Centers for Medicare & Medicaid Services (CMS)

Getting Started with QPP: An Overview of MIPS for Small, Rural, and Underserved Practices

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>> Hello. And thank you for joining today's webinar, "Getting Started with QPP: An Overview of MIPS for Small, Rural, and Underserved Practices." Today, Adam Richards, health insurance specialist from the Center for Clinical Standards and Quality at CMS, will provide a brief introduction. Other speakers for today's call include Molly MacHarris, Mary Wheatley, and Dr. Ashby Wolfe. You can listen to the presentation through your computer speakers and provide feedback through the chat box. Following the presentation, we will open up the phone lines for your questions and feedback. Any questions not answered on the phone should be directed to the QPP Service Center. The slides, recordings, and transcript from the webinar will be posted to the Quality Payment Program website in the next week or so. I would now like to introduce Adam Richards. Adam, you may begin.

>> Great. Thank you, everyone, for joining us. And welcome to our discussion on getting started in the Quality Payment Program and, really, more specifically, getting started with participating in MIPS, the Merit-based Incentive Payment System, for the first performance year, which is, currently under way. We designed the elements of this webinar a little differently than which you may be accustomed. And that is largely because of the anticipated diversity of our participants. Some of you may have a background or previous experience with CMS reporting programs. Some may not have as much experience. Some may be from small practices while others are from, you know, maybe medium-sized or larger rural facilities. Regardless, we've embraced this diversity. And we welcome all of you. And we will do our best to provide you with the straightforward basics of the Merit-based Incentive Payment System. So, let's get started. We'll go to the next slide, please. For the Q&A Session Information, just a brief note -- we will answer as many question as time allows at the end of the presentation. If your question is not answered during the webinar, there are some contact information there for you. And please note that we will be taking questions via the phone. The Q&A chat box is really meant for technical issues only. Next slide, please. So, the Quality Payment Program is comprised of two tracks from which clinicians may choose. The Merit-based Incentive Payment System is which we will cover in some depth today, as well as advanced APMs, or Advanced Alternative Payment Models, which we won't have a lot of information on. But just as a brief overview, Advanced APMs are really a subset of alternative payment models, which let practices earn more for taking on some risk related to patient outcomes. We have additional information available for those interested in Advanced APMs, at qpp.cms.gov. Or you can also visit our innovation center for a number of resources, a lot of a great resources. So, we encourage you to take a look at those. Next slide, please. So, the discussion structure for the webinar today is divided, really, into two parts. The first part is, "What do I need to know about MIPS?" And this is where we're going to cover the basics -- eligibility, participation, elements of reporting, submitting data. We'll talk about the performance categories. And we'll wrap up with scoring. Part two of the discussion structure is, "How do I prepare for and participate in MIPS?" And this is really the "how do I do it" portion of the discussion. So, this is where we'll talk about some tips on how to take theses policy elements and requirements and really put them into action for the first performance year. So, we're gonna jump to the next slide. And it is my pleasure to introduce Molly MacHarris, MIPS Program lead with the Center for Clinical Standards and Quality, to talk about the MIPS basics and what we really need to know.

>> Thanks, Adam. And thanks, everyone, again, for being here with us today. So, let's go ahead and jump into slide six. So, I'll start talking us through what is the MIPS program. So, MIPS stands for the Merit-based Incentive Payment System. And what MIPS does is it consolidates three of the programs that you all may be familiar with. Those include the Physician Quality Reporting System, or PQRS Program, the Physician Value Modifier, or VM Program, and the Medicare EHR Incentive Program for eligible professionals. Those programs are ending. 2016 is the last year for the majority of those programs, but the last, time frame that payments will be adjusted for those programs being calendar year 2018. One piece I do want to note is that the Medicaid EHR Incentive Program, that will continue, as will the Medicare EHR Incentive Program for hospitals. MIPS and the Quality Payment Program have no impact on those sides of the EHR Incentive Program. So, let's go ahead and just to slide seven. So, what comprises the MIPS? There are four performance categories, which include quality, cost, improvement activities, and Advancing Care Information. And then, if we go ahead and jump to slide eight, you can see how, if you have participated in any of these programs in the past, how they can relate to the performance categories. So, when we talk about quality under MIPS, in a lot of ways, it's very similar to the program that is ending, the PQRS Program. When we talk about costs, it's very similar to the resource use or cost-measurement side of the Value Modifier Program. And when we talk about the Advancing Care Information performance category that really deals with the usage of electronic health records, so similar to the Meaningful Use Program. I'll go over this in a lot more detail later on but just want to make clear that what we're talking about for MIPS, some of these pieces are new. But if you have any experience in these programs that are ending, it shouldn't be completely unfamiliar. So, let's move on to slide nine. So, we've heard a number of questions. One of the questions has been, "What do you have to do if you have no previous reporting experience in any of the programs that are ending -- again, the PQRS Program, the VM Program or the Meaningful Use Program?" So, what we've done in the first year of the Quality Payment Program is we have implemented a "Pick Your Pace" approach, which really allows you, the clinicians, to be able to tell us how much you are able to participate in the new Quality Payment Program. There are a number of tracks under the Pick Your Pace, which I'll talk about a little bit later. But what that does is it allows flexibility. There also is, in many instances, for those of you who have really minimal interactions with Medicare, you would be completely excluded from participation, which means that you don't have to participate at all. And, again, I'll talk through this in more detail later on. So, let's go ahead and jump to slide 10. So, when does MIPS officially begin? As Adam noted at the onset of this call, we are in the beginning of the overall performance period. 2017 is the performance period. So, any 90 days in 2017, that's when we would look to see for folks to participate. Then we would look to have all data submitted to us by no later than the end of March in 2018. We'll then give you feedback on all the data you've submitted. And then, beginning in 2019, that's when your claims will begin being adjusted under MIPS. Under MIPS, the adjustment percentage is 4%, which can fluctuate, depending upon what your total score is. And on the next slide, slide 11, I'll turn this back over to Adam to talk through a lot of the technical assistance that we have available.

