

Centers for Medicare and Medicaid Services
Rural Health
Open Door Forum
Moderator: Jill Darling
April 20, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome to everyone to the Centers for Medicare and Medicaid Services Rural Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press pound key.

I would now like to turn the call over to Ms. Jill Darling. You may begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon, everyone. Thank you for joining us for today's Rural Health Open Door Forum.

Before I hand it off to Carol Blackford, just real quick one brief announcement. This open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact CMS at press@cms.hhs.gov.

Just real quick, we did a little switch of the agenda today if you received the latest update from us. So, just to inform you. So now I will hand the call off to our chair, Carol Blackford.

Carol Blackford: Thank you, Jill. And welcome to everyone on the call. Thank you for joining us today and thank you all of our CMS staff here in Baltimore, in D.C., and then all of our regional offices for joining and participating on the call today.

We have a very full agenda despite the fact that we're switching things around. It is – it's a very full agenda so I won't spend too much time at the start, but I did want to kind of do my annual plugs that I put in every year. This is the start of our Medicaid payment rulemaking season. We had our IPPS notice of proposed rulemaking that was recently released and we'll spend some time today talking about some of the provisions included in that rule.

But I wanted to take an opportunity just to remind folks that there are public comment periods available with all of our rules that come out of the agency and I want to encourage everyone to take advantage of that opportunity. I know the rules themselves are can be cumbersome and not everyone is excited about the opportunity to read through them page by page, but we have a wealth of information on our Web Sites, we have facts sheets and press releases, and those -- that that sort of – those source of documents. So please take a look at those.

If you see something in there that you're excited about or not so excited about, please take advantage of the comment period to tell us about that if you think that some of our proposals are not quite right or with would had impact on you, please let us know that, but also give us some thoughts or some suggestions on different approaches that we could take.

We do in fact read through every single comment that received. So please take advantage of the opportunity to submit those comments to us.

And with that, I think we're going to go ahead and get started with the agenda.

Jill Darling: Thanks Carol. First, we have Craig Dobyski who will start off with the clinical lab fee schedule and implementation of Section of 216A of the Protecting Access to Medicare Act

Craig Dobyski: Thank you, Jill. The Protecting Access to Medicare Act of 2014 or PAMA, added Section 1834 A to the Social Security Act which required significant

changes to the Medicare Clinical Laboratory Fee Schedule. Under the final rule, private payor rate data from applicable laboratories will be the basis for the revised Medicare Clinical Lab Fee Schedule beginning January 1st, 2018.

The first data collection period, that is where private payor rate data is obtained from claims for which the laboratory receive final payment during the period, occurred from January 1st, 2016 to June 30th, 2016. A six-month window, where laboratories review their data for accuracy and completeness followed the data collection period.

The first data reporting period, that is where applicable information must be submitted to CMS, began January 1st, 2017 and officially ended March 31st, 2017.

For most laboratory test paid on the new clinical lab fee schedule, this data collection, data reporting, and payment rate update schedule repeats every three years. However, industry feedback suggested that many reporting entities would not able to submit a complete set of applicable information to CMS by the March 31st, 2017 reporting deadline; and that additional time was needed to review the data collected, address any issues identified and compile the data into CMS's required reporting format.

As a result, On March 30, 2017, CMS announced that it will exercise enforcement discretion until May 30, 2017, with respect to the data reporting period for reporting applicable information and the application of the Secretary's potential assessment of civil monetary penalties for failure to report applicable information.

We note that the 60-day enforcement discretion period is a maximum amount of time CMS could permit and still have sufficient time to calculate the new clinical lab fee schedule payment rates, which are scheduled to go into effect on January 1st, 2018

At this time I would like to turn the presentation over to my colleague Sarah Harding who will discuss the CMS data collection system. Thank you.

Sara Harding: Thank you, Craig. We want to take some additional time to talk about some of the resources and the data collection system. But we do have available if indeed you are involved or a laboratory that would be effected by – by the time I'm looking to a report data.

CMS has created a data collection system that will assist labs and compiling all of the information and then submit it to CMS. This provides laboratories a secure method of either uploading or manually entering applicable information.

If you haven't yet access the system or registered of access, and you feel that you do represent a laboratory that maybe considered in applicable laboratory, please take a look at the resources that we have available on the CMS Clinical Laboratory Fee Schedule PAMA regulations Web Site. We will – we'll be able to send out a link to the webpage following the call today so that you can take a look.

But on that page, you'll find a series of resources including a very detailed user guide, as well as a data template file that's required to use if you're seeking to upload data to the system. This is simply a CSV file similar to Excel spreadsheets that is available for you to use. To collect your data, it is required as the template for uploading information to the system.

As far as registering for the system, we are using a service offered by CMS called the Enterprise Identification Management System. As I mentioned the registration process can be found in the use guide that is available online.

We do have several resources that are in place to help labs, help users through the registration process. We have a CLFS system specific help desk in place to help you navigate through the system and answer any system related questions that might come up.

The best way to contract this help desk is to send an e-mail to, I believe it is, clfshelpdesk@dcca.com. DCCA is the name of the developer that CMS use to create the site.

Now I did just want to take a minute just to give two quick tips to accessing the system. I realize this may not be relevant to the general call but if these tips may help you. First is the system requires two individuals to register to (vote) one who can submit data and one who will certify the data.

One individual has to register first as a submitter. This individual also needs to be registered under the CMS PECOS system. Again, we can provide some assistance if anything needs to be updated.

The certifier does not need to be a PECOS, but they do need to communicate with the submitter to gain access to the system. Once the submitter registers for the system, they're given a password that they can share with the certifier. When the certifier first enters the system, they're asked for that password to allow access.

So it is a good idea just to know ahead of time who the two individuals will be, who will be responsible for laboratories data submission and certification.

Another quick tip is to ensure that your data are formatted correctly prior to submitting it. The data template online that I mentioned does show exactly how data should be formatted. For example, a payment rate for a specific laboratory (test) should only have two decimal places, and the volume of (test) should be a whole number. The system does check for formatting and it will not accept data with any formatting errors.

I wanted to mention this because this does seem to be a frequent stumbling block that some laboratories are running into. The best is to make sure your file is as clean as possible, follows these formatting guidelines. If the system does find errors, it will generate a report