[Classical music plays]

Hello, everyone. Thank you for joining today's Quality Payment Program Data Submission Office Hours: MIPS Attestation for Advancing Care Information and Improvement Activities. During the Office Hours section, CMS subject-matter experts will answer commonly asked questions about MIPS Attestation for Advancing Care Information and Improvement Activities. First, CMS will answer a selection of pre-submitted questions. You can submit additional questions through the phone or the questions box, which CMS will address at the end of the webinar as time allows. And now I'll turn the conference over to Adam Richards, Health Insurance Specialist for CMS. Please go ahead.

All right. Thank you, and good afternoon, everyone. Welcome to our final Office Hours session on MIPS data submission for the 2017 Performance Year. We're certainly glad to have each of you here with us again today. We've had significant interest in these sessions thus far, and we hope that we'll be able to answer each of your questions as we get ready to move into the final stretch of the submission period, and I think this is our first opportunity to remind everyone today that that submission period does close on March 31st. If you didn't have a chance to attend a previous session, we certainly encourage you to visit the Quality Payment Program Library on cms.gov and listen to those previous recordings. There was a lot of really great information covered. For example, we just recently had an excellent discussion about submitting Quality -- Quality data through the MIPS submission feature, which is valuable to review for those who are on the line and still have some questions around that specific topic, but today our goal is to shift the focus to submitting data for the Advancing Care Information and Improvement Activities Performance Categories. We have a fantastic group of subject-matter experts assembled to help address your questions, and we'll try our best to answer as many questions as we can. However, please note that not all of our policy representatives and product representatives are here today. So, if need be, we will certainly take questions offline, and we can always respond at a later point. Also, just a note that there may be times to where the group in the room, where we want to talk through some of the questions to provide you with the best overall answers and guidance. So if you do hear silence for a bit, don't worry. We'll be right back. Finally, before we get started, I do want to remind each of you that there is still plenty of time left to submit. If you need help, of course, please contact the Quality Payment Program Service Center, and we'll have that information posted on the slides in just a bit, or feel free to reach out to one of our no-cost technical-assistance organizations. I know very well that they're all standing by right now, ready to help you through this submission process. So please take advantage of that free help. At this point, I think we're going to get ready to jump into our kind of first half of the discussion today. So if we move on to Slide 3. So we're going to start with some of our trending questions. These are the questions that some folks have submitted prior to our session today, but also questions that we've seen trending over the last few Office Hours sessions. I'm going to start, just kind of open it up, and we can get into these, but, basically, "Who needs to submit MIPS data by March 31st?" I'm happy to kind of open that one up, and then we'll get into further questions. So this really is for MIPS-eligible clinicians. They need to submit by March 31st. So those who are doctors, physician assistants, nurse practitioners, clinical nurse specialists, or certified registered nurse anesthetists, these are the five clinician types for MIPS, and those five clinician types that have filled more than $30,000 in Medicare Part B-allowed charges and saw more than 100 patients in 2017 with the latter known, is known as our

low-volume threshold. So, of course, if you are unsure of your status, you can visit qpp.cms.gov, and use the NPI Lookup Tool for quick eligibility determination. So we encourage you to use that tool. Getting into the second question, so, really, once you've identified if you're a MIPS-eligible clinician, and then you get into the data-submission feature itself, we have a question around file types. So, "Can you explain the different file types that are available for formatting and submitting my data?"

Yeah, I can speak to that a little bit. So there are a few avenues that users can make use of to submit their data and measures information. So the first is to simply use the submission user interface available in the application by navigating to the Advancing Care Information or Improvement Activities pages. Another option is to directly make use of the submission API feature if you'd like to submit that data without a user interface, and finally is being able to upload a file using the "File Upload" buttons that are available on each of the category pages, and with those particular file uploads, you can either upload a QPP-formatted JSON file, a QPP-formatted XML file, or a QRDA III-formatted XML file, and if you'd like to know a little bit more about how to structure the syntax and data around the QPP-formatted files, you can use the Developer Tool link down at the bottom of the QPP website.

Excellent. I think the next two questions we're going to pair together, and these are some frequently asked still around the submission feature itself, but, one, "Where is the 'Submit' button, and how do I really know if I've submitted my data successfully in the feature?"