>> Okay. Thanks, Molly. The one thing I want to point out here -- and this is very important -- at the very top of this is the technical assistance program that we have to support the Quality Payment Program, both MIPS and Advanced APMs, is free. This is free support to clinicians participating in the Quality Payment Program. And I spoke with a clinician a few weeks ago. And it was actually an interesting story. And she refers all of her colleagues to the technical assistance programs because it is free. And she said, "There's not a lot you can get free anymore." And this is one of those programs. So, we certainly encourage everyone to participate, take advantage of this opportunity. There are three major components to the technical assistance program. We have the Transforming Clinical Practice Initiative, the Quality Innovation Networks and Quality Improvement Organizations, or the QIN QIOs, and the Small Underserved and Rural Support, which we have titled the QQP SURS Program. The QPP SURS

Program, it really is for those small practices with 15 clinicians or less. We are working to get the SURS Program out there and get it going. We anticipate this in early 2017. So, it is forthcoming. But all of these programs will help with a number of different elements. So, some of the examples include understanding MIPS expectations and time lines, reading MIPS feedback reports, creating a score improvement plan. Some more of the broader elements are evaluation of practice readiness and practice facilitation, assessment of health information technology and optimizing that information technology, change management to strategic planning. And the list goes on. I mean, all of these technical assistance organizations are well-equipped to prepare you for the Quality Payment Program and to really help you participate and succeed. One thing I also want to mention is that we have a "no wrong door" approach for the Technical Assistance Program. So, no matter where you reach out... So, if you reach out to the SURS Program or the QIN QIOs -- and there may be a better fit for you just based on your practice size and your patient population. We'll make sure you get to that right door -- the right entry into that right door. We'll get you with the right program. And we'll make sure that you have all the assistance that you need. Aside from these three major technical-assistance programs, we also have additional support available through the Quality Payment Program website at qpp.cms.gov. There's a lot of great educational resources out there. We also have the measure selector. So, you can take a look at the different MIPS performance categories and the measures that are available. We also have the service center with the information available on this infographic. And for those who are in alternative payment models or advanced alternative payment models, or are interested in additional information, we do have the Innovation Center's learning systems, which is available to provide support for those in APMs and advanced APMs. So, again, these are free sources. Please take advantage of these. They are ready. They're here to help. And they're ready to go. Could we go to the next slide, please? And I will turn it back over to Molly to talk about eligibility.

>> Sure. Thanks, Adam. We should be on slide 13. So, who is eligible to participate under MIPS? You're eligible to participate under MIPS if you are considered a physician, a physician assistant, a nurse practitioner, a clinical nurse specialist or a certified registered nurse anesthetist. One thing I do want to note is that physicians under Medicare include not only doctors of medicine and doctors of osteopathy but also dentists, podiatrists, and optometrists, as well as chiropractors. You're also eligible to participate in the MIPS if you bill more than $30,000 annually in Medicare Part B and if you see more than 100 Medicare patients in a year. So, let's move on to slide 14 where there's an example of what this actually means. So, in this example, we have Dr. "A," who he is an eligible clinician. He has billed $100,000 in Medicare Part B charges and has seen 110 patients in a year. Therefore, Dr. "A" is eligible for MIPS. So, let's move on to slide 15. So, who is exempt from MIPS? So, you are exempt from MIPS if you are -- first, if you become newly enrolled in Medicare for the very first time in calendar year 2017. So, again, this would be the first time that you enroll with Medicare. This doesn't deal with circumstances where you used to work in a practice in Iowa. And now you've moved to another practice. This is when, for the very first time, you enrolled in Medicare. You would be exempt. I'll come back to this middle one because I want to explain the low-volume threshold in more detail. The one on the right-hand side deals with significant participation in an Advanced APM. APMs are the other track of the Quality Payment Program. There's the MIPS track and the APM track. And, if you successfully participate in an APM, to a certain threshold, you would also be exempt from MIPS. For the middle exemption, the low-volume threshold, again, that low-volume threshold is $30,000 and 100 patients. But you'll note in this slide, on slide 15, we're using an "or" here, whereas in the prior slide, we said, "$30,000 and 100 patients." So, let's go ahead and jump to slide 16 for an example to talk us through this. So, Dr. "B," so she's an eligible clinician. She billed $100,000 in Medicare Part B charges. But she only saw 80 patients. So, she would be exempt from MIPS because she did not see more than 100 patients. The reason why this context changes, if it's $30,000 or 100 patients or $30,000 and 100 patients, it changes when --

