestation. As we noted, attestation is also considered a submission mechanism. And attestation can be used only for the Improvement Activities and the Advancing Care Information performance-categories. So, again, we encourage groups to look at information that we have on our website that specifically outlines requirements for attestation and what needs to be done in order to meet the requirements for attestation. All right, next slide, please. So, in regard to administrative claims, here is the checklist. And for groups reporting data via, you know, administrative claims, we just want to note that this is an available option only relative to the Quality performance category. And we also encourage folks to also look on our website relative to information relative to what is required for administrative claims. All right, next slide, please. So, here is the checklist for the CMS Web Interface. And, as I noted earlier, the CMS Web Interface is only available to groups of 25 or more eligible clinicians. And the web interface is available for groups who want to report for the Quality performance category, Improvement Activities performance category, and the Advancing Care Information performance category. And, so, I just want to note that I'm going to get into further information relative to the web interface. But this is a checklist, and we encourage folks to look at this checklist and actually look at the information that we have on our website, specifically because in order to use the web interface, you're going to need to use the CMS Enterprise Portal, and groups will also need to have an Enterprise Identity Management account. So, please look on our website to get information relative to how to be able to report via the CMS Web Interface. Next slide, please. So, as I previously noted, groups have the option to administer the CAHPS for MIPS Survey. And this is a checklist that groups will need to meet in order to administer the CAHPS for MIPS Survey. There's a couple of things I do want to highlight here. Similar to the web interface, for groups that want to administer the CAHPS for MIPS Survey, you will need to register with the CMS Enterprise Portal. And, also, they will also need to make sure that they register. So, I actually want to go on to the next slide to get to more specifics. So next slide. So, you know, last year and other previous years, groups had to register in order to participate in the web interface or utilize any other type of group-reporting option. But under MIPS, registration is not required. It's only required for groups that want to report utilizing the CMS interface or groups that want to administer the CAHPS for MIPS Survey. So, those are the only circumstances in which a group would need to register. But for all other circumstances, in terms of submitting via QCDR, EHR, or qualified registry, you do not need to register. Only for the CMS Web Interface or administering the CAHPS for MIPS Survey. The registration period started on April 1st and will conclude on June 30th of 2017. And, so, right now, groups have the option to register for the web interface. All right, next slide, please. All right, so, now we're going to discuss payment adjustments. So, how are payment adjustments applied? Groups will get one payment adjustment based on their group's performance. CMS assigns the adjustments to the combination of the TIN, regardless of whether the performance is measured at the individual or group level. An individual NPI included in TIN, but excluded from MIPS because they are identified as a new Medicare-enrolled clinician, a QP, or partial QP, would not receive a MIPS payment adjustment, regardless of their MIPS participation. CMS will only apply the MIPS payment adjustment to Medicare Part B-allowed charges. If a clinician-billed

Medicare Part B charges under more than one TIN during the performance period, CMS will take the clinician's highest final score from the performance period and assign the score to the MIPS-eligible clinician for that performance year. This includes clinicians that work in multiple practices, creating a new TIN/NPI combination, during the performance period, and clinicians that submit data as part of a group and individually. Next slide, please. Right now, we just want to go over important dates to remember. So, next slide. So, here are the important dates that groups need to remember and also just, essentially, for MIPS participation. So, as you all know, starting January 1st, this is the beginning of the 2017 MIPS performance period. As I previously noted, April 1st -- that was the opening date for groups to register for the CMS Web Interface or to administer the CAHPS for MIPS Survey. As I also previously noted, June 30th -- that is the deadline for groups to register for the CMS Web Interface and to administer the CAHPS for MIPS Survey and to make that selection. Also, October 1, 2017 -- this is the last day to begin partial 90-day participation. And December 31st of 2017 -- this is the last day of the 2017 performance period. So, from January 1st to March 31st of 2018 -- this is the MIPS-data-submission period for the 2017 program year. So, now I'm going to turn it over to Lindsay to go over the rest portion of the presentation and, again, the Q&A session.