Yeah, so the nice thing about the Quality Payment Program for this rendition of the application is that everything that is submitted to the application is stored and evaluated in real time, and so as long as you're able to see the effect of the measures data that you're submitting on the user interface, or the "Success" message that is seen for a file upload, then you know that the data has been submitted and stored and evaluated successfully, and it is also important to note that the U.I. that is displaying measures data is only currently displaying it for the entity for which you are currently viewing. So if you are navigating to report as a group versus report as an individual, you might see a different measures data represented in those various entities based on what was submitted for those entities.

Excellent. Thank you. Actually, the fourth -- or, I guess, the fifth question on here is one that we saw come out of the last two sessions. So a question, "Once I get into the feature, can I submit both as an individual and group within the data submission feature?"

That is correct. When you log into the application, depending on your authorization model for who you're allowed to submit for and how, you should see the capability on the dashboard for various groups and practices in order to report as a group or report as an individual.

Perfect. And, really, our last, I think, question here just for the time being on the submission feature itself is, "Will clinicians or submitters have access to their data and performance scores after the March 31st deadline?"

That is also correct. The feedback application portion of the user interface will be opening after that time. So the submission window and user

interface will close, and then the feedback window for that measures data will open and have richer information that is available for what has been submitted, and then, eventually, for the final-score information.

Great. Thank you. Let's move on to our next slide. We'll break away from the kind of technical features within submission features for just a bit. I think we will return in a question or two, but to start talking a little bit about those frequently asked questions around the Advancing Care Information Performance Category. So, I'm going to start with the very first question on here, and I know we do have some of our subject-matter experts on for Advancing Care Information, so "If I plan to 'test' for the first year by submitting the base score for Advancing Care Information, does this need to be for a 90-day period or can I submit less than that, less than a timeframe of 90 days?"

So it's going to depend on the performance period that was being evaluated at the practice in particular. The business logic for the 90-day performance period is that for a submission that is less than 90 days for that performance period, the base score and the scoring capabilities for Advancing Care Information is going to be capped at 50 out of 100 and will not have the performance-score capabilities for those base measures, but a performance-period selection of 90 days or greater will increase that cap and will allow for the performance score for those measures and will also open up the ability to submit the optional performance measures and bonus measures below that.

So I think the answer to the question here is, yes, if you're testing, your performance period can be anywhere from one day to 89 days, and you can only submit the base measures. That's all you'll be scored on. If 90 days or more, you can submit base and performance and bonus measures.

Excellent. Thank you, both. And, Elizabeth, I'm going to throw the next one right back to, "How is the Advancing Care Information performance category score calculated for group reporting?"

Adam, do you want me to take that?

Sure. Absolutely.

Okay. So if a group -- So a group of clinicians, that is, with multiple NPIs under the same TIN chooses to submit for Advancing Care Information as a group, they would sum all their data for the group, and that would include people within the group who have a special status that includes a hardship or some other kind of reweighting, such as being hospital-based, they would include all the data for the group and submit it together. If the group is on several EHRs, they would add the numbers for each measure they plan to submit across the EHRs. The only way a group would not have to submit Advancing Care Information is if the entire group qualified for some sort of reweighting, meaning they have a special status, such as hospital-based, ASC-based, or non-patient facing, for example, or they submitted a hardship exception application and were approved if they had either -- If the whole group, 100% of the group has qualified for reweighting, then the whole group would be reweighted, and for the group, the entire group would share the same score for Advancing Care Information.

Excellent. Thank you so much. We're going to jump into the next question, our third question, so for the Advancing Care Information, "I applied for a

hardship exception in 2017." So they met the 2017 deadline. "Will I see this information and/or adjustment within the data submission feature? Will I see any information on this?"

So this information will be reflected after the close of the submission period within the feedback report, but will not be displayed during the submission period.

Perfect. Thank you. Also, kind of sticking with the submission feature itself, "Is there a way that I can look up my Edition of Certified EHR Technology within the feature?"

There is. On the Advancing Care Information page, there is a tool near the top of the page that will allow users to look up their EHR technology and to see which track is recommended based on that version year. However, looking up your EHR Technology year is not a requirement in order to complete your submission or to move down the page, and if you find that you would like a more full-fledged set of results, you can also navigate directly to chpl.healthit.gov in order to see a wider range of search options.