based off the perspective that you are talking about it from. So, if we're talking about it from an eligibility perspective, you're eligible if you bill more than $30,000 annually and see 100 patients. You're excluded if you bill $30,000 or bill less than or equal to $30,000 or less than or equal to 100 patients. It becomes a double negative. I apologize for that. I realize that can be slightly confusing. So, I hope this helps clarify it. If it doesn't, we're more than happy to talk through this in more detail later on. So, let's go ahead and jump to slide 17. So, what does it mean if you are exempt? If you're exempt, that means that you don't have to participate. You can, however, volunteer to participate. You can volunteer to participate in any one of the performance categories. This could benefit you, because you may be eligible in a future year. Maybe you're not eligible in this first year due to falling below that low-volume threshold we were talking about. But you suspect that your Medicare-patient population may increase in future years. Or it could be that you are part of a clinician type that's not eligible now. But you were previously eligible under the PQRS Program and you want to continue to participate. If you do volunteer, we will still provide to you informative feedback. But you won't be able to receive any of the payments that are associated with MIPS, whether those would be bonus, incentive payments, or the negative penalties. Let's move on to slide 18, so "Eligibility for certain types of facilities." So, rural health clinics and federally qualified health centers, they're not subject to the MIPS payment adjustment. However, eligible clinicians that work in RHCs or FQHCs that bill under the physician fee schedule are required to participate in MIPS. And then let's move on to slide 19 for information on Critical Access Hospitals. So, you're eligible to participate. So, apologies. If you participate in method one, clinicians themselves would be eligible to participate. But the payment adjustments would not apply to the facility of the Critical Access Hospital itself. For method two, Critical Access Hospitals, for clinicians who have reassigned their billing rights over to that Critical Access Hospital, they are able to participate -- so similar to how you were able to participate under the meaningful use or PQRS Program. And then, for eligible clinicians who have not assigned their billing rights over to their CAH, the payment adjustments would apply similarly to the method one Critical Access Hospitals, meaning that it would apply but not to the facility itself. So, let's move on to slide 20. So, our last special eligibility scenario is for the non-patient facing clinicians. So, these clinicians could include pathologists, certain types of radiologists, certain types of anesthesiologists, et cetera. These non-patient facing clinicians are eligible to participate. They're not exempt. Rather, these types of clinicians, they have a little bit more flexibility in what they're required to do, which I'll talk about in more detail later on. But you would be considered a non-patient facing clinician based off of a certain threshold. If you participate as an individual, that threshold is less than or equal to 100 patient-facing encounters. And then, if you participate as a group, it would be that 75% of your clinicians would have to meet that 100 threshold. So, let's move on to the next slide, slide 21, and then to 22. So, participation, what do you need to know? So, on slide 22, this is the "Pick Your Pace" approach for the Quality Payment Program, which I mentioned earlier. And hopefully many of you have seen this before. So, again, what the Pick Your Pace does is it provides flexibilities for clinicians who have differing needs and differing abilities on being able to participate in the Quality Payment Program. There are four tracks. The first deals with participation in Advanced Alternative Payment Models. I won't talk about that in to too much detail. We have separate educational sessions related to APMs. I will talk through, however, the three options that are related to MIPS -- the test option, the partial option, and the full-year option. And for clinicians who do not participate in any of these options, they would be getting that automatic negative 4% penalty, which we really want to avoid. We really want everyone to participate, even if it's very minimally, so they don't get that negative 4% adjustment. One other piece I wanted to call out because we've received a number of questions related to this, is you do not need to tell us, CMS, how you want to participate under the "Pick Your Pace" options. You can just simply start reporting. You don't have to sign up for the "Pick Your Pace" options. And you can change your option throughout the year. If you initially think that you want to participate using the test option and then you think you can participate a little bit more fully, you can

go ahead and do that. You don't have to notify us of any of those changes. So, let's dive in to slide 23 for the test option. So, what the test option is, is where you would submit just a minimal amount of data to us. And that would get you to the neutral point, where you would avoid that negative 4% penalty. And so what I mean by "minimal amount of data," it could be as minimal as one quality measure, one improvement activity, or the base elements of the Advancing Care Information performance category. Those base elements of either four or five required measures - that depends upon your addition of certified EHR technology. Again, you don't have to do all of these. You could just do one of these things and avoid the negative 4% penalty. Let's move on to slide 24, the partial option. So, the partial option is if you want to participate a little bit more fully than just one measure, one time, or one improvement activity. So, this could be where you participate for a 90-day period. It could be where you participate in more than one performance category. So, maybe you want to do quality and improvement activities. And under this option, since you've been participating a little bit more fully, your adjustment for your payment would be a little bit higher. One piece to note is that, if you are looking to just participate for a 90-day period, the last full 90-day period begins on October 2nd of this year. So, keep that date in mind if you want to report for a 90-day period. And let's move on to slide 25 for the full participation option. So, the full participation option is if you want to participate in as full a manner as you can. So, what this could look like is you could participate for a full year. It could be that you participate in all the performance categories. It could also mean that you don't necessarily participate in all the performance categories for a full year. And I know this can get a little confusing. So, let's go to slide 26. And I can talk through this in more detail between the difference between the full-year option and the partial option. So, when we look at the full option and the partial option, think of these as options along a spectrum. So, if you can participate for a 90-day period for one performance category, that's great. If you can participate for longer than a 90-day performance period for one category, that's even better. It doesn't have to be either 90 days or a year. It could be 120 days, 6 months, 9 months, 10 months. And it could be for any of the performance categories. One of the main takeaways that I want folks to really get from this is that the more you participate in the MIPS, that means the overall higher potential incentive you could earn because that means that we, CMS, would be receiving more data, which means that your total numerical final score would potentially be higher. Again, I know this can be a little complex. So, if there are any questions on this, we can definitely talk through this again during the Q&A period. Let's move on to slide 27. So, MIPS reporting -- what do you need to know? On slide 28, there are two main options of how you can participate. The first is as an individual, so on your own, which is based off your unique NPI and your unique Tax Identification Number. And then the second option would be as part of a group, which is where two or more clinicians have reassigned their billing rights over to a TIN. One piece to note, if you decide to participate as a group you would -- or as an individual, you would do so consistently across the entire MIPS Program. So, if you decide you want to do quality and improvement activities and you want to do quality as an individual, you would need to do improvement activities as an individual. Another piece I'll note for group reporting -- Just because you are part of a medical practice with more than two clinicians, it does not mean that you have to participate as a group. It's an option available to you. So, there could be a 10-person practice, and everyone participates individually. That's completely fine. These are all just choices available to you. Let's move on to slide 29 for the submission methods and what you need to know. The submission methods means, "How can you actually participate? How can you get your data in to us?" So, on slide 30, there's a chart here that lists out the options that are available. You'll note, across the three categories, there's three that are consistent across both individual and group reporting. That includes qualified clinical data registries, qualified registries, and electronic health records. We also have other options available. Let's move on to slide 31. If you do decide to participate as a group, you would need to register by no later than June 30th of this year only in the instances where you decide to report using the Web interface or if you elect the CAHPS for MIPS survey. In all other instances, you can just simply work with your registry, your QCDR, or your

