[Classical music plays]

Hello, and thank you for joining today's webinar on Advancing Care Information performance category in MIPS. Today Elizabeth Holland, senior technical adviser at the Center for Clinical Standards and Quality at CMS will provide an overview for the Advancing Care Information performance category. After her presentation, you will have the opportunity to ask questions. Dr. Daniel Green and Lisa Marie Gomez from the Center for Clinical Standards and Quality at CMS will be available to answer questions as well. Ms. Holland and the other speaker 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 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. Elizabeth, you may go ahead.

Thank you. Today, we're going to talk about the Merit-based Incentive Payment System a little bit, and then we're going to dive into the overview of the Advancing Care Information performance category. Next slide. And the next slide. So, MIPS, or the Merit-based Incentive Payment System is one track of the Quality Payment Program. The other track is the Advanced Alternate Payment Models, or Advanced APM. Next slide, please. There are four components of MIPS. And MIPS was, just to back up a little bit, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. Streamlined three existing programs -- the Physician Quality Reporting program, or PQRS, the Value-based Modifier, and the Medicare Electronic Health Record Incentive program. They were all streamlined into the Merit-based Incentive Payment System, or MIPS. And your participation in MIPS will determine if your Medicare physician fee schedule receives a positive, a neutral, or a negative update. You can always find more information about MIPS and the Quality Payment Program on our website. That's qpp.cms.gov. So, MIPS consists of four performance categories -- Quality, Cost, Improvement Activities, and Advancing Care Information. Next slide, please. These categories are weighted for the 2017 performance period, which is also the MIPS transition year. The weights are as follows -- 60% for Quality, cost is weighted at zero, Improvement Activities are 15%, and Advancing Care Information is 25%. It's very possible that these weights will change over time, but right now, these are the weights that we're looking at. Next slide. So, clinicians who participate in MIPS include those clinicians who bill more than $30,000 to Medicare Part B in the calendar year and provide care for more than 100 Medicare patients a year. And both of those statements have to be met for someone to participate in MIPS. So the MIPS-eligible clinicians are considered physicians -- and by that, physicians include doctors of medicine, doctors of osteopathy and chiropractors, for example, and other clinicians, such as physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. And those are the clinician types for the first two years. After that, it's very possible that we may expand the definition of MIPS-eligible clinicians to include, for example, occupational therapists, physical therapists, clinical social workers, dieticians, et cetera. But all of the inclusion of those additional types would be made through rulemaking, so a proposed rule and then a final rule. Next slide, please. So, now I've told you who's included in MIPS, there are other provider types that are excluded from MIPS. They include clinicians that are newly enrolled in Medicare. So, if you enroll in Medicare for the first time during a

performance period, you don't need to report to MIPS during that year. Also, if you are below the low-volume threshold, that means your Medicare Part B charges are less than or equal to $30,000 in a year or you see fewer than 100 Medicare Part B patients. Also, you don't have to report to MIPS if you are participating in an advanced alternative-payment model, and more information about them can be found on our website. Next slide, please. So, for the transition year of 2017, we're calling the way you participate, Pick Your Pace, which means you have several options to determine how you will participate. Really, we're begging you to participate, because if you don't submit anything to CMS for the 2017 performance period, you will receive a negative payment adjustment. But we're trying to make it really easy so that will not happen, hence Pick Your Pace. So as I mentioned, you can participate in an advanced alternate-payment model. You can test, which means you submit some data, and more about exactly what that means in a minute. You can participate for a partial year, so less than a full year. Or you can submit data for the full year. But you have a choice in 2017. Next slide. So, if you choose to test. If you choose to test, this means you will avoid a negative payment adjustment in 2019. So, what does that mean? What amount of data do you need to send? That would be one quality measure or one improvement activity or the required or base score of the Advancing Care Information performance category. And I'll explain fully what their required and base measures are when we get to the Advancing Care Information portion of this presentation. Next slide. So, as you saw from tests, PEPs is pretty easy to achieve. But the next level to receive a higher positive payment adjustment is partial participation. So, that means you need to select 90 consecutive days within the calendar year 2017 for which you're going to submit data. This reporting period started January 1 and concludes on December 31. Therefore, October 2 is the last year you can -- the last day of the year that you can begin to collect your data and still have a full 90 days within calendar year 2017. Okay, next slide. So, for full participation, that means you submit a full year of data in the full calendar year for 2017. And so that also means that you would submit six quality measures, improvement activities that are either four medium-weighted or two high-weighted improvement activities and either four or five Advancing Care Information measures. Next slide. Under MIPS, we also have the ability for you to report as an individual or a group, and you can select which one you would like to choose. If you are in a group, that means there's more than two clinicians, two or more, whose MPIs -- individual MPIs have reassigned their billing rights to a single Tax Identification Number, or a TIN. So if you report as a group, your data gets aggregated and sent as the group, or individually, you report just for yourself. Next slide. When you report, your reporting at this time is across a category, so that you have to either submit as an individual or a group. But by each category, you can choose your submission method. So, for example, if you're an individual submitting, you could submit your quality by a qualified registry, but your Advancing Care Information you may choose to attest. So you can choose a different submission mechanism for each of the categories. Next slide. So, when does the MIPS system officially begin? We are currently in the first performance year of the transition year. It began January 1, and it runs through December 31, 2017. The date of submission period will be after the close of the calendar year and will end on March 31, 2018. And we'll have more information on submission, when submission will open, on our website. Next slide, please. So, the Advancing Care Information performance category essentially replaces the Medicare Electronic Health Record Incentive Program. It does not replace the Medicaid Electronic Health Record Incentive Program. The Medicaid EHR Incentive Program continues on as a separate program. So, starting in 2017, it is possible for a MIPS-eligible clinician