>> Yes, thanks, Lisa Marie. Next slide, please. So, right now, we're going to begin our Q&A portion of today's webinar. There will be two ways that you can submit a question, one of which is to submit it through the Q&A box that you should see on your screen to the left. And thank you, we've already received quite a few via that chat box. If you would prefer, you could also dial in. It's 1-866-452-7887. You should also see that on your screen. And while we wait for people to dial in, we'll read a few of the chats that have already come through. But, again, if you'd like to ask your question via phone, please go ahead and dial in now. We've got about 45 minutes left of the webinar, so the speakers from CMS who are on the line will try to answer as many questions as they can during this time. If your question is not directly answered, we do encourage you to please contact the Quality Payment Program Service Center. That's qpp@cms.hhs.gov or 1-866-288-8292. So, with that, again, please, if you're interested in asking a question via the phone, please dial in, and we'll get started with some of the questions that have come through the chat. So, the first question -- "My certified EHR technology is 2014-certified. Can I use it for group reporting or does the CEHRT have to be 2015?

>> Okay, so, you can use 2014 or 2015 certification in 2017 for group reporting.

>> Great. Next question. "Is the performance period the same if reporting individually or as a group? I.E., are both reported over a 90-day period?"

>> This is Lisa Marie. So, the performance period will depend on, whether it's an individual or a group, what pick-their-pace option that they choose. And it also depends relative to the performance category. But, overarchingly, relative to, the partial Pick-Your-Pace option, that's a 90-day performance period, whereas, like, for the other options relative to the full year, it's up to a full year. So, it just depends on your Pick-Your-Pace and what you, as an individual or a group, decides to do. If anyone else wants to elaborate, please feel free to elaborate, if you want to.

>> Okay, great. Next question. "Is it mandatory for groups with more than 25 clinicians to submit using the web-interface submission method?"

>> So, the CMS Web Interface is not a required submission mechanism for groups 25 or more. It's just that if you are a group that has 25 or more eligible clinicians, the CMS Web Interface is a submission

mechanism that is available to you, along with all the other available submission mechanisms. But the web interface is only for those 25 or more as an option.

>> Great. Thank you, Lisa Marie. Next question. "Is CAHPS mandatory for 100-plus clinicians?"

>> So, under MIPS, it is not required. It is optional for all groups. Under PQRS, it was required for 100-plus, but under MIPS, it is not. It is optional for any group size.

>> Great. Okay, let's turn it over to the phone lines now for a couple questions.

>> Our first question is from an Inquirer.

>> Hi. I wanted to say, first of all, thank you so much for this presentation. I also wanted to say how much I really do like the CMS website. It's very, very helpful. I have a question, though. One of the educational items on the website had to do with CMS benchmarks, based on the method that you're using to submit. We're submitting through a qualified registry, because we're a multi-specialty group, very specialized. I'm having difficulty trying to find benchmarks for some of the measures that are approved for registry reporting. And I'm curious to know if there's going to be an update to that file on the website or what the plans are with regards to that. Thank you.

>> So, currently, we're evaluating the addition of QCDR measures to the website itself. That's the measures themselves. Subsequently, we'll evaluate, if they are added, adding the additional details you discussed.

>> Your next question is from an Inquirer. Inquirer, you may proceed with your question.

>> Hi. I have a question regarding ACI. We are currently on a 2014 CEHRT and we were planning on using the 2017 transition measures. If we move to a 2015 CEHRT this year, can we still use those 2017 transition measures?

>> Yes.

>> Thank you.

>> Okay, great. Let's go back to the chat for some more questions that have come through there. A question about hardship exceptions. "Is there a hardship exception for changing to 2015 EHR in May 2018?"

>> I'm sorry. I think I need clarification. If you're changing in 2018, does that prevent you from reporting for 2017?

>> Yes. Sorry. Maybe we'll take a different question. That's not super-clear.

>> The hardships -- we're just taking hardships for people who can't report in 2017. 2018, we're proposing new things, when we have a new rule out.

>> Okay, great. Question -- "Do all providers in a group need to report the same 90 days?"

>> Hi, Lindsay. Could you repeat the question, please?

>> Sure. "Do all providers or clinicians in a group need to report the same 90 days, the same performance period?"

>> This is Lisa Marie. Yeah, so, in a performance period, the entire group -- Because -- As I noted, the requirements for a group is that you aggregate your data across the TIN, and you must meet the definition of a MIPS-eligible clinician. I mean, you must meet the definition of a group during the entire performance year. And, so, in order to actually assess a group, the group, if they're reporting for a 90-day period, would have to be over the same 90-day period. So it's a consecutive 90-day time frame.