EHR. And they will submit your data to us on your behalf. This is a change from how things previously worked under the PQRS or VM Program. The feedback we received is that requiring registration across the board was unduly burdensome. And that's not what we intended to do. So, let's move on to slide 32. So here's just some helpful information on some of the submission methods. I won't go through this. But I would suggest to folks that they take a look at this later on. So, let's jump to slide 33 and then 34. So, I'm gonna dive into the four performance categories and what you need to know. So, on slide 34, the first performance category that I'll talk about is quality. Quality counts for 60% of your final score. Your final score will be a number that ranges from either zero to 100. And you want to ensure that your final score is above the number three. If your final score is above the number three, that means that you will not be getting a penalty and that you would be getting a slight or potentially higher bonus, depending upon where you rank between that 3-to-100 scale. So, what makes up your final score, the first category, again, is quality. Quality we have finalized over 270, 280 measures that are available. The requirements are that you would need to select six measures. One of those would need to be an outcome measure. If an outcome measure isn't available, you would need to select another high-priority measure, such as appropriate use, patient experience, patient safety, efficiency or care coordination. And, again, you can make the selection either through our comprehensive set of close to 300 measures. Or you could make a selection from a specialty set. Let's move on to slide 35. So, what does this mean, again, within the context of the Pick Your Pace? So, under Pick Your Pace test for quality would be submitting one quality measure. And partial and full could mean submitting six quality measures with one outcome or one high-priority. In all instances, it doesn't mean that you have to do six quality measures. If you find that you are able to do three or four measures, we would encourage you to do that. Let's move on to slide 36, the cost-performance category. So, we haven't talked too much about cost. And the reason why we haven't is because we're actually not assessing costs for payment purposes in this first year. Rather, we will be calculating the cost-performance category based off of your claims data that you submit to us. And we will provide you feedback on how you performed on the cost category. We have included two measures that were previously part of the physician value modifier: the Medicare spending for beneficiary and a total cost measure. And we also have included 10 episode measures. So, let's move on to slide 37, the Improvement Activities performance category. So, this is the new category that's available under MIPS. This was not previously available under the PQRS or VM or Meaningful Use Program. It's brand-new. And so what Improvement Activities does is it really deals with practice improvements that you make within your own practice. We have over 90 activities to select from that span nine categories. Those categories are listed on the slide here. And, generally, for most clinicians to get the fullest points under improvement activities -- so, there's 15 points here -- they would have to do no more than four activities. On slide 38, there are a couple special considerations under this category for certain types of clinicians. So, the first is if you are part of a small practice. You're a solo practitioner. If you work in a rural or HIPSA area, the most you would have to do to get the fullest points here is two activities. Also, if you are part of a patient-centered medical home, you automatically get full credit under this category. And then there are also some special considerations if you are part of an APM, where you can get full points. So, let's move on to slide 39. So, what does improvement activities mean for the Pick Your Pace? So, again, test means attesting to one improvement activity for 90 days. Partial and full means attesting to either the maximum of four activities or, depending upon the activities you select, you may have to do a little bit less. We do have a high-weighting and a medium-weighting of these activities. So, you could do two high-weighted activities or four medium activities or any combination to get you there. Let's move on to slide 40, the last performance category, which is Advancing Care Information. Again, this deals with the usage of electronic health records. And this counts for 25 points towards your final score. What we've done with the Advancing Care Information performance category is we've really restructured this from the way it previously worked under Meaningful Use. We heard a lot of feedback that the way it was working and wasn't working, that we

didn't have enough flexibility in there, and that, if you missed one measure, you would potentially fail completely. So, we've reworked it to build in a base score and a performance score. There are two sets of measures to choose from based off of your addition of EHR. So, on slide 41, you can see what those measure sets are, if you have either 25 edition certified EHR technology, or 2015 edition rather, or if you have the 2014 edition. And then, on slide 42, so what does this mean under the Pick Your Pace? So, the test would mean that you would do the base measures. Again, those are either four or five measures, depending upon your edition of certified EHR technology. And then partial or full would be mean doing more than the base, so doing some of the elements that are part of the performance side of Advancing Care Information. On slide 43, there are some additional flexibilities under this category. We will automatically reweight this category. And what I mean by reweighting is that we will zero it out and give those 25 points to the quality category. So, that means your quality portion of your final score would now count for 85 points. So, that happens if you are a hospital-based clinician, if you are a non-patient facing clinician or if you are a nurse practitioner, physician assistant, certified registered nurse anesthetist or a clinical nurse specialist. You do not have to participate in the Advancing Care Information category. You can, however, choose to do so. And, if you do, then we will assess you based off of the information you provide to us. You also... If you don't meet any of these under number one, you can also ask for us to reweight this category to quality for three reasons: One, if you have insufficient Internet activity, if there are extreme and uncontrollable circumstances, and then a third is if you have lack of control over your ability of certified EHR technology. For those of you who are familiar with the Meaningful Use Program, these are very similar to the hardship exemptions that were previously available there. So, moving on to slide 44, from here, I'm going to go ahead and pass it back over to Adam. Thank you.

>> Thank you, Molly. So, now we're gonna talk a little bit about the MIPS scoring methodology. And I'm going to hand it over to Mary Wheatley, our principal healthcare policy analyst with the Mitre Corporation, to walk us through a few slides on scoring.