to report on the Advancing Care Information Performance category under MIPS for Medicare and participate in the Medicaid EHR Incentive Program. Although the measures under the Advancing Care Information performance category are based on the meaningful-use requirements under the EHR Incentive Program, they are not the same. So if you choose to participate in both programs, you can, but the requirements are slightly different. For the Medicaid EHR Incentive Program, you'll report to your state, and you may continue to receive incentive payments through 2021. Next slide, please. So, who can participate? So, all MIPS-eligible clinicians -- and for Advancing Care Information, you can participate as an individual or a group. Next slide, please. When you're reporting in 2017 for performance periods in 2017, there are two measures that you can use. And these measure sets are based on the addition of your Certified EHR Technology. You can choose the Advancing Care Information Objectives and Measures, which are based on stage 3, or the 2017 Advancing Care Information Transition Objectives and Measures, which are based on modified stage 2. Next slide, please. So, as I mentioned, the measures are based on your -- they're two measure sets based on stage 3 and modified stage 2. They are also based on the addition of the EHR technology that you have. So if you report on the Advancing Care Information Objectives and Measures, you would be using the 2015 addition or a combination, or you could report on the 2017 Advancing Care Information Transition Objectives and Measures if you still have your technology that is certified till the 2014 edition. In 2017, we will accept either technology certified to the 2015 edition or in the 2014 edition, but our current policy is that in 2018, all MIPS-eligible clinicians must report using 2015 edition Certified EHR Technology. Next slide, please. Okay, so, requirements for 2017. You can either submit test, which means you submit either four or five base measures, which are based on the 2014 or 2015 edition, or you can submit more information and report for a partial or a full year. Next slide. So, as I mentioned --

Sorry. Real quickly, sorry, go back to the last slide, since I think we're one off. So slide 21, please. This is -- no. Other direction. Sorry about that, Elizabeth.

It's okay.

I just want to make sure you're reading the right -- everyone sees what you're speaking to. Okay, I think we're all good.

Okay. Still can't see them, but that's fine. The MIPS score for Advancing Care Information is 25% of final score. So, to achieve that 25%, we have a base score, which is also required, plus a performance or plus a bonus score. And both the performance score and the bonus score are both optional, but we add them all together. So now I'm gonna dive deeply into what comprises the base score. Next slide, please. Okay, so, depending on the Certified EHR Technology you have, you can report either the Advancing Care Information Objectives and Measures or the 2017 Advancing Care Information Transition Objectives and Measures. If you choose the Transition Objectives and Measures, you would report on the four measures. If you choose the Advancing Care Information Objectives and Measures, it's five measures. And this is the base score. You must achieve the base score to get a score. We do have in-depth specification sheets that are posted on our website. That's qpp.cms.gov. But we're in the process of making them even more comprehensive, and we're working to get the revised specification sheet soon, hopefully in the next month or so. So be sure to check our website, because they'll be a lot more information on each of these measures laid out

in those specification sheets. Next slide. So, that you understand how to fulfill the base score for a security risk assessment, you must submit a "yes," and for all the other measures, the requirement is to perform the action for one patient. The patients can be different patients. They don't have to be the same patient for each measure. And this is where we have diverged from the meaningful-use requirements, where now, for the base score, it's one patient instead of the higher thresholds that we used to have under the EHR Incentive Program. Next slide. So, the second part -- so you start with the base score. And if you fulfill the base score, then you can fulfill the performance score. It's totally optional, but it's a way to increase your score. Depending on the measures that you choose. So, the first box on the left is the Advancing Care Information Objectives and Measures performance measures, and the one on the right is for the 2017 Transition Objectives and Measures. You may note that some of these measures have a little asterisk next to them, and those are measures that are base score measures, as well. So, you don't need to just send us a 1. If you have more patients that you fulfill the measure for, you would submit the full numerator and denominator. And as long as there's a 1 in the numerator, you'd fulfill the base score, but you could also earn additional points for the performance score. So these measures you can pick and choose which ones you want to submit, and you can choose as few or as many as you like. You don't have to submit all of them if that's not what you choose. Okay, so Next slide. The bonus score -- that's the third component. So we went from base to performance and now bonus. And there are two ways to get a bonus score. One is if you report to an additional public-health or clinical data registry. For example, if you have EHR technology certified to the 2014 edition, you could report to a specialized registry. If you have 2015 edition CEHRT, you could report using Electronic Case Reporting. That's what the 14 and 15 in parentheses means, depending on the addition of your Certified EHR Technology. And that would earn you additional 5%. And it doesn't matter if you do more than one. If you do one or more, you're limited to a 5% bonus. For the improvement activities, there are certain improvement activities that you can earn a 10% bonus for, and I'll talk about that on the next slide. So, improvement activities, as I mentioned in the beginning, are one of the other categories of MIPS. These improvement activities listed here are part of the larger set of improvement activities, but these are special in that they require the use of Certified EHR Technology. So if you were to perform one of these actions and you report it to us, we will give you an additional 10 percentage points towards your Advancing Care Information score if you perform any one of these activities on this list. It doesn't matter if it's a medium- or a high-weighted activity. You would get an additional 10% towards your Advancing Care Information slide. Okay, next slide. So, we've definitely heard a lot of opinions about the meaningful use under the EHR Incentive Program, so one of the things we try to do with MIPS and the Advancing Care Information category is to make it simple and to make it much more flexible, so I'd like to point out some of the ways that we are doing this. The first is that we will automatically re-weight the Advancing Care Information category for certain categories of MIPS-eligible clinicians. For example, MIPS-eligible clinicians who lack face-to-face patient interaction -- this would be based on the codes that the MIPS-eligible clinician bills to Medicare. We make that determine and automatically re-weight the 25 Advancing Care Information category scores to the quality category. In addition, there are certain categories of MIPS-eligible clinicians that we are going to re-weight in 2017, as well. Those are the nurse practitioners, the physician assistants, the certified registered nurse anesthetists, the clinical nurse specialists. These particular MIPS-eligible commissions were not eligible under the