Excellent. Thank you. Moving right along these Advancing Care Information questions, getting into the last ones -- and I know we do have some of our subject-matter experts on from the SSP side of the house, Shared Savings Program side of the house. So, "If I'm in an ACO, an Accountable Care Organization, what happens if one of our TINS does not report Advancing Care Information?" If anyone can take that on?

If one of your TINs does not report Advancing Care Information, it will receive a zero for the ACI roll-up at the end of the submission period. So, essentially, for however many NPIs are underneath of the TIN, they'll receive a zero while creating the final score for that SSP.

Excellent. Thank you. And we're going to keep on moving along, jumping into our next slide to talk a little bit about the Improvement Activities performance category -- a couple of questions, a couple of trending questions that we've seen come in. I know that the first one we've heard quite regularly. So, "I'm in a small practice and submitted my Improvement Activities, and I thought my score was going to be doubled based on my special status. Why don't I see this dynamic scoring in the submission feature?" So I can start with the answer there, if anyone wants to jump in. The Product Team, our team here have certainly provided a great feature with some great functionality, and while there are some updates to the functionality that will be added in the future, the special status factors -- so the Small, Rural status, for example, will not be applied to performance until after submissions have closed. So eligible clinicians and groups may submit updates to their MIPS performance until the close of submissions on March 31st, as we've been saying throughout the presentation today, our discussion, and updates to MIPS scores to include the application of special status on scoring and other functions, such as the application, new benchmarks on measures that met benchmarking requirements will be fully reflected within final scores that are provided later this summer. I think we should be pretty good there. So, jumping into the next two Improvement Activities-specific. So, "I attested 'yes' to my Improvement Activities and received the completion designation, the trophy. Do I need to do anything else or keep any documentation that I completed all of these activities?" And I believe we have Angela on the line.

Hi. Thanks, Adam. Yes, you will need to keep some documentation for whichever activity that you submitted. If you go onto the QPP website and go to the Resource Library, you can click that link, and it will actually take you to a new spot on the cms.gov website where it outlines the validation document for the improvement activities. In that document, you will find that each activity has a suggested documentation listed, and you would just go to whichever activities you've attested for, and you will be able to see, based on each activity, which documentation we are asking you to maintain for a period of six years.

Excellent.

And if I may, the only additional item that I would add as to whether the user in this state is completed with Improvement Activities from another question that we've been seeing is that if you're also trying to attest on the Advancing Care Information page for the CEHRT-used measure, which is down at the very bottom -- ACI-IA CEHRT-1, you must also have an accompanying Improvement Activity on the Improvement Activities page that is identified as CEHRT-used or CEHRT-eligible, and there are 18 Improvement Activities that qualify for that option. So even if you've achieved the full score for Improvement Activities, you may want to look into CEHRT-eligible activities if you're trying to earn that bonus.

Great. Thank you. Thank you, both. Next question on Improvement Activities. "Can a group use the CAHPS for MIPS Survey as a Quality measure and an Improvement Activity for the same performance year?"

Thank you, Adam. This is Angela again. The answer to this question is yes. You would have to attest to the Improvement Activities separately from the Quality measure, however. So I just want to note that and make sure folks understand that.

Okay. Excellent. Thank you. Okay, so we're going to keep charging along. I believe this is going to bring us to our open question-and-answer session. Yes, we can go to Slide 6. Perfect. Thank you. This will bring us to kind of the open-discussion portion of our Office Hours session. In just a minute, I'm going to turn it over. As you can see on the screen, we do have the instructions. Moderator, if we can go through those one more time for folks, please.

We are now going to start the Q&A portion of the webinar. You can ask questions via the Q&A box or phone. To ask a question via the phone, please dial 1-877-388-2064. If prompted, provide conference I.D. -- 8249909. Once you've dialed in, you may press Star 1... [Indistinct]

Okay, so we'll just -- As everyone's kind of dialing in, the instructions are on-screen, so feel free to give us a call. We'll kind of open up the lines in just a second. I will say we're getting a lot of very good questions. We've got our subject-matter experts certainly within the Q&A, answering as many questions as they can at the time. I will also remind folks that in addition to the recordings of these Office Hours sessions, which I certainly encourage you to review. As Angela mentioned, we do have the link on qpp.cms.gov to get you over to the CMS Library. So in addition to reviewing these recordings, we do have a number of training videos for different aspects of the submission feature. So not just aspects of the feature, but also scenarios. So certainly encourage you to navigate over to the CMS Library. That way you can take a look at those training videos

within the last stretch of the submission window. So, at this time, we're going to open it up for our first caller. Moderator, please.