>> Great. Thank you, Adam. So, if we can move to the next slide. So, as Adam said, we're gonna go... So, Molly just gave you an overview of all the measures and activities that are going to go into your MIPS score. So, I'm just gonna briefly talk about how we kind of create that score. And we're gonna go category by category so you can see how this all kind of translates to a single score at the end. So, we'll start with quality -- the quality performance category. And, again, for most people, this is gonna be 60% of your final score. And to recap, generally, people have to submit approximately 60 measures of the available measures. When you submit a measure to us, whether it's a test or Pick Your Pace, we're gonna look at that measure. And we're gonna try and score it. And we're gonna assign that measure somewhere between 3 to 10 points, based on certain criteria. And if we have enough data that we can reliably score it against the benchmark -- Well, at a minimum, if you submit a quality measure, we're gonna give you 3 out of 10 points just for giving us the information. If we're able to reliably score it against the benchmark, and we won't go into that in too much detail. But if we have enough sample size, if we have a benchmark, we're able to do that, then we can get up to 10 points based on how well you do on those measures. But the biggest thing here is that if you don't submit a measure, you get zero points. So, if you submit even to test your pace, you get a minimum of 3 points. But you can get up to 10 points, especially -- which is easier to do if you submit more cases so that we can actually measure you. We will say that there are some bonus points available for certain types of measures. And, again, more information's available, especially through the technical assistance and such. But there are bonus points for electronic reporting. There are bonus points for selecting, you know, measures with outcome measures or other high-priority measures. So, if we can go to the next slide, please. And it's not quite showing up here. So, the next category is the cost category. And, for this year, we just want people to

kind of get used to the cost measurement and what that means in MIPS. So, for cost, no one's required to submit measures. It's something that CMS will calculate. And we do it through claims data. And, again, similar to the quality score, we're gonna assign a certain number of points for each measure and how it compares to the benchmark. And those benchmarks are available on the QPP website if you're interested in it. What's important to note is, again, for this year, the cost score is while we're calculating the score for you, it's not gonna contribute to that final score that gets used for the payment adjustments. So, it's really for informational purposes for the first year. Next slide. So, for improvement activities, again, the idea here is you choose the inventory of activities that Molly mentioned before. And it's really, like, how many and with the goal of you're getting towards 40 points. I think particularly for this group, what's important to note is that if you're in a small or rural practice or you served an underserved practice, then the number of activities you need to report is less. So, we basically have said that basically each activity report is worth, you know, double the amount. So, you only have to report a maximum of two medium activities or one high-weighted activity in order to get the maximum number of points for the improvement activities. But the way -- again, the way the scoring works is you just report each activity. Each activity is worth a certain number of points. And if you're in a patient-centered medical home, you automatically get full credit in the improvement activity. Next slide. And so the last performance category is the Advancing Care Information. And, as Molly said, this got restructured so that the base score is worth 50% of your score. So, if you meet that base score, you will automatically get 50% credit. And, as you report additional measures -- again, the measures change based on your certification -- you can increase your score up to a maximum of 100%. And so, in general, when you consider all the ways you can report, you have a base score. You have ways you can get additional performance in certain measures. And you can get bonus points for reporting to additional registries or for using electronic health records for your improvement activities. You have the ability to get up to 155 points, which means that there's multiple ways to get to that maximum credit because maximum credit plus any score is 100%. So, there's lots of ways to get to 100% in the Advancing Care Information. And so, if you take that... So, what we do is we take these algorithms. And we apply it to all these activities that are submitted for these different categories. As you go to the next slide, what we do to calculate your final score is, you know, similar to when you were in school, we take your score for each category, which is somewhere between zero and 100% for each of these categories. And then we multiply it by the weight. And then we end up with a final score that is somewhere between zero and 100 points. And that final score is important because that final score is what we use to determine the payments for 2019. And so, if you go to slide 50, I want to spend a little time talking about these points. So, what we have done in this first year for Pick Your Pace, we have said that if you get 3 out of 100 points for your total score, you can avoid a negative payment adjustment. And that means, if you report a quality measure, if you report an improvement activity, if you report the base score for a Advancing Care Information, you will get at least 3 points. And you'll get a neutral point. So, the only way it's only if you don't participate and you get zero points, is where you get a negative 4% payment adjustment. And this is a policy that we certainly implemented for the first year because we want people to really get, you know, used to the MIPS Program and used to the scoring and learn how all the pieces sort of fit together. We also created a point, a target. And that's 70 points. And so, in MIPS, we have this algorithm that we have to calculate to determine what your payment adjustment will be if you exceed 3 points. And so what we have to do is we have to get everyone's scores in. And we have to see how much money is available to distribute and how many people qualify for additional bonuses. And then, we have to calculate what the amount is. But the reason I want to bring up the 70-point mark is that 70 points, there's a $500 million set of funds for the first few years. And if you get 70 points, you get access to the additional funds. So, what we can say is that 70 points you'll get a minimum additional half-percent adjustment, along with whatever adjustments we calculate for MIPS. So, what does that mean? It means that if you score at least 3 points, you're gonna avoid a negative adjustment. The higher your score, the

higher your adjustment will be. But we can't tell you what exactly that is because we have to calculate all the scores first and see how many people we have to distribute money -- how much money there is to redistribute and how many people we have to redistribute to. But, if you get to 70 points, you know that you'll get a little bit of a bump up because you can access those additional funds for exceptional performance. And so, with that, I'd like to go ahead and turn it back to Adam.

>> Okay, great. Thanks, Mary. We're gonna enter into part two of the webinar today. And this is really the getting started, the, "How do I do it?" portion of the webinar. So we're going to start, really, with a checklist for preparing for and participating in MIPS. And it's my pleasure to introduce another colleague, Dr. Ashby Wolfe, chief medical officer for Region Nine CMS and a family physician, to run us through this list and give us some pointers on how to get started.