Medicare EHR incentive program, so we're gonna give them some more time to get up to speed with the requirements of Advancing Care Information so that they can have their score re-weighted. The thing about re-weighting is we automatically re-weight you to quality, but if you choose to report, then we will score your data. So the choosing to report data cancels your re-weighting. Okay, so, the second option here is very similar as the hardships were under the EHR Incentive Program. So a MIPS-eligible clinician can apply -- that is, submit an application to have the Advancing Care Information Performance Category re-weighted to zero. Again, that 25% would be assigned to the quality category. And there's certain reasons, such as insufficient Internet connectivity, extreme and uncontrollable circumstances, which includes vendor issues, and a lack of control -- the availability of certified EHR technology. These applications are going to be for the Quality Payment Program. You cannot apply using the applications that are posted now on the EHR Incentive Program. The applications for the Quality Payment Program hardship will be available sometime this summer on our qpp.cms.gov website. Okay, next slide. So, the third category is the hospital-based MIPS-eligible clinicians. So, if a MIPS-eligible clinician is classified as hospital-based, this means that 75% or more of their Medicare services are performed either in the inpatient, in the on-campus outpatient department, or in the emergency department, we will re-weight their category and assign those 25 points to the quality-performance category. We will determine that you place where the services are performed by the place of service codes, so its place of service codes 21, 22, and 23. Again, if data is submitted, then we will score the performance, and they will not be re-weighted. If MIPS-eligible clinicians are part of the group, and let's say you're a hospital-based, eligible clinician and you're part of a group that bills under 110, the group can choose to submit your data with theirs or exclude it. But you will receive the same treatment as the rest of the group, and you will receive whatever adjustments the group gets. In addition, for a group to have their Advancing Care Information category re-rated, all members of the group must qualify for re-weighting. Next slide. Okay, so, this is where we really need your help. We've heard a lot of dissatisfaction with the meaningful-use measures, and we would love, love to improve them, but we need your help. So, we have an annual call for measures for MIPS, which includes the Advancing Care Information performance category. We're looking for measures that assess the use of Certified EHR Technology, specifically measures that measure patient outcomes, patient safety, measures that would be applicable to nurse practitioners, PAs, CRNAs, and CNSs, and measures that are cross-cutting to support improvement activities and the quality-performance categories of MIPS. So, measure submission. If you have measures you'd like to submit, we have certain data elements we'd ask you to submit, and they're shown on this slide. Pretty straightforward, but we have more information. Next slide. If you have measures, you can find more information by going to the fact sheet, which explains the measure-submission process. The submission deadline is June 30, and it also includes the place where you can submit your measures to, the e-mail address. Okay. So, I explained the measures for the Advancing Care Information category -- sorry, next slide. Now I'm gonna explain the scoring. Just to review, it's the base score plus the performance score plus the bonus score, and you must fulfill the base score in order to get a score in the Advancing Care Information performance category. Next slide. So, to satisfy the base score, you need one patient in the numerator, and you need to answer "yes" for the security-risk analysis. And from the measures that had the little asterisk that overlap between the base and performance score, if you have more patients in your numerator and denominator, it will include your overall performance score. So, next slide. The base score. As I mentioned, it's worth 50% of your total 25%. So you

either meet the base score or you get a zero, and if you get a zero, you will get an Advancing Care Information performance category score of zero. Again, the Advancing Care Information measures are based either on the 2015 edition or for the 2017 Advancing Care Information Transition Measures, the 2014 edition. Next slide. So, for the performance score, depending on the measures you choose to submit, your score will be based on the numerator and denominator that you submit. The measures range from -- under Advancing Care Information, you can earn up to 10%, and for immunization, it's zero or 10%. It's a zero if you submit a note or "yes" if you submit a "yes" that you do the immunization registry reporting, you would get an additional 10%. Some of the performance measures under the transition set are worth 20%, and that just reflects the differences between modified stage 2 and stage 3, where some of the measures are now split into more detailed measure specifications. Next slide. So, this is how we calculate the scores for each performance score measure. Depending on the numerator and denominator you submit, we will convert that performance rate into a percentage score. So if you score -- if your rate equates to a numerator and denominator that would be 11, you would earn 2%. But I'll go through some examples in a minute which will make this much more clear. Next slide, please. To get a bonus score, again, you submit one or more to the clinical data registries, and you'd get an additional 5%. And for the improvement activities that use Certified EHR Technology, you'd get an additional 10%. Next slide, please. So, the Advancing Care Information performance categories, we sum up the three components -- the base score, the performance score, and the bonus score. So, if you earn the base, you get 50%, and the performance score you can earn up to 90%. And the bonus score, you can earn up to 15%. Now, I know you're saying, "Wait a second. Is this new math? This adds up to way more than 100%." And you're totally correct. It adds up to 155%. But your score is capped at 100. So if you earn 100, 101, 110, 155, you get the full 25% for your Advancing Care Information category. And this is just another way that we're giving people the opportunity to succeed and do well in this category. Okay, next slide. Now I'm gonna walk through some specific examples so you can fully understand how this scoring works. So, in scoring Example A, the clinician is reporting using the Advancing Care Information Objectives and Measures. This means they have 2015 edition Certified EHR Technology. They answer yes to the security risk analysis, and then they submit these numerators and denominators, all of which have more than one patient in the numerator. So therefore they fulfill the base score. They earn 50% of their Advancing Care Information score. Next slide, please. So, then, this MIPS-eligible clinician decides to submit performance measures. They submit the numerators and denominators, so when they submitted, for example, provide patient access, it's the same numerator and denominator. You don't have to submit it twice. You submit it once, and it counts towards your base score and your performance score. So that 250 numerator over a 500-patient denominator equates to a performance rate of 50%, and that we convert into a percentage score of 5%. So for each of the measures, we turn the numerators and denominators into a performance rate and then equate them to the performance score. Then we add up all the percentage scores to come up with the performance score. In this case, it's 37%. Next slide. The third component is the bonus score, and so in this case, this clinician submitted to a registry and earned an additional 5% and also reported an improvement activity using Certified EHR Technology. So they earn an additional bonus score of 15%. Next slide, please. So, to review, we add up the base score, the performance score, and the bonus score to receive the total score. And in this case, it sums to 102%, and as I mentioned, it's capped at 100%, so this provider would earn the full 25 points on their Advancing Care Information performance category. Next slide. Here's another example. This