>> Great.

>> I believe that you can actually use the same 90 days for each category within the group. So you can have a 90-day period for Advancing Care Information that was different from your 90-day period for Quality. But all those in the group would use the same 90-day period for the individual category.

>> Okay, great. A question that's sort of in the same spirit -- "Do all providers in a TIN need to report the same measures for IA, Quality, and ACI?"

>> If all members of that group are reporting as a group, then yes.

>> And IA -- just to clarify, for Improvement Activities, its activities. Those are not considered measures.

>> Great. Question -- "Do I need to notify CMS on how my providers will be reporting in time frame?" I guess maybe two questions -- notify CMS how they're reporting, and do they have to notify of what time period they're using?

>> So, in the MIPS program, folks reporting as individuals or groups are not required to pre-register. It is the act of us getting the data submissions that will define whether the person has chosen to report as an individual, as a part of a group. So there is no pre-registration in that.

>> And the reporting period is reported when you submit your data.

>> Yes. It is a factor of the file and the format you submit -- thank you very much – it’s defining the time period, the begin and the end date of the time period within the performance year that you are reporting on.

>> And just to add on to what Adrian just indicated, the only circumstance in which registration is required is relative to utilizing the CMS Web Interface, in which you will have to register in order for CMS to know that you are utilizing that submission mechanism.

>> Great. We'll do one more question and then we'll turn it back to the phone lines. "For test pace, can we report one category or do we have to report all three?"

>> For tests, you just have to do one category.

>> Okay, great. Stephanie, let's go back to the phone lines.

>> Your next question is from an Inquirer.

>> Hi, everyone. Thank you for doing this today. I had a question regarding the hardship exceptions for 2017. Will these be applied to all the MIPS categories or only the ACI? And sorry. One more. What about the audit situation? Will it also only be for ACI, will it be for all categories, or will there be no more audits? Thank you.

>> We are still determining how we're going to monitor program performance, but we are planning to put out some guidance related to audits and retaining documentation to support your submissions. For the hardship exceptions, the ones that were laid out in the original MIPS rules are for only the Advancing Care Information performance category.

>> And then -- sorry -- just to add to that, if you go to the QPP website, there is a link for data validation, where there's a fact sheet in there that talks to data validation and auditing and document retention, in the event that you are audited. Right now, you'll see the criteria for Improvement Activities listed, and Advancing Care and Quality will follow soon after.

>> Your next question is from an Inquirer.

>> Inquirer, you may ask your question.

>> We'll proceed to the next question. Your next question is from an Inquirer.

>> Hi. Sorry. I tried to get myself off of mute. I have, actually, two questions. The first question is -- for CAHPS for MIPS, since it can be considered one of the measures in the Quality category, can it replace the outcome measure even if the outcome measure exists within the system to be reported on? That's the first question. The second question is -- we're a large academic medical center and have chosen not to use qualified registry, because of the cost burden, and use EHR, and our EHR only supports 29 out of the current 54 measures. But we have a large number of specialties. 75% of our providers are specialties. Does that mean for the measures that we report, the specialties are also required to perform on those same metrics? For example, diabetes screening. Thank you.

>> Is Dan on the line or is Dan available to answer the question, these questions?

>> I think we need to take this one, at least the second part of the question, back. We don't have the correct presence for this. We do apologize. As far as the first question, I think the question was related to CAHPS, which is a patient-experience supplemental measure for Quality. We are tracking to it not replacing an outcome measure. So it counts towards your patient-experience measure, but it does not replace an outcome measure.

>> Sorry. And just one last thing. If you do choose to use CAHPS -- just a shameless plug -- that does require registration. Of course, it has to be two or more eligible clinicians to qualify. And that registration for CAHPS is open now through June 30th.

>> Great. Let's go back to the chat box. We have quite a few questions that have come through there. Question -- "Is there a list of approved CMS consultants to help organizations with MIPS? We are located in Michigan and would like assistance from experts."

>> So, this is Adam Richards. So, not from CMS necessarily, but we do have a number of technical assistants, organizations that are out there right now. We have the Transforming Clinical Practice Initiative, the Quality Innovation Networks and Quality Improvement Organizations, as well as the Small, Underserved and Rural Support. All of these organizations are out there, available to assist you. If you check out qpp.cms.gov, there is information on ways to contact all of those organizations.