>> Thank you so much, Adam. And good afternoon or good morning, everyone, depending on where you're accessing the call from. It's my pleasure to be here. And I am going to be walking you through this final segment, where we'll discuss the practical aspects of the program, the how-to of participating in this MIPS pathway of the Quality Payment Program. And thank you to Molly and Mary for that detailed review of MIPS. I'm gonna try to break down some of what Molly and Mary discussed and described on the next several slides. So, if we move to slide 52, you'll see a checklist. Really, we hope this will be useful to you as clinicians, as practice managers, as part of the care-support team, in preparing for participation in this transition year 2017. And you'll see, on this slide, there are a number of points to take a look at. I'm going to be walking you through each of these checks in the next several slides, including looking at how you determine your eligibility, how you might choose to submit your data, what submission method to look at, and how to choose your measures, et cetera. This checklist is really meant to serve as a general guide to every clinician who would be participating in MIPS, regardless of your level of experience with prior reporting programs, like PQRS or Medicare Meaningful Use. So, we're gonna walk through each of these items. Just remember this checklist is really a means to help you get started. You have the flexibility to determine how many elements are really applicable to you in your practice. And don't feel that you need to complete this checklist in order or all at once. We're gonna talk through each step. And you can really personalize it as you see fit and as it would be helpful. So, moving through slide 53 to slide 54, let's talk about that first checkpoint, determining your eligibility. So, how do you do this for your practice? Well, to go back to the eligibility piece that Molly mentioned earlier, really, it's a question of determining your annual patient count and billing amount for Medicare Part B. And, getting back to that specific question, did you bill more than $30,000 in Part B allowed charges and provide care for more than 100 Medicare patients in a given year? Again, this applies to Medicare Part B Fee-For-Service. So, really taking a look at your claims of service provided between September 1st of 2015 and August 31st of 2016, will be key in order to determine your eligibility. Now, CMS will be providing additional information to you this spring to help you in this effort. The key thing I want you to take away from this is that there is this two-part piece to the eligibility. If you are a physician, nurse practitioner, PA, certified registered nurse anesthetist, or nurse specialist, you have to be able to answer that question. Did you bill more than $30,000 in Part B allowed charges and provide care for more than 100 Medicare patients in that year? Now, as I mentioned, CMS will be providing additional information to help you determine this eligibility. And we've been really deliberate to make sure that all clinician information is up-to-date and that our eligibility data is accurate. So, let's move on to the next data point -- the next decision point here on slide 55. How do you choose to submit data? Do you participate as an individual or as part of a group? So, on slide 56, you'll see this particular checkpoint. And eligible clinicians have two options for participating in the MIPS pathway, as was mentioned previously. You can participate as an individual, meaning that you as a clinician would report information under your unique National Provider Identifier, or NPI, combined with your Tax Identification Number, or TIN. So, using this

combination, we can identify you as an individual participant in MIPS. Alternatively, if you and at least one other clinician in the group would like to participate as a group, we would take a look at your data under the single Tax Identification Number to which you and your fellow clinicians have reassigned your billing rights. So, it's important to note that if you as clinicians decide you want to participate as a group, your group is assessed as a group across all of the MIPS performance categories. Now, we encourage clinicians to begin discussing how they want to participate in this performance year. It's not just about knowing that this choice exists. It's about talking to your clinician colleagues if you have them and really identifying the best option for your practice and the population of patients that you're serving. Now let's talk about the next decision point, choosing a submission method. And how do you do this? How do you get your data to CMS? So, on slide 58, you'll see a few suggestions. The good news is that if you have already been submitting data to CMS through either PQRS or Meaningful Use, for example, chances are you are already familiar with some of the submission methods that we have as options to report in the MIPS Program. As was mentioned earlier, depending on whether you're participating as an individual or as a group, our submission methods for MIPS include claims, attestations, qualified registries, qualified clinical data registries, electronic health records and for groups of 25 or more, the CMS web interface and the CAHPs for MIPS survey. So, in making this determination, it's very reasonable to speak with your specialty society or to get additional help through one of our technical assistance contractors. You don't have to make these decisions on your own. We have a list of technical assistance that's currently available on our website. As was mentioned earlier, you can visit qpp.cms.gov for information on your submission options, as well as information about using our technical assistance program for decision support. So, let's move to the next decision point. Now that you've made some initial determinations about eligibility and about how you're going to get your data to CMS, you can prepare to participate in 2017. So, on slide 60, you'll see a couple of additional suggestions about how you do this additional preparation. So, thinking through your practice readiness, if you've previously participated in a quality reporting program, like PQRS or Medicare Meaningful Use, that's an opportunity where you can build off what you've learned already. Additionally, think through if you're prepared to begin reporting data for the 2017 transition year. You can review the options for participation, including whether you simply want to test the system, as Molly was mentioning earlier, or if you'd like to participate more as a partial-year participant or for the full year. So, there's a couple of different pieces here on this slide that are worth thinking about, as you begin to plan your method of participation. Now, let's talk about the data itself. What information are you sending to CMS? And how are you going to make that decision? So, moving through slide 61 to slide 62, this slide really details some of the information that would be helpful as you choose your measures and activities, what data you will be sending into CMS. Step by step, you can review the measures or the improvement activities that make the most sense to you based on your specialty and your scope of practice. So we highly recommend going to qpp.cms.gov and clicking on the "Explore Measures" tab right at the top of the page. That will take you to an opportunity to review each of the performance categories that are available in MIPS. And you can select a performance category of interest. You'll have several different ways to sort this information, looking critically at the quality measures, the Advancing Care Information measures or the improvement activities. And, depending on which performance category you choose, you can actually search by keyword, by specialty. You can even search by method of submission. So, for example, if you are a clinician who wants to report a quality measure or wants to take a look at what quality measures match up with your specialty, and let's say you take care of a significant number of patients with arthritis, you can actually go to the "Quality Measures" tab, type in the key word "Arthritis." And the tool will actually sort for you which measures are applicable there. You can also search by specialty. So, if you're a dermatologist and you want to see what quality measures apply to you, simply use the drop-down menu. And you can identify which quality measures apply there. By searching these different options, you can actually see all of the information that's pertinent to that measure or to the improvement