One moment for the first question. Again, if you have a question, please press Star and the number 1. Your first question is from Randi Terry.

Yeah, I have a couple questions. My first question is, under the Improvement Activities, can you use the same Improvement Activities from one year to the next?

Hi, this is Angela. Yes, unless otherwise specified within the Improvement Activity, you can do that.

Next question is, we have one of our vendors that is not able to submit our Quality scores. We've been working with them from January 15th. Any suggestion on that? Do we just not get to submit those, or...? We can't submit them manually, and if the vendor can't submit them, and they're a pretty big vendor in the industry.

I'm sorry. Is this a QCDR that you're talking about?

Yes, it's a Quality.

Okay. Okay. I did some checking to make sure it wasn't Improvement Activities. Do we have someone from the Quality Team on the call?

Yeah. So this is Tim. So, can you help me understand when you're saying they can't submit as in they cannot access the Interface or they can't produce a file based off of their performance in the data from 2017?

They can't do either. Their software will not allow us to submit. We get an error, and we tell them just give us a QCDR-III file, and they can't do that, either.

You mean a QRDA file?

QRDA. Thank you.

Yeah. So in these cases, usually they need to work -- There are other vendors potentially outside the vendor which they are working with now that can be granted access to do manual abstraction or extraction from their system to build the file. I don't have, nor can we really go into all that on this call, but there are registries that have that function available.

Okay, thank you.

Thank you.

Okay, thank you. We'll take our next call at this time.

One moment for the next question. Your next question is from... [Indistinct]

Hi. I have two questions. My first question is, does the providers billing under a TIN that ceased prior to the 90-day period, are they excluded from reporting or will they face a penalty?

I'm sorry. This is Tim. Could you say that one more time? I apologize.

Mm-hmm. If a provider was billing under a TIN, and the billing ceased prior to the 90-day period, are they excluded from reporting or will they face a penalty?

So, let me say that back so that I'm understanding. So the individual was part of a group or a TIN that was eligible on, let's say, August 29th. It ceased to be participating in October. Correct? Or something of that nature?

Yes. So they just didn't bill up to a 90-day period, and then they switched to a new TIN.

But it was in 2017?

Yes.

Yeah, they need to report. They need to submit.

Okay. And then my other question is, I know if a provider gets a hardship exemption that the points are redistributed from the ACI to Quality, but does that still stand the same if they're in a MIPS APM?

This is Tim again. I don't know if we have any APM experts on the call, but I don't know of any APMs that have a hardship.

So -- I'm sorry. Do you mind repeating the question?

If a provider has a hardship exemption, are the points redistributed from the ACI to Quality if they're in a MIPS APM?

So that would only occur if the entire APM entity is actually reweighted. Otherwise, essentially, what will occur would be the practice would have a zero-over-zero contribution to the ACI roll-up score.

Thank you. I hope that helps. And we'll take our next caller.

Our next question is from... [Indistinct]

Hello. I'm in an Advanced APM, and CMS has said that if you're in a Medicare Shared Savings Program that you're required to test to ACI because it's used to calculate ACO Measure 11, and from what I... [Indistinct] reporting the first two years, you only need one EC to attest at the TIN level to satisfy the reporting requirement. I guess my question is, what is the benefit to my providers for them attesting to ACI if they won't get an ACI score since they have QP status?

I believe what you're asking about is actually a program requirement for SSP. So if there's an issue with the program requirement, I would follow up with the SSP Team.

And do we have our SSP Team on?