MIPS-eligible clinician chooses to use the 2017 Advancing Care Information Transition Objectives and Measures, so they still have their 2014 edition Certified EHR Technology. And we understand that in 2017, many, many providers are switching from 2014 edition to 2015 edition, so we do expect that the majority of MIPS-eligible clinicians will submit using the Advancing Care Information Transition Objectives. So, in this case, the base score has four measures. They achieve the base score because they have a "yes" in security risk analysis and more than one in each of the other -- more than one patient for each of the other measures. Next slide. For the scoring, they submitted additional performance measures, and some of these, for example, provide patient access, is not worth 10%. It's actually worth 20%. So that rate gets doubled. So, again, we add up the percentage score to earn the total performance. Next slide, please. In this case, this provider chose not to submit any bonus items, so they earned zero bonus score. Next slide, please. So, again, we add up the performance, so the base score plus performance score plus the bonus score, and that achieves their total score. We multiply by .25 to convert it into points, and so this MIPS-eligible clinician would earn a 22 score out of 25 for the Advancing Care Information performance category. Next slide. So, here's another scoring example. I think I have four examples. They submitted their measures, but they answer no, they did not perform the security risk analysis. So therefore, they do not earn an Advancing Care Information performance score, 'cause they did not fulfill the base score. And in this case, it does not matter if they submit performance measures or bonus measures. They will not be scored. They will get a zero for Advancing Care Information. Their score will not be re-weighted to quality. They just get a zero added to their total score. Okay, next slide. This is our scoring example. So, I wanted to illustrate if a provider's -- these are two providers, and they both achieve the base score. But I wanted to show that there are alternate ways that you can achieve a maximum score. So, clinician one performed very highly on several measures and chose not to report on others, and so his score sums to 51%. So when you are calculating his Advancing Care Information score, it would be 50 for the base plus 51, which would give him 101%, so he would achieve 25% Advancing Care Information performance category. The second example, she submitted all of her measures, but her performance rate is not quite as high. Yet because she submitted all of her measures, it's still actually summed to 51%, so she would still earn the same score. It would be 50 for the base, 51 for the performance measures, which would be 101%, and that would equate to 25% for Advancing Care Information. Next slide. So, as I mentioned, this webinar today is based almost primarily on the Advancing Care Information performance category, but we have lots of information on our website about the other performance categories. And to achieve your final score, we would sum the other categories together, so quality, which is worth 60%, cost in 2017, which is worth 0%, improvement activities, which is worth 15%, and Advancing Care Information, which is worth 25%, to get your final score. Next slide. So, where can I go to learn more? You probably have forgotten the website, so I'll repeat it again -- qpp.cms.gov. And we have technical assistance available. This is just to give you a sense of the range of technical assistance we have. And I think I want to go to the next slide, because this really illustrates, if you find yourself on this chart, you can figure out which type of assistance is most geared to you -- for example, if you're a small or solo practices, you may want to use the small, underserved, and rural support. Or if you're a large practice, you can go to a Quality Innovation Network QIO. So these are all -- this chart is on our website, and these are great resources for you to achieve success under the Merit-based Incentive Payment program. So, I think that now concludes the presentation part, and now we will be happy to take questions. And if we

can't answer the questions, we'll do our best to get you an answer at a later date.

Yeah, so, you will see on the screen right now a number to dial in with a passcode if you need it. So for those who are interested in dialing in and asking your question on the phone, please go ahead and start to dial in. We also have a large number of questions that you all have been submitting through the Q&A feature of the webinar, so while we wait for those who are interested in dialing in to answer their questions on the phone, we will read a few of the chat questions for Elizabeth and the rest of the CMS team aloud. So, first question, when will the list of qualified registries in QCDRs be made available to us for 2017 reporting? I know that's not ACI-related, but is anyone able to answer that question?

I can answer that. The qualified registries should be going up within the week. The Qualified Clinical Data Registries should be up about mid-May or sooner.

Thank you, Dr. Green. Next question has to do with the denominator for performance score or the maximum potential. How many patients must be included? Could we have tens of thousands of patients who fall into the denominator for any of these measures?

It doesn't matter how large the denominator is. It matters the ratio between the numerator and denominator. If you have 10 in your denominator and 10 in your numerator, you will earn a high score.

Okay. Thank you. A question about health information exchange. Can providers refer internally to each other to satisfy this measure?

We understand that there are some issues with providers not being able to achieve the health information exchange measure or measures. And we are working on a potential solution, and we will certainly message that when it is available.

Okay, great. I think there have been a few questions about the certification requirements. Here is one -- do you submit ACI measures from either the 2017 Transition Measures or the regular ones, but not a combination?

You can submit a combination. You can submit just the 2017 Transition Measures, or you can submit just the Advancing Care Information measures, or you can submit a combination of the two. However, you will not be scored for multiple submissions on multiple measures. For example, if you do e-prescribing, you'll only get scored on e-prescribing once. You won't get scored twice.

Okay, and just to clarify, what is the distinction between the ACI Objectives and Measures and the 2017 Transition Objectives and Measures?

The Advancing Care Information measures are based on stage 3, and they use the functionality in the 2015 Certified EHR Technology. The 2017 Advancing Care Information Transition Measures are based on modified stage 2 of meaningful use, and they utilize the functionality of the 2014 Certified EHR Technology.

Great. We'll do one more in the chat, and then we'll go to the phone lines. Does submitting meaningful-use attestations for 2017 year satisfy the MIPS requirement for the 2019 payment adjustment?

No. You must submit under MIPS.

Okay, great. Stephanie, can we go to the phone lines?

Our first question is from Mary VanHoomissen.