activity that you're interested in reporting. Now, moving on to slide 63, a couple of tips to think about here. So, definitely consider your patient population and the clinical conditions that you treat. It's worth thinking about what areas of your practice might be the most amenable to practice improvement goals. For myself, I'm an actively practicing family physician. I continue to see patients as part of my job at CMS. And for an example, if I wanted to really look critically at my patients for whom I'm treating for diabetes, I could really make that a theme in terms of my practice improvement goals -- looking at focusing on increasing diabetic control among my patient population, choosing quality measures and perhaps an improvement activity that might support those goals and being able to sort through on the measures tool the valuable information that would then be provided to me in the CMS feedback reports. So, those are things worth thinking about as you're selecting what measures and improvement activities or Advancing Care Information measures are the most applicable. Now, for those of you who have not participated in PQRS or Medicare Meaningful Use, you may not be as familiar with the existing feedback reports that clinicians receive under those programs. The Quality Resource Use Report, or QRUR, is currently the way we're providing information to clinicians who are participating in our legacy programs. It's a report card of sorts, provided to clinicians by CMS. And it provides an overview of the quality of care that clinicians are providing to their patients as well as a review of the cost of that care. That quality information is actually pulled from PQRS data. And the cost information comes directly from claims. So, if you're a clinician who has been participating in PQRS or Medicare Meaningful Use, we would highly recommend that you take a look at your existing QRUR to potentially identify measures that could match up with your practice improvement goals, as well. Now let's move on to slide 64 and talk about how to verify the information that you need to report. Slide 65 provides an extensive list of this information. And I do want to emphasize a few key specifications that may be helpful to you in reviewing the information that you need to report. Taking a look at the measure number, the measure title, of course, is important to know which populations are applicable there. And looking at the submission-method option, not every quality measure or improvement activity can be submitted by the same submission method. So, looking at what submission method makes the most sense to you is very important. Additionally, the measure description and instructions on reporting, as well as the criteria for the measure are key things to take a look at. And, remember, many of the Measures for MIPS are measures that have been developed by specialty societies. They've been rigorously tested and validated. And some of them have been in use previously in PQRS and Medicare Meaningful Use. So, some of the measures will probably look very familiar to you if you have been participating in this program. The new elements of MIPS is the increased flexibility. So, making sure that you, as a clinician, can pick measures that match up with your specialty and your scope of practice. So, definitely taking a look at these details will be key ways to assist you in making a decision. Now, let's move to slide 66 and then 67 and finally talking about the submission of data, making sure that you have an eye on the time frame for when you need to submit your data. We at CMS highly recommend that you send in your data to CMS before the submission deadline, which is March 31st of 2018. So, depending on how you're participating in MIPS, you're capturing data about your performance in 2017. And you'll be tracking your progress throughout the year. You'll begin submitting this data on January 1st of 2018, with a deadline for getting that information to us by March 31st of 2018. So, again, highly recommended that you submit your data early so as to not miss the deadline and make sure that we have timely receipt and accurate data. So, remember, these steps we've just been discussing will help participating in MIPS possible for all eligible clinicians, really, regardless of their previous experience with any of our legacy programs. CMS would really encourage you to discuss MIPS with your colleagues, with your specialty societies, and with CMS, as we are working together to learn from your experience and to continually improve the program to the benefit of not only you, our clinician partners, but also your patients. So, with that, I will turn it back over to Adam for Q&A.

>> Great, thank you, Dr. Wolfe. And we can go to the next slide, please. So, we are now going to open it up for a brief Q&A session. We have the information... Oh, go back a slide. Thank you. We have the information on screen. The phone number, if prompted to use a passcode, is on there, as well. We will try to get through as many question as possible in the next 10, 15 minutes. Again, if your question's not answered, we have a number of options to get -- for you to submit that question to us. And we will get it answered for you. In addition to questions, we're also encouraging feedback on other educational methods that you find helpful to learn about new concepts. And I think what I'll also do is throw out this challenge -- as you ask a question, give us give us an idea or a topic as a part of MIPS or the Quality Payment Program that you'd like a little bit more information on. That way, we can continue to build out our educational resources for you. With that said, we're gonna open up the line. We'll take callers now, please.

>> At this time, if you would like to ask a question, please press star then the number one on your telephone keypad. Again, that's star, then the number one on your telephone keypad to ask a question. Our first question comes from Breanne McCullen.

>> Hi. Thank you for taking my question. One request is whether you are able to present to the small and solo provider groups that this is target market on the Medicaid EHR Incentive Program because many clinicians will be dual-eligible. So, they're confused about how they continue in the Medicaid program and how they participate in MIPS. And then the question is for the group. So, if it's a 10-provider practice, can eight of the providers elect to do growth and two of them, for example, elect to do it individually? Thank you.

>> Sure. This is Molly. I'll answer the second question. For the first question, I'll defer to Adam. But so your question of, "If there's a 10-person practice, could eight of them participate as a group and two of them as individuals?" The answer to that is no. Unfortunately, they would not be able to have a subset of their practice participate as a group and then some other people participate individually. The way that group reporting works under MIPS is that it's one TIN, one Tax Identification Number, with, again, two or more NPIs. So, assuming that 10-person practice just have that one TIN, if they want to participate as a group, it would be for all 10 of their clinicians. Or, alternately, each of those 10 clinicians could participate individually. And then I'll turn it over to Adam to address the first part of the question.

>> Sure, thanks, Molly. And thank you for that recommendation for additional information on the Medicare EHR Inventive Program and how that will impact dual-eligibles. It is something that we will definitely look into. We'll take the next question, please.

>> Our next question comes from Jill Daugherty.