>> Great. We've had a few questions, so I think maybe just helpful to clarify. "For those who are part of ACOs, do they have to register for the web interface?"

>> No. ACOs do not have to register to report for the web interface.

>> Great. "Administrative claims can only be used as a submission mechanism if participating as an individual -- is that correct?"

>> That's not -- Go ahead, Lisa Marie.

>> No, go ahead, Adrian. Go ahead.

>> All right, I can take it. This is Ashley. So, administrative claims is an option for groups reporting Quality only. So it's only applicable for Quality reporting and for groups.

>> Great. "How do we report if we do not have an EHR?"

>> The one standard mechanism available to clinicians who don't have an EHR is to enlist the help of a QCR clinical qualified data registry or a registry. There's a list of registries approved by CMS on our website, qpp.cms.gov.

>> But if you do not have an EHR, you cannot report on the Advancing Care Information performance category.

>> Okay, great. And I did see a few people ask about the lists. Can you just clarify what lists are posted and what lists are coming soon in terms of qualified QCDRs and qualified registries?

>> So, registration, on qpp.cms.gov, we have listed the CMS-approved qualified registries. And we will soon be also posting the list of qualified clinical data registries.

>> Thank you. Okay, we can go back to the phone lines for a few more questions.

>> Your next question is from an Inquirer.

>> Yes, we have two questions. The first question is -- for previous years, in the info use out of stations, we would submit them through the EHR portal by the individual. How will that work for ACI, in terms of group reporting?

>> You would just pool all the data together for each provider.

>> But we still do it...

>> I'm sorry?

>> No, I was just going to clarify. We would still do it at the individual level? Just the same measure data?

>> No. Through the QPP submission mechanisms, you would select the measures you want to report and then just report the numerators and denominators for the whole group for each of those measures. You don't have to submit individual data. You just add them all up and submit them as a group, per measure.

>> Okay, thank you. And, just to clarify, if we had 1,000 providers before, we would have to go in 1,000 times and key something in. You're saying, now, even to get approval from the providers, we don't need to do that any longer. We literally have to go into one system and input one numerator, one denominator.

>> Correct, as long as it's a group associated. All the NPIs are associated with the one TIN.

>> Okay. So, second question -- so, when reporting as a group, are you allowed to carve out non-patient-facing clinicians from the ACI category but leave them in for the Quality category?

>> The non-patient-facing policy is the same across all performance categories.

>> So you're saying I cannot carve out an anesthesiologist, for example, from ACI, but leave them in for the Quality reporting.

>> Well, for ACI, you can always report. If somebody's carved out, you can still report, if you want them to be scored.

>> Right, but I'm asking, if I want to leave them in for Quality, can I carve them out for ACI? Or are you saying I cannot?

>> No, I'm saying you could.

>> Okay. You can. Okay. And they would just receive the same group score for ACI and Quality?

>> Yes, the same group score.

>> Okay. Thank you.

>> Or they could also report individually.

>> Right, but we want to report as a group. So I just want to make sure I can carve them out if I want to.

>> Okay, thank you.

>> Thank you.

>> Your next question is from an Inquirer.

>> Hi. Can one entity with multiple providers choose to report some providers individually, while the remaining providers report as a group?

>> So, groups have the option to report at the individual level or at the group level. It can't be a combination of both. So if a group decides to report at the individual level, then all of the NPIs under that TIN would individually report. If the group decides to report at the group level, then the group is required to aggregate the data across the TIN, and the group would be assessed, collectively, at the group level across all performance categories. They would be assessed and scored across all performance categories across the entire TIN.

>> Okay. Now, what the gentleman just before me was talking about -- carving out certain providers -- that doesn't --

>> So, Elizabeth, I don't know if you want to elaborate on how that works with, like, non-patient-facing, but, in general, like I said, all groups are required to either report at the individual or group level. You can't necessarily carve out folks and not -- So, let me further elaborate. So, there may be circumstances in which, let's say, there are clinicians who do not meet the definition of a MIPS-eligible clinician, like a physical therapist. Or let's say there is a clinician who is considered a new Medicare-enrolled eligible clinician during that performance year. So, if those individuals who are excluded -- You could, let's say, exclude them in terms of, like, the data that you include, or you can include them in the data, in which their data would be included in, like, the scoring portion of the assessment, but those individuals wouldn't get the MIPS payment adjustment.

>> Okay.

>> So, if there are other subtleties here that we're not picking up, I would recommend that you submit your question to our service center, and then we can research this and get you our written answer.

>> Thank you.

>> Okay, let's go back to the Q&A chat questions. "If a clinician doesn't meet the low-volume threshold, can they still report with the rest of the group?"

>> So, this is Lisa Marie. So, as I noted, groups have the option to report at the individual level and at the group level. So if an individual is determined not to have exceeded the low-volume threshold, in which they're excluded, and if that group that they're participating in is reporting at the individual level, then that individual will not have to report or will not participate in MIPS. However, if, let's say, the group that they're participating in, that they're practicing in, is reporting at the group level, because of low-volume thresholds, it is determined, like I said, at the individual level and at the group level. If the group is determined to exceed the low-volume threshold at the group level, then the entire group is required to participate in MIPS. So, as I said in my presentation, the low-volume threshold is the only exclusion in which there is at the individual level and at the group level. And, depending on

how a group reports, whether at the individual level or the group level, will determine now the NPIs in their TIN will participate in MIPS. Does that answer your question?

>> Okay. All right. Question -- An ACI question. "How is the performance rate calculated for the ACI measures? Is it based on benchmarks, like the Quality measures?"

>> No. No. It's taken from the numerator and denominator that you submit. And then we turn that into percentage, and then that equates to the score for each measure. And then we add up the measures to get your total ACI performance score.

>> And there are some resources on the website. If you go to the qpp.cms.gov page, click on "webinars," there was an ACI webinar. It's in the archived webinars, but it does break down scoring. And there's also an ACI fact sheet that has an overview of the scoring methodology, as well.

>> Great. I think there are still a lot of questions coming through about groups that include clinicians who are not eligible. So can you just clarify again, if you have providers in your group that are not MIPS clinicians, whether or not they can or should be included?

>> All right, so, this is Lisa Marie. So, I'll go over the various exclusions relative to how they would participate in MIPS in various scenarios. So, in regard to the exclusion relating to new Medicare-enrolled eligible clinicians who, basically, first enrolled for the first time during the 2017 performance year, and then the other exclusion in relation to those who have a QP status and those who have the status of a partial QP but that did not choose to participate in MIPS. So, those individuals are excluded from MIPS. If those individuals are part of a group -- So, again, groups have the option to report at the individual level or at the group level. So if a group reports at the group level, then, obviously, those individuals who are newly enrolled or have a QP or a partial QP status would not report at all. If they wanted to, they could voluntarily participate in MIPS, but they would not receive a payment adjustment. Okay, if the group that they're in, the practice that they're in -- if they are reporting at the group level, as we noted, the group is to aggregate the data across the TIN. The group could, if they wanted to, not report on those individual data. But even if the group left their data in reported aggregate across the entire TIN, which included those who are excluded, their data would be included, so their data would be for assessment and scoring purposes. However, those individuals would not receive a payment adjustment. So, as I noted, relative to the low-volume threshold, that's a different dynamic. So, we make our determinations for low-volume-threshold exclusions at the individual and at the group level. So, if you're a group reporting at the group level and if you're a group that exceeds the low-volume threshold, then your entire TIN is required to participate in MIPS, even if there were NPIs, who, let's say, were excluded at the individual level and did not exceed the low-volume threshold. And that's because our policy is that when we do the low-volume threshold, we also do an analysis and assessment at the group level, which is why if a group were determined to exceed the low-volume threshold, the entire TIN would be required to participate.

>> Okay. Thanks, Lisa Marie. So, a couple questions about exemptions that are specific to the ACI category. "So, for ACI, if a non-patient-facing group does not need to report the ACI category, do they still have to report under the EHR incentive program?"

>> So, MIPS is implemented in 2017, and the only people who could potentially report for the EHR incentive program are people who have never participated in the EHR incentive program. So most people who used to be part of the EHR incentive program will instead report under MIPS in 2017.

There are new people who are new to the EHR incentive program but not new to Medicare. If they were planning to report to the EHR incentive program in 2017, they need to go to the EHR incentive program website and apply for a hardship. And then that would get them out of reporting to the EHR incentive program and would give them a hardship so they would not be subject to the 2018 EHR incentive program payment adjustment, and they would only have to report under MIPS. Medicare EPs who are still eligible for the Medicare EHR incentive program, eligible to earn an incentive -- they would continue to report to their state.

>> Okay. And then a sort of similar question about ACI. "Even if we report as a group for MIPS, will certain providers be exempt from ACI? If so, what types of providers will be exempt from ACI?"

>> So, there's many different kinds of exemptions. We have hospital-based providers. So if a group is 100% hospital-based, they would not need to report the Advancing Care Information performance category, and the 25 points that are in that category would be re-weighted to Quality.

>> Also, the physician's assistants, the nurse practitioners --

>> And certified registered nurse anesthetists and -- One more. Clinical nurse specialist.

>> Clinical nurse specialist. So, those you will not need to include in your group reporting, but, also, you may also -- for your group, if your whole group is eligible for a hardship, you may apply for a hardship.

>> Okay. And one last ACI question before we go back to the phone lines. "So, for ACI, do the exclusions, like there were for meaningful use, still apply?"

>> Sorry. We had an issue with mute. No, the exclusions do not apply for 2017, currently.

>> Okay. All right, let's go back to the phone lines.

>> Your next question is from an Inquirer.

>> Hi, there. And I apologize, because I think you have already answered this question. But we're a large multi-specialty group, who -- part of our physicians are participating through the Next Gen program Advanced Payment Model, and the other specialists will be submitting as a group. So, if I understand correctly, we can include our primary-care physicians in the Next Gen, under the group reporting, only to enhance our performance under the group reporting, but because they're excluded as a QP, they will only be subject to the 5% increase, versus any additional percentage that they could get under the MIPS.

>> I think there's a few questions in there. First of all, as a Next Generation ACO, the ACO participants are scored as a MIPS APM, under the APM scoring standard rules, if the NGACO participants are on a ACO-participant list on one of three dates. And those dates are March 31st, June 30th, and August 31st. Any one of those dates will do it. Assuming that the participants are on a snapshot date and assuming they have not met the threshold to be a Qualifying Participant, they are then scored under the APM scoring standard, which provides them special scoring. Under the APM scoring standard, the ACO reports on their behalf for Quality. So there's nothing that they need to do, other than have their ACO report Quality. They are not assessed on cost, or on the Improvement Activities, there's also nothing for them to do. They are already given full points for the Improvement Activities score. The

only category they actively have to report is ACI. They have their choice of reporting at the individual or Group 2 level, according to all applicable rules for ACI reporting. What CMS will do, which is on the back end -- we will aggregate those scores. So, let's say you have a participant in an NGACO that reports both as an individual and also reports under a group TIN. That same TIN NPI score -- we'll take the highest of it and add that together with all the other NGACO MIPS-eligible-clinician scores to get an average group score, which will then be applied to each MIPS-eligible clinician in the NGACO.

>> Your next question is from an Inquirer.

>> Hi. Can you hear me?

>> Yes.

>> Go ahead.

>> Okay. Thanks. I think you just answered my question. I have two, though. But my first one was -- if the clinician's part of an ACO and they do the web interface through their ACO and they are part of a TIN that is doing group, would they submit their ACI through the group? So I think, if I heard you correctly, yes, that would not be a problem. It could go through the group. Is that correct?

>> I'm sorry. Could you just -- I didn't catch the entire question. Could you just repeat that again?

>> Yes. I have two. So, let me just confirm my first question I believe you just answered. It involved -- a clinician is part of an ACO and they are also part of a TIN that is going to submit as a group. Their ACI would be submitted under their group. And I believe you said that, yes, that's correct. That can be done. And then you explained how it would be --

>> Yes. So, the answer to the first question is definitely yes.

>> Yes. Okay, so, here's my second, and I don't know if you've ran into this. But if an emergency-department clinician wants to use the emergency-department specialty Quality measures, they're going to submit via claims. But they don't have any claims or they have very few. Will they pass? But let me explain why this would happen. The reason is that there are several --

>> Before you go on, are they part of an ACO?

>> No. This would be a total -- They're their own entity. And they -- But the quality measures -- And this is what I don't know if anyone realizes for claims. Several of them do not include the E.D. encounter codes. So, for example, documenting meds, smoking cessation, care plan -- none of those, though they are listed in the E.D. specialty Quality Measures in the claims section -- they cannot be used, because there are not the correct codes that would allow them to substantiate an encounter. Hence, some of these doctors may have no claims. And I guess they're very concerned about that.

>> So, hi. This is Ashley. So, similar to another caller, we don't have the correct person in. But I think what you're saying -- we are aware of a coding issue with the E.D. specialties. So, I'm wondering if we could get you to our service center, and then we can escalate you that way. But this sounds very familiar to me, so I know this is something that has been on our radar. So apologies for that. But to get you a personalized answer back, the best route would be through the service center.

>> Great. Not a problem. Thank you so much.

>> Thank you.

>> Okay, great. We have about five minutes left, so we will go back to the chat and ask a few more questions that have come through there. A couple questions related to, basically, the variability between performance categories. So, one question -- "Can we report Quality for a year but ACI for only 90 days?"

>> Yes.

>> Okay. And then a similar question. "Do all Quality measures have to be submitted by the same reporting method or can you report some via claims and some via registry?"

>> All must be submitted by the same -- All Quality measures must be submitted by the same submission channel.

>> Same submission channel per category.

>> Yeah.

>> Great. "If participating in test pace, what's the minimum reporting period for the clinician? Could reporting be less than 90 days?"

>> So, for the test option in Pick Your Pace is one Quality measure or one Improvement Activities are the base measures for Advancing Care to 4 or 5, depending on your CEHRT. So, the minimally required data to avoid a negative payment adjustment would be one Quality measure or one day for one patient. That would automatically exclude you from the negative payment adjustment.

>> And the same for Advancing Care Information -- one day, one patient. But you have to do the whole base.

>> Great. "For a group, how many Improvement Activities will need to be reported as a group? Is it different than how many you would submit if reporting individually?"

>> Hi. This is Angela Foster. It is not different between individual and group. You would report the same number.

>> Great. And then a very similar question. "Is there any way to report Improvement Activities initially or is it only as a group?"

>> You absolutely can report individually. You don't have to report them as a group.

>> Great. And then a few questions have still come through about whether or not groups have to register. Can you just clarify what registration is required, if any, for groups?

>> So, only groups that want to utilize the CMS Web Interface or administer the CAHPS for MIPS Survey will need to register. And that registration deadline is June 30, 2017.

>> Great. Just a couple more questions. "What is the impact on a group score if has EHR and can't report to the ACI category?"

>> So, you're saying if the whole group does not have an EHR and they cannot report. They would get a zero for the Advancing Care Information category.

>> But, just to add to that, overall, just remember that, overall, you can still perform well in the program. So, we're talking individual categories, but, overall, ACI is 25% of the final score, and so, potentially, a group could still perform well if they did not report their CEHRT through ACI.

>> Great. Okay, I think we have time for one more question before we wrap up. I think just an overall clarification about the determination of the low-volume threshold. "How does CMS determine the low-volume threshold? Is it at the group level or the individual level?"

>> So, the low-volume threshold is determined at the individual level, which is the NPI level, and the group level, which is the TIN level. And we do that in order to allow groups to make determinations in how they would want to participate in MIPS. So, that's information that groups have to make the decision. So, again, if a group is determined -- If a group selects to report at the group level and if their group was determined to exceed the low-volume threshold, then their group would be required to participate in MIPS.

>> One clarification I'll just add, Lisa Marie -- I think you're completely correct -- is that when we calculate at the individual level, it is calculating it for the NPI for that specific TIN. So, if a provider has multiple TINs, we will calculate multiple low-volume thresholds, one for each TIN in which they billed CMS during the applicable time period.

>> Great. Thank you all so much. And thank you to everyone who joined today's session. Just a reminder, if, unfortunately, we did not get to your question on today's call, we encourage you to contact the Quality Payment Program Service Center. Again, you should see that on your screen, and its qpp@cms.hhs.gov or its 1-866-288-8292, if you'd like to ask your question via the phone lines. Next slide, please. And just a quick reminder that CMS is looking for representatives from organizations of all sizes to participate in some feedback sessions on the website. If you're interested in participating, please e-mail partnership@cms.hhs.gov to participate in a one-on-one feedback session. And that is all the time we have today. Thank you again to Lisa Marie and everyone who joined today's webinar.

>> Thank you. This concludes today's...