Hi. This is Mary VanHoomissen from Valley Medical Center, and I have a question about the health-exchange measure. Currently, our providers are exempt if they have less than 100 transitions. Is that still true with MIPS?

There is currently not an exclusion under MIPS, but we understand that this was an oversight, and we're working on solutions to come up with a solution to correct this oversight.

Great. Thank you very much. That would be very helpful, especially for -- we're a large, integrated clinic network, and we keep our referrals internal. [ Laughs ] And we use one EHR, so it kind of -- yes, we are in support of you fixing that.

We are working on it.

Thank you.

Your next question is from Callie Tompkins.

Hi. I'm Callie, and I'm with InSight EyeCare. We were curious how many patients have to send messages through the portal for the 2017 MIPS. I know last year, we just needed one patient per doctor.

There's no requirement. It's one patient you need to submit for one patient if you're reporting as an individual or one patient if you're reporting as a group. If you do it for more than one patient, then you have the potential to earn a higher performance score. But there's only the requirement for one patient for the base to required measures.

Okay, 'cause I know we have a lot of patients who actually go into the portal. They receive their information, but they don't have a lot that send us actual messages, and I know we were curious that they were gonna keep that split this year and if so if it was just one again.

Our next question is from Christina Cascante.

Hi. This is Christina from Baptist Health South Florida. I just had a question regarding the 5% bonus for submitting for a public-health registry besides immunization. Will you get the 5% if you're in active engagement? So if you're just registered or testing, or does it have to be with production data?

Any of the three options for active engagement.

Terrific. Thank you.

Your next question is from Michael Wald.

Hello, and thank you for a quality webinar. My question revolves around you prescribing as a base measure. If you have a denominator of zero, is that permissible to still receive a full score for the base measures?

Similar to the health information exchange Oversight, we have an oversight for e-prescribing, and we are working on solutions to try to rectify this.

Perfect. Thank you.

Your next question is from Kim Sweet.

Yes, hi. On one of the slides -- I don't know what number it was, but it was the improvement activity... We had the list of activities, and you were saying that if you do those on the EHR system that you get the bonus. My question is, do you have to submit the results through your EHR to CMS or a third party, or will that count for a bonus, just doing attestation?

You would be submitting for your Advancing Care Information performance category. So whatever method of submission you choose, that's where you would submit that you performed that improvement activity.

Great. Thank you very much.

Your next question is from Philip Williams.

Hi. My name is Philip Williams from Eagle Consulting Partners. I noticed on the website, the QPP website, that under the 2017 Transition Objectives and Measures that the medication-reconciliation measure seems to have some discrepancies in it. I just wanted some clarification and, also, in the final rule, if those discrepancies are there, too. I wanted some clarification on the transitional measure, if it's supposed to include problem list and medication allergies or if it's not? Because it's not very clear in the documentation.

Yes, you are correct, it is not clear, and that was an oversight on our part. Yes, we are working to fix that.

Just to clarify, which would be the transitional measure, then?

It should be linked to what was required under modified stage 2.

Okay, thank you very much for answering my question.

Sure.

Your next question is from Tara Smith.

Hello. This is Tara Smith. Thank you for your time. My question is specifically for considerations for behavioral health. We ran into some issues with meaningful use. We have an inpatient acute facility, which is place-of-service billing 51 and 52, which is aligned with the acute-care hospitals. So I'm wondering if you can refer me to someone to speak about the challenges or exclusions that are needed for the inpatient? We do have an outpatient network that can meet the measures.

You can certainly contact our service center and ask them to refer you to me -- Elizabeth.

Okay, okay. I will do that. We have some state laws that govern our use of the HIE and of course SAMHSA with substance abuse. So I'd love to be able to contact you about this.

Okay.

Okay, sounds good. I will do that. Thank you.

Your next question is from Debra Tracey.

Thank you for the webinar. I wanted to support question number 1. We have very limited interoperability between EHRs here in Florida, and I wanted to say the HIE is a big problem. We can't get electronic data to another provider who doesn't have the same electronic record. And then I wanted to point out, I don't know if you know this, but I have one of the top-five electronic records in the country rated by Medscape and MGMA. And we don't have a MIPS dashboard yet. We don't have a PQRS dashboard yet. We don't know what our numerators are or are denominators are on there. And our QCDR that our specialty society applied for hasn't been approved yet. So we're kind of here after the first quarter in the dark about where we are on our MIPS performance. And, you know, we're trying to get to that high, extraordinary-performer level, and it's pretty much of a challenge in this environment, with you requiring these things, and yet nobody's ready for them. That's it. Thank you. I don't know if you have a comment on that or if you know about that.

We are aware of some of these concerns, and that's why we're trying to make it as painless as possible in the first year, allowing you to pick your pace and not get penalized. And so I think as long as you are recording your measures, I believe you'll do very well.

Thank you.

Okay, let us go back to some of the questions that have come through the chat feature, and then we can go back to the phone lines in just a minute. So, one question that has come through a few times now is whether or not as a group, if we report as a group, does each individual need to see 100 or more Medicare Part B patients until $30,000, or is it individual, or is it collectively as a group?

Hi. This is Lisa Marie. So, groups have the option to report at the individual level or at the group level. So if a group decides to report at the individual level, then the low-volume threshold is determined at the individual level, in which, as you know, there is the element relative to the $30,000 or if there is 100 patients. So that would be applied to each individual. But if a group is appointed at the group level, the low-volume threshold will actually be determined at that group level, go it's relative to the entire group. So in order for the group to be excluded from this as a result of let's say not exceeding a low-volume threshold, the group as an entire or as a collective entity would have to not exceed the low-volume threshold, which would either be the $30,000 Medicare billing charges or would have provided care for less than 100 Part B beneficiaries.

Thank you, Lisa Marie. Another question that has come through a few times, I think just a clarification about how ACI measures will be submitted. One person said, "For the EHR incentive program, we reported measures through the EHR incentives website. How do we report ACI measures to CMS?

You have many options. It's not just through at a station. I don't know -- do we have any ability to go back to the slide?

Yes. What page do you want?

The data-submission one. Let me see. 13.

So, for Advancing Care Information, if you are submitting as an individual, you can either attest, you can submit through a QCDR, you can submit via a qualified registry, or you can submit through an EHR. So it's four different mechanisms you can choose, but you need to choose just one to submit your Advancing Care Information performance category.

Thank you. If attesting as a group, does the one patient apply to the whole group, or each provider in the group needs to have one patient?

If you're reporting as a group, it would be one patient for the group.

Great. Okay, someone asked about a clarification on Medicaid. Is continuing to submit Medicaid meaningful use optional now if the provider submits to MIPS, or will they still be penalized if they stay on Medicaid meaningful use?

Okay, you only need to participate in the Medicaid EHR incentive program if you are still eligible an incentive. The payment adjustments under the EHR incentive program end in 2018, so starting in 2017, the participation in MIPS will determine your payment adjustment starting in 2019 so that once -- for Medicare EHR, you add a station in 2016, and then you start your submission of data under MIPS in 2017. But participation in Medicaid doesn't count towards MIPS. You have to do MIPS separately.

Great. For a full year of Pick Your Pace reporting, is ACI a full year, too? I thought ACI was 90 days in 2017 and 2018.

We believe that you can earn the maximum score if you submit for a full year, because you would have more patients in your numerator and denominator. The reporting period is 90 days. If you submit for 90 days, you will still earn a positive adjustment. It's just possible if you submit for a year you will earn a higher positive adjustment.

Okay, thank you. Let's go back to the phone lines. Stephanie?

Your next question is from Lori Johnson.

Hi. I had a question related to the immunization, submitting data to the immunization registries. So, if you wanted to submit the ACI 2017 measures, not transitional measures, so I guess that would equate to the stage 3 measures, but your state is not ready for the bidirectional immunization interface. How will that impact you?

Well, it's a performance measure, so either if you're still -- the way we've structured it is you can use a combination of measures so that if you

can't do the immunization under the Advancing Care Information performance measures, but you could do it under the transition measure, you could submit it as a transition measure and still earn the 5%. But if your state isn't ready, you just would -- if you don't want to do that and your state isn't ready for you to achieve the immunization under the Advancing Care Information measure, because it's not bidirectional, you wouldn't be able to submit for that measure. Does that make sense?

I think it does, but then you'd lose out on points. So what we should do to get the maximum performance score is use the transitional. So you can pick and choose between the two? You don't have to either submit all the transitional or all the --

Correct. Correct, correct. You can pick and choose between the two. That's why on the slide that said, "Or a combination."

Okay, all right. Thank you.

Yes, 'cause we're trying to be as flexible as possible.

Okay. Thanks so much.

Mm-hmm.

Your next question is from Thomas Magrino.

Hi. This is Thomas Magrino from the Mary Washington Health Alliance. We're an ACO MSSP Track 1, so we're not an Advanced APM, but we do plan on doing group reporting through the Web interface for the quality portion, and we'd like to do that for the ACI portion, as well, if possible. We do have some concerns, though, around the all-or-nothing, the attestation measures, such as the health-information security risk assessment. If one of our practices out of, like, the 90 or so that we have says no and all the others say yes, what do we attest to the CMS?

You're submitting as a group under 110?

Yes. So, have an ACO tax ID. However, we have multiple independent billing TINs under us.

Okay. But it would be -- MPI is associated with 110. So if one person in that group can say yes to the security risk assessment, then you would submit yes. It's just one yes.

Excellent. Right, well, thank you very much.

But we do point out that performance of the security risk assessment is actually a HIPAA requirement.

Oh, yeah, yeah. I mean, that was just an example.

Okay.

One is the other attestation. One slipped my mind.

Right, okay. Great. Thanks.

Great. Thank you.

Your next question is from Shana Banner.

Hi. Thank you for my call -- or for letting me ask questions. So, we have a behavioral-health clinic that has several MBs that are psychiatrists. So, are psychiatrists considered eligible clinicians?

Yes.

They are. Okay. So they would be part of the group. We have a hospital and several clinics under one tax ID number, so they would be considered part of the group?

Yes, they would. But if you don't have data for them, you wouldn't submit data, but they would still be part of the group, and they would earn whatever adjustment the group earned.

I'm not sure what you meant by that, if we don't have data for them.

Even if you don't have data, if they're part of the same tax ID...

Mm-hmm. Okay.

...and you're submitting as a group, whatever data you submit counts for all the members of that group.

Okay, okay. I don't want to use up a bunch of time, but as a group, how do you identify the providers that are under a group? Are you using PECOS and the tax ID number associated with their MPI under the PECOS, or do you have to actually register somehow that, who's in our group?

Lisa Marie, do you want to respond?

So, you're asking how we determine which MPIs that are associated with the TIN? Is that what you're asking?

How do you determine what providers are under our tax ID number that qualify for QPP?

So, yeah, what we do utilize is information. We actually use claims data in terms of when we see things come through, we look at claims data to look at, you know, what's being utilized in terms of, you know, relative to the TIN, and then go to a participating TIN -- the MPIs associated with the TIN. So that's how we can determine those who are associated with the TIN.

So it's all based on clean data?

Yes. And I guess, like, there's, also -- so, are you, like, also asking about, like, how exclusions are applied, too? 'Cause I think -- I want to make sure I'm understanding, like, your question. But essentially, like I said, yeah, we use claims data.

Okay. And that's Medicare claims only?

And these are just Part B claims?

Correct.

All right. Thank you.

Your next question is from Sedaka Singhill.

Hi. Thanks for my question in time. These are all regarding the performance measure, and we are not on EHR, so we will not get any points for those, do we? We do e-prescription, but besides that, we are not done EHR yet.

Right. You need to be on an EHR to earn points under the Advancing Care Information performance category, correct.

Okay. And one more question -- how -- I know you didn't cover that. How we can submit, like, measures for the quality-care measures.

How to submit?

How we get the measure submit to the qualities. Just claim basis?

You have several options, and its QCDR, qualified registry, EHR, or claims.

So --

You just need to choose one of those mechanisms.

Okay. Thank you.

Your next question is from Luke Maxwell.

Yeah, thank you very much. This is Luke Maxwell from Care MD. I just wanted to know that if a provider is part of an ACO, the Accountable Care Organization, are they even eligible for the Advancing Care Information? You know, can they partake in the MIPS program if they're a part of the ACO?

Yes, they can participate in MIPS.

All right. Thank you very much.

Your next question comes from the line of Aaron Hubbard.

Hi. This is Aaron. My question is, does all the data for the Advancing Care Information have to come from the certified EHR?

Yes. All the measures are based on Certified EHR Technology?

So, can I ask you a follow-up question to that? If we run the state health-information exchange, if they're pulling data from the state HIE and just -- that doesn't count, then?

It doesn't go through an EHR at all?

It doesn't go through the EHR. It's Web access. Do you log on to it to pull the information off of it? It's not connected to the EHR at all?

Okay, what I'd like you to do is submit this question to our call center. You can call, or you can e-mail them, and then we'll get an answer, okay?

Okay. Okay. Thank you.

Okay, we can go back to some of the chat questions, and then we can go back to the phone. Someone asked, "We have multiple clients who do not have EHR systems. Will they need to submit hardships for re-weight?

If they don't have EHRs, they could submit a hardship if they fall into one of the hardship categories. And the Quality Payment Program hardship applications up, there'll be more information on each of the hardship categories.

Okay, great. One question -- are you allowed to use more than one reporting mechanism?

For 2017, within each category, you must choose a reporting mechanism. You can choose three different reporting mechanisms, one for quality, one for Advancing Care Information, and one for improvement activities. But within each category, you must use the same method.

Okay, great. Another question about certification -- so, just to clarify, we are on a 2014 edition. I was told by help desk that we can only submit the ACI transition measures, but I heard today we can pick from state 2 mod or stage 3. I guess they're looking for clarification there.

We know that lots of people are in the process of transitioning, so they may have some modules of 2015 edition and others of 2014 edition. In those circumstances, they can do either one, either measure. But there are certain measures under 2015 edition, if you don't have, like, for example health information exchange, you may not meet the requirements of the measure if you only are on 2015 edition. You may have to report using the transition measure if your EHR technology can't support the Advancing Care Information performance measure. You have to check measure by measure to see if you can fulfill that measure.

Okay, great. Another question, is the positive adjustment based on the denominator value alone? You mentioned earlier that it is the proportion of numerator over denominator that determines the performance score. But then it was stated that the positive adjustment could be higher with more time due to a larger denominator value. So it's looking for clarification if a larger denominator contributes to a higher positive adjustment or if the ratio would stay the same.

It's the ratio. We just assume that if you have a larger denominator over time, your numerator would also increment and be higher.

Okay, great. If no EHR, can a third party help us get on to an EHR system before October to submit by the end of the qualifying year? Perhaps you can clarify the submission date, as well.

Well, you need to be on Certified EHR Technology for 90 days in the calendar year to be able to submit the Advancing Care Information performance category measures, so that October 2 date is the date you'd have to be on Certified EHR Technology in order to successfully report for 2017.

Okay, thank you. I think you already said this, but someone was asking for clarification. You mentioned working on something for HIE because it's been

hard to achieve. Will you be considering an exclusion for the e-prescribing measure? I think you answered this, but -- Yes. We are considering options of how to enable more people to fulfill the base measures of health information exchange and electronic prescribing.

Okay, thank you. Let's go back to the phone lines.

Your next question comes from the line of Heidi Harding.

Yes. Can you hear me?

Yep.

Okay, thank you. It's a three-prong question, related to what somebody else had asked. The first is my understanding is that in an ACO, for example, an MSSP Track 1 ACO of 10 participating billing TINs, each billing TIN would have to submit their data for ACI, correct?

Correct.

Okay. And if the billing TIN -- it is mentioned, I've seen, that there is a weight that is applied to how much weight each billing TIN gets for the scoring. What is that weighting factor? Is it the number of MPIs in each billing TIN compared to the total number in the ACO?

I'm sorry, I can't answer that question. Does anybody else on the line know the answer? If not...

Would the person be able to just repeat the question? 'Cause I know it's like a three-pronged question, so I was just trying to, like, follow. Could the person repeat the question?

Okay, yeah. So, what is the weighting -- there is a weighting factor that is applied to the score each of the participating billing teams gets for ACI for the overall score of the ACO? And what is that weighting factor? Is it the number of MPIs that are in the participating billing TIN as compared to the whole of the ACO?

Yeah, that's something that APM... Yeah, would you be able to submit that question to the service center? 'Cause I know we don't have folks who are SMEs for the APM side or the APM scoring standards. So yeah, if you could submit that there, we'll get you an answer.

Okay. I didn't ask it for that reason, so I think I need clarification, then. So is it the billing TIN that gets only that ACI score individually, or aren't they all lumped together for the whole of the ACO? We're a Track 1 ACO.

Okay, yeah. All of your questions do relate to the APM, like, scoring standards. I can see that you're asking if things are applied at the MPI level, which could be the individual level, or at the group level. And, again, we don't have our colleagues who are the experts relative to, like, the APM side. So I wouldn't be able to answer your question. I apologize.

Okay. So, I'm gonna try and rephrase it in another way. If I have 10 participants -- I am a Track 1 MSSP, so I'm not an APM, and it's very possible I'm not asking the question correctly, then. Each TIN would have to

actually attest or somehow get their data in for ACI, the ACI component, correct, of MIPS?

Correct.

Okay. Is it a collective score for all of those billing TINs that is calculated and applied to all MPIs and all billing TINs and their MPIs for the ACO, or does each billing TIN get a separate ACI score?

That's the part we don't know, because it's based on the ACO scoring, and we don't have the ACO experts on this call.

Yeah, 'cause it's relative to, like, group reporting, like, under MIPS... I don't know how that works in terms of, like, the ACO, like you're saying, like, if it's just applied to each MPI or if it's each TIN associated with the ACO. And that's what we don't know, 'cause we're not the experts on that element.

Your next question comes from the line of Deann McTallins.

Hi. This is Deann from... Thanks for the webinar. Two questions. Question about the references to groups and whether any of the conversations today about groups has its requirement of registering by June 30. And so how would they know, then, to utilize the CMS Web interface and/or administer the consumer assessment of health providers in the system survey? And, then, the other is are the denominators -- I looked at the specification sheet you referenced earlier -- did those include all patients or Medicare patients only? I had heard in a previous webinar that was referenced Medicare only, which definitely counters that to what we have been doing for... Thank you.

So, I can answer the denominator question. It's all patients.

Great.

In regard to your first question, if you're wanting to report utilizing the Web interface or if you wanted to also administer the cap survey, yes, you would need to register through the portal and register for the Web interface. And the deadline, as you noted, is June 30. So you are correct with regards to groups wanting to utilize that submission mechanism. If groups want to use other submission mechanisms, such as like EHR, QCDR, or a qualified registry, you do not need to register. We only are requiring registration for groups that want to report via the Web interface, the CMS' interface, or if they want to administer the cap survey.

Thank you.

Your next question comes from the line of Ashley Taylor.

Hi. This is Ashley Taylor with HCA PSG. I was just wanting confirmation regarding providers that render services for multiple TINs. Will they need to submit separate attestations for each TIN MPI combination for each performance category?

This will be a summary. So, if there is, let's say, an MPI, clinician within MPI who works in multiple facilities or practices, and they have obviously, you know, TIN/MPI combinations. So for each individual TIN/MPI combination, that individual would need to participate in MIPS for each,

like, TIN/MPI combination. So if someone would be practicing in three practices, that individual would need to report from MIPS for all performance categories relative to those TINs that they're associated with. So, also, and the factor we'd have to consider is if the person may be excluded based on one of the exclusions. So yes, we're required to participate for each TIN that they're associated with, but that person may be eligible for an exclusion, so that would also apply in that circumstance.

Awesome. Thank you so much. We thought that was the case, but we just wanted confirmation. So thank you.

You're welcome.

Your next question is from Shelly Laurenson.

What's the patient education if you're using the ACI measure for the transition?

Does that need to be electronically provided to the patient, or is it more in correlation with the modified stage 2, where it did not have to be electronically provided?

If you are reporting under the 2017 Advancing Care Information transition measures, it would be the same as what was required under modified stage 2.

Okay, thank you.

Your next question comes from Doug Blinco.

[ Clears throat ] Hi. Good afternoon. This is Doug Blinco with WellStar Health Systems in Atlanta. My question is about -- can you hear me? I'm sorry.

Yes.

All right. My question is about the improvement activities and how they correlate with the bonus points for ACI. So, improvement activities are a separate category, and I understand that piece, but do the improvement activities -- or does the improvement activities category define whether or not you actually get the bonus points based on what you pick, or can you pick separate EHR-derived improvement activities to use as bonus points?

Okay. Let me see if I understand this. So, you can submit as many improvement activities as you want. When you are submitting, if you choose to attest, for example, it will show you how many -- it will increment your score as you're submitting based on whether you're submitting high or medium, but then it will also tell you if the improvement activities that you select are ones that would count for cert. When you submit your Advancing Care Information, you need to submit your -- if you are submitting improvement activities under cert. So you would still submit separately, but you could have overlap as to which ones they are.

Right.

So you submit one.

So would I --

I'm sorry?

I was gonna say, so when I have my conversation with my population health folks and we talk about improvement activities, my goal as the ACI coordinator is to really just get them to include the ones that I need them to include so that I can use them for bonus points?

Yes.

Along with everything else that they're gonna submit to? All right, cool.

So if you choose two high-population health on this cert list, that would get you the full improvement activity score and give you the bonus under ACI.

Right, perfect. Thank you so much for that clarification.

Mm-hmm. Okay, we only have just a couple minutes left, so I will just take a couple final chat questions, and then we will conclude today's webinar. One question, will there be a registration process like there was for meaningful use?

At this time, that is not a requirement, just the requirement, as Lisa Marie mentioned, for if you are submitting as a group for the Web interface or for cap.

Okay, thank you. Does the security-risk analysis need to be done during the 90-day reporting period, or can it be done at any time during the year?

It must be done within the calendar year. So it doesn't have to take place during the reporting period, but it must be done during the calendar year.

Okay, great. I think we have time maybe for one more question around... If you have a provider that is a new participant, but didn't attest in 2016 for meaningful use -- I think the question is what should they do this year?

So, they're a new provider.

Yes, new participant. They didn't clarify.

Okay. So, if they've never done meaningful use, they would need to submit a hardship under the EHR incentive program. That hardship application is up on the EHR incentive program website now, but they need to submit a hardship, because they could still be subject to the EHR payment adjustment in 2018. So that would take care of the EHR payment adjustment. For MIPS, if they are a new provider to Medicare, they do not need to report in 2017. However, if they're just new to meaningful use and to EHR, they would need to participate in MIPS, so they would have to do the Advancing Care Information performance category.

And this is Lisa Marie, just to also add on that. So, everything that Elizabeth said is absolutely correct, but also thinking about the other exclusion. So, also, let's say if someone may be required to, as Elizabeth noted, relative to, like, ACI and EHR, but if they do not exceed the low-volume threshold, then that person would also be excluded from MIPS participation.

Okay. Thank you, Lisa Marie. And we are at time, so thank you to everyone who joined the webinar today. If we did not get to your question, please feel free to e-mail the quality team at program service center at qpp@cms.hhs.gov, or you can call 1-866-288-8292. And thank you, all, for your questions and feedback.

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