>> Hi, there. I have just one quick question. And then in terms of educational resources, I would request that CMS... You may be working on this already. But if you could release a scoring tool on the QPP website. So, right now, you can select measures out of a menu and add them to a cart and download those, say, into a PDF or other document type. But I haven't seen a formalized tool released by CMS where a practice could literally put in their measures, performance, and create a score based on that file for performance through all of the categories and essentially forecast what their end score might be, based on their current performance. I think that would be extremely, extremely helpful to all practices. My question is in the MIPS eligibility, of the provider types that are listed, I don't see certified nurse midwife. And I haven't seen anything specifically stating whether or not they are excluded or are ineligible. Can you tell me how nurse midwives will be looked at?

>> This is Molly. I'm fairly certain that they are not eligible for the first two years. I can try to check on that real quick. So, we can take the next question. And let me look at that piece.

>> Your next question...

>> But I'm... Yeah, sorry. Go ahead, operator.

>> Your next question is from Caltana.

>> Hi, there. I have two questions. One is for the QPP Program for the MIPS. Are we reporting only Part B fee-for-service data? Or are we reporting for all payers? And then the other question is, we have a practice of 45 eligible clinicians. And then, the last time we talked to them, they wanted to report it as a group. And then, now the issue that we run into is that we share the same TIN with our hospital and our clinic. So, we do have three hospitalists, four anesthesiologists, one PA and then one NP. So, how do we get them to participate in the ACI model?

>> This is Molly. I apologize. I missed that first part of your question while I was trying to look up the nurse-midwife piece. Would you mind repeating that? Sorry.

>> No, no, no, no. That's fine, Molly. So, the first part was, are we only reporting for, like, Part B fee-for-service? Or are we reporting for all payers?

>> It's Part B.[1]

>> It's only Part B? And then the second question was so, you know, we have a group of 45 eligible clinicians. And then we share the same Tax ID in the in-patient setting with the hospital and the clinic. So, if we reported as a group, I don't see, like, how do I get, like, ACI fit in because I know the hospital is doing their own Meaningful Use. And then I'm not sure how do I submit the ACI as a group for those three hospitalists that I have and four anesthesiologists and one nurse practitioner and one PA that's working in in-patient setting.

>> Okay, sure. So, just to close the loop on the nurse-midwife piece, I was able to find it. Those are not eligible to participate for the first two years. They could be eligible to participate in the third year. So, they would fall under the option that they can volunteer because I know they were able to participate previously under PQRS. So, just to close the loop on that past question. And, then, to answer your question for Advancing Care Information, so it sounds like you want to participate as a group. But, based off of the mix of your practice, you're not exactly sure how that would work. Is that right? I don't know if the caller's still there.

>> Yeah.

>> Maybe we lost her. So, assuming that's what she was trying to get resolved -- so the way that group reporting works under the Advancing Care Information performance category is that at least one of the

[1] In most cases, clinicians must report all payer data. This excludes the Quality performance category measures for claims, the CMS Web Interface, and the CAHPS for MIPS Survey submissions, in which case, clinicians are only required to report Part B data.

clinicians would have to meet all of the elements of the base score, and/or the performance portion of the score. Also, the way that group reporting would work for instances where you have a mix of both eligible and non-eligible clinicians, we've left that pretty broad. We've left it at the group's discretion. So, if you want to have those additional clinicians participate under the Advancing Care Information category, if you want to have their information included and assessed, you can certainly do that. When you submit your data to us or when you work with a vendor to submit your data, that will be a question that you would be asked. But you're not required to do so. And if I didn't answer your question, I'd recommend that you send it over to one of the resources that we have that Adam noted earlier, such as the service center or other resources, to get you the fullest response. I apologize if that didn't answer it.

>> Your next question is from Sheila Bunyi.

>> Hi. I just want to say that this is an awesome presentation. It answered a whole lot of my questions. But I have two that are lingering. Number one, I want to confirm that if a practice has four doctors but only two of them use the EHR, they can attest as a group and only include the two that use the EHR.

>> Yes, that's correct. So, on top of what I was just saying, it will be discretion on the group there. So, yes, that is correct.

>> Oh, second question: I would also like to confirm that, like PQRS, you can pull a file out of your EHR and submit it yourself rather than paying the EHR to do it for you.

>> Yes, that's also correct. We do still have that option available. We don't have the different terms that we did under the PQRS Program. Based off of the feedback we received, we found that people found it just more confusing than it needed to be. So, we just have EHR reporting. But it can either come from you, your clinic directly. Or you can ask your EHR vendor to submit it on your behalf. Thank you.

>> Your next question is from Eric Mortenson.

>> Hi. I just wanted to clarify. Appreciate the webinar here but wanted to clarify the minimum test requirements. You had minimum test requirements in all three categories. But the minimum points required are three. Am I safe to say that if I send one quality measure for one patient for one claim that meets the minimum, and I don't have to do all three categories to meet the minimum?

>> Sure. This is Molly. Yes, that would meet the minimum. That would get your final score to the number three. So, you would just have a neutral adjustment, meaning no adjustment in 2019. I would encourage you, however -- I'd be remiss not to do this, to go ahead and do it more than once if you have the ability to do so. You know, stranger things have happened where maybe, you know, some sort of error or some sort of issue happens. Maybe you put the code on the wrong spot on the claim. So, yes, while you can do just one measure one time for one patient, I would encourage you to do a little bit more than that, just to make sure that, you know, everything goes through smoothly.

>> Okay, thanks, Molly. And that's going to be the end of our Q&A session. Unfortunately, we are out of time. And we want to make sure that we are honoring everyone's time. We appreciate having everyone on this call today for this webinar. Again, if you didn't get through, we have multiple options to get your question over to us to our service center. The contact information is on the final slide here. We will also be -- we anticipate we'll also be posting these slides so that this information will be available in case you

just want to go back, take a look, refresh. Otherwise, we appreciate everyone being here today, and we look forward to future presentations. Thanks, everyone.

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