Yeah, this is Rabia Khan. So, for ACOs meeting the Advanced APM definition, we do need to calculate that ACO-11 Quality measure. So the measure is also used to help meet the Advanced APM status. So we do urge you to have your ACO participant TINs report -- ACI, and in terms of the ACO-11 Quality

measure, what we do is, to meet the Numerator of our measure, you must meet the base score for ACI reporting. And we'll be using the data that has been collected from MIPS for ACI reporting to calculate that. I hope that helps.

Thank you, Rabia. I think we'll go on to our next question.

Our next question is from Mike [Indistinct]

Hi. Is there a way that the ACO can tell which of the TINs has reported their ACI?

There is currently no way for the APM to see which one of their participants has recorded ACI.

Okay. So, but that doesn't negatively affect the ACO if one of the TINs did not. It only affects the TIN. Correct?

No. If the TIN does not report when they're creating the ACI roll-up score for the APM entity, that TIN will essentially contribute zero points out of however many participants are part of the APM.

So, is there a plan to have a way that the ACO can see that information?

For year one, there is no functionality that will exist that will allow for the APM entity to view that data.

But this is a good piece of feedback, something that we can certainly consider going to future years. I hope that helps at least answer some part of the question.

Yeah. And at times, we have a number of TINs that are in the ACO and some of the smaller practices may or not understand this fully, or we're not always 100% confident that they've done what they've said they've done.

Makes sense. Yep. We definitely captured that feedback. Thank you so much.

Yep. You're welcome.

Okay. Let's move on to our next question.

Our next question is from Kristy Wisner.

Yes. Thank you for taking my question. Yeah, I have a couple ACI-related questions. I put them in the chat. I'm not sure if they were answered or not yet, but my first question is, if you're using group reporting for ACI, and the TIN has to report for the ACI performance category that's not automatically reweighted, can they report if they only have the CEHRT report -- that CEHRT type inpatient so they basically don't have any ambulatory CEHRT, giving that MIPS is in all settings, not just an outpatient program?

Yes, they can report using that TIN.

So they can just use their inpatient report as a whole and use that to do a test?

Yes.

Okay, great. My second question is that if the TIN -- again, it's using group reporting for ACI, and they want to attest to one of the public-health registry measures, like immunization, if the interface is for the inpatient CEHRT, not to ambulatory CEHRT, does that satisfy the measure?

Yes, as long as they meet one of the active engagement levels.

Okay, great. And then my final one, I just want to confirm that if a group is reporting for IA activities, and they want to make sure they get the ACI CEHRT bonus, they can submit more than the maximum number of activities to achieve the 40 points? Like, for example, if they submitted PCMH that's worth full credit, and they also submitted another activity like [Indistinct] that's qualifies for the bonus, and they do the CEHRT bonus and they do that activity -- [Indistinct] the score of all those IAs, right, and you'll get that bonus?

As long as you also say "yes" when you're submitting your ACI bonus. You have to submit it under both categories -- under IA and ACI.

Okay. But CMS won't limit it to once you achieve 40 points, stop looking at other activities submitted. Correct?

That's not my understanding.

Okay, perfect. Great. That's answered all my questions. Appreciate it. Thank you.

Thank you. Just quickly just to give all the subject-matter experts just a bit of a breather, I've seen a lot of questions coming through, or the chat about the recordings, where they're to be posted, so I do remind everyone that these will be in the Quality Payment Program Library that is currently on cms.gov. You can access that site with all of the resources by going to qpp.cms.gov, going to our Resource Library, and it will certainly redirect you to the Quality Payment Program Library on cms.gov. Once again, I do recommend in addition to kind of going back and listening to some of the previous Office Hours sessions, which had a lot of the basic components that we covered, certainly taking a look at the Data Submission Training Videos. We do have excellent videos on individual and group submission for MIPS, submitting Advancing Care Information for APMs, data submission for QCDRs and Qualified Registries. We also have our newest video. It was just released a few short weeks ago, but it's basically the MIPS Clean Space Measures and how you'll see those inside of the submission feature. So, I certainly encourage you all to check those out certainly after the call and as we get into the final stretch here. So we'll move back to the phone lines and keep going. I know we do have a few folks online, so we'll take the next caller.

Our next question is from Julie [Indistinct]

Hello? Hi. So we're in a Track 1 ACO, and we plan to individually report for those providers who joined our ACO TINs after the August 31st snapshot. When I look on the QPP website by NPI, it looks like the providers are still associated with the previous TIN. So how do we determine their eligibility with our TIN and who's responsible for reporting with the current TIN or their previous TIN?

That one we may have to take back. I'm kind of discussing in the room a little bit, but we may want to take that one back just to make sure that we're...

Can we repeat that one more time? Because I'm not sure if we have the people in the room to answer it, but we may.

Sure. So we're in a Track 1 ACO, and my understanding is that for those providers who join an ACO TIN after the August 31st snapshot, they can't be included in group reporting, so we have to report for them individually. So, for those individual providers, I look on the QPP website to determine their eligibility, and it looks like they're not associated with our current TIN or with our current organization's TIN. It looks like they're still associated with a previous organization. So my question is, who's responsible for submitting -- for reporting for these physicians, and then how do we determine their eligibility with us, with our current TIN?

Yeah. Thanks for that. And, yeah, we're definitely tracking with you now. That is something that we want to take offline. So I think what I'm going to do is have our moderator, our support team capture your information, and it will have that question, so we can work through it offline.

Okay. Thank you.

Thank you. Okay, we're going to charge along to our next call.

Our next question is from Tammy Ferrell.

Hi. Is my understanding correct? [Indistinct] as a group, but then also have data for individual providers that are within different EMRs within the TIN that I can submit data individually, as well?

I'm not sure if I'm tracking the conversation fully, but depending on the authorization model of your login, if you can see those practices available from the dashboard and navigate to their category pages, you should be able to submit as an individual there.

...or if that would block me out, then, from submitting individual data?

Sorry. You cut out. We're having some trouble. Can you repeat that last portion?

So, within my dashboard, I can see both -- For the individual providers, I can see both a group submission and individual submission link there, but because I haven't loaded group data yet, I didn't know if that would then close out the individual link ability. One of the questions that was posted here on the side, it gave me the impression that I could submit both group data and individual data if it was coming from different EMR, and then the QPP site would take the best scoring for that provider.

So, essentially, what would happen is, as Richard mentioned, you can navigate down to the NPI level within the application. If you are submitting data for both group and individual after the submission period closes, it will evaluate both of those submissions for a final score, and whichever one is better it will use, so if the individual score is lower than the group score, the group score would override that NPI score.

Okay. And just to be clear, it would be not after the 31st of March. It would be data submission before then. Does that change the answer?

All data must be submitted before the end of March.

Okay. And then you had referred the training videos and you had referred to the Resource Library in regards to the data-submission files, the QRDA file or the XML file. Is that on the Resource Library through CMS?

The training videos are in the Resource Library. I think that's what you're asking for. Yes. So those instructional videos are in the Resource Library. They're under the 2017 Tab. So you'll be able to see what I mentioned earlier about submitting as an individual in a group for MIPS, the Advancing Care Information for APMs, QCR's Qualified Registry Data Submission, and seeing your claims score inside the submission, as well.

Great. Thank you.

Sure.

Okay. Thank you. We'll move on to the next call.

You're next question is from Leslie Budge.

Hello. This is Leslie. Can you hear me?

Yes, Leslie. How are you?

Hi. So, my question is this. I work with a group of physicians, and they have a new physician joining their practice this year. The physician was previously in practice, and she was using her own TIN for billing Medicare. So she's abandoning that TIN because she'll be using the group's TIN. Does she still need to report data for 2017, or because she won't be using that TIN, it's a moot point?

I believe that would be contingent on the eligibility within her own TIN. So if she was reported enough and became eligible for QPP, she would need to report for both that individual TIN, and then she would have to -- the new TIN, reporting, as well. And has she --

[Indistinct]

So my understanding is the program tracks by TIN, right, and so if you don't bill under that TIN anymore, you're not going to get a payment adjustment.

So just -- Sorry, just out of curiosity, has she gone on to the Lookup Tool, and is she eligible for each one of those TINs that are on there? Is she [Indistinct] as eligible?

Yeah, she is eligible for the old TIN. The new TIN has not been registered yet.

If she is eligible, then she would need to report. Otherwise, she would receive a negative payment adjustment.

Even under the new TIN?

Yes. So I think to best answer your question, the negative payment adjustment would be applied to her old TIN...

Right.

...and then in 2019, there is a caveat in the program that your payment adjustment will follow the NPI.

Oh.

So if you move from TIN to TIN, and that's the only other score we have -- Like, if you're in two groups, and you, in 2019, bill in a third group, we'll take the better of the two that we scored in this performance year, and we'll apply that payment adjustment, but if there's only one existing payment adjustment, and it's a negative score, that could potentially follow that clinician.

Okay. So she'll have two TINs. I'm advising her to do the -- just test the one measure, like the Improvement Activities, so she's covered where she won't get a deduction?

That's good advice. That would give her a neutral, and a neutral would follow her. So there would be no negative payment adjustment.

Okay. Thanks for your help.

Thank you. We'll keep on moving. We'll go to our next caller. Again, folks, I know that there are a lot of questions coming into the chat box. We've got a number of our experts in there answering questions. They're going to try as hard as they can to get as many questions as they can. If we don't get to your question, we'll definitely try to at least put out some education and other resources that help answer these questions in the future, but we'll keep moving along. So we'll go to our next caller, please.

Your next question is from Sue [Indistinct]

Hi, Sue.

Hello. I was just commenting. Again, I know you answered this question. We are part of a Next Gen ACO, and we had validated with a CMS Rep that we did not need to report ACI, and now I'm hearing over and over that we do need to report ACI, but our CMS Rep told us we did not. Because one of the questions coming into a Next Gen program is to submit your EHR. That was one of the perks, if you will, of being in an Advanced APM. So I guess I'm very concerned with mixed messages.

Yes, and unfortunately we don't have our APM Team on the line, I don't believe, so we can't confirm the information that you received from the CMS Rep. When you say "CMS Rep," were you referring to the Service Center?

Not the Service Center, the one that's assigned to us as a Next Gen ACO.

Oh, so the Model-specific support. Okay. Yeah, we --

This is Kim. I would say I think up until now, the answers we have been giving have been more related to Shared Savings Program ACO questions. So I

would think you probably want to go back to your Next Gen representative and just clarify that these answers don't also carry over to you. Like, it was already mentioned we don't have representation from Next Gen.

Okay. Thank you.

Thank you. Okay. Moderator, do we have anyone else on the line right now?

We do. One moment for the next question.

Our next question is from Rachel Groman.

Hi. I was wondering if you could clarify whether a QCDR vendor that opts to report ACI data as part of their sort of package of data when they upload the data, are they also required to submit the information-blocking attestations on behalf of their participants, or can individuals go into the data-submission portal separately and make those attestations? And the reason I'm asking is because we have a QCDR that was not aware that this was a requirement, and they submitted ACI data, but now they're getting zeros for everything because that package of data did not include the participant's information-blocking attestation.

Hi, there. Yes. A registry or QCDR submitting on behalf of a practice would need to submit any of those attestation statements, such as an information-blocking statement. As a group or individual user in the application, you can go in and submit those yourself, but your measures data that is being submitted is going to be compartmentalized as a different submission method. So a registry is usually submitting either the registry or Electronic Health Records submission method, but the submission methods on the user interface are separate and compartmentalized, and so the only two options would be for the registry or QPDR to include the attestation statements, such as information blocking, or to submit the data directly on the application yourself with the attestation statements and all of the measures data.

So CMS will essentially view them as two separate submissions if the individuals go in and try to do it themselves, but the registry also submitted the data.

Yeah, that's very correct. They're the same submission object, but they are separated within that object by the submission method, and so their score is analyzed and evaluated separately.

Right. Okay. And do you know where -- I don't know if we have the right people on the phone, but do you know where this requirement was listed? Because there seems to be some confusion in the QCDR community about them having to collect the attestation data.

I think that was listed in the final rule.

These are requirements that were dictated within the final rule. They've just been captured within the format to ensure that they're reported, that they are not actively doing any information blocking, and that they will cooperate with ONC.

Right. Right. I'm aware that the provision is in the rule, but I didn't see anything in the rule that said like a third-party vendor is required as part

of a sort of ACI package of data to collect that in addition to the measure data.

Yeah, it's a requirement for the category to receive credit, so in order for you to receive an ACI score, the attestation statement would need to be a part of the submission.

I hope that helps. Sure.

I want to go back to the previous question that we had for Next Gen reporting ACI. I did just follow up. If you are a QP, you are not required to report ACI data for Next Gen.

Yeah. Thank you. And we still do want to encourage -- I think it was Sue -- to follow up with the Model Team and just make sure that she does have the correct information coming from them for Next Gen. So, again, just a reminder. We will be posting a recording of this session in the Quality Payment Program Library on cms.gov. We do ask that you give us around a week or two. We do like to go through the transcripts, make sure everything is accurate, but we will have that posting recorded soon. So we have about five minutes left. We'll try to get through at least one or two additional callers today. So if we have anyone else on the line, we'll take them now.

Our next question is from Maggie Olson.

Hi. We just wanted to go back to the question of when providers move from one TIN to another. If a provider was previously in one organization and is now in ours, and we are submitting for them included in our group reporting, how would we know whether or not their previous TIN would have submitted for them or submitted individually? Just concerned about the ability or the opportunity for us to be obtaining a penalty that we aren't aware of or have no control over.

Can you just give us one second? We'll just kind of talk through this. We're going to put our heads together quickly. Thank you.

Yep.

Okay. We're going to try this. Sorry for the delay. We just put our heads together. I think we've got an answer for you.

Yeah. So I'm going to simplify this for my purposes. So they were in TIN "A," and now they're in your TIN "B," and you're going to submit a Quality submission and get scored for that particular TIN "B" combination with that NPI. Separately, that TIN "A" that they were previously in will or will not submit a submission and get scored. So if they didn't submit, they'd get the full minus-4 penalty. If they did submit, then we assume they'd get anywhere from a zero to a positive. In the future, if they're not in TIN "A" anymore, and not going to be billing in 2019, the implications of that payment adjustment would be negligible even if it was a minus 4 because they're not using that TIN/NPI combination to bill from. So as long as you're scored, and you do better than what that old group did in their submission, there shouldn't be any negative implications. If in 2019, they're still in your TIN "B," and they bill in 2019, they'd be applied to whatever payment adjustment was associated with your TIN for this year, and if they were in any new TIN combinations in 2019 that didn't exist now, they would receive

the higher of the payment adjustment between yours and that previous TIN "A." So I don't know if that completely answers your question.

So -- Yes. That's great. I just want to be clear. So, if -- Using your example. If TIN "A" did not submit anything for that provider, let's just say for 2017, would our TIN, TIN "B" take the negative payment adjustment for that provider if we do not do better than what TIN "A" reported?

No, you're --

Or would it matter because they didn't report at all?

Right. You're going to get -- For your TIN, you'll get whatever score you qualify for with your submission, and that will be the only score that would be applicable to you.

Okay. We wouldn't get a negative payment adjustment for that specific provider whether or not they previously submitted because we did on their behalf.

Yeah. Every TIN/NPI combination is its own entity when it comes to application of payment adjustment. So you and your TIN are only going to be applicable for what you submit and score.

Perfect. Thank you very much.

Okay. Thank you so much. We have reached the top of the hour. Just a couple of things before we sign off today. Again, we will have the recording, the transcript posted very soon. We do know that there were a lot of questions that came in. As you could hear by the conversation on the line today, some of these questions are very challenging. They challenged us in the room. Certainly, there's many moving parts, and there's a lot of nuance that we need to get through. So we tried to get through as many as we could today. We know there's a lot of questions still coming in. Some of our experts are still in the chat trying to answer those questions, but I will say all of the questions that you provide to us, we do look at as valuable feedback -- so ways that we can continue to improve the Quality Payment Program -- certainly different thoughts and ideas on the education outreach that we need around certain topics. So, please, keep submitting your questions, keep submitting your feedback to us because it does continue to help us strengthen the program. At this time, I do want to take the opportunity to thank all of our subject-matter experts who were on the line today for their valuable input in answering these questions. I do want to remind everyone, if you do still have a burning question, please send it to our Quality Payment Program Service Center. They're able to answer these questions, as well, or certainly route them to the right folks and get you an answer. I do want to thank each and every one of you for being here today. Just remember, we are in the final stretch of the submission period, so March 31st is the final day to submit your data, and we'll talk to you all again soon. Thanks, everyone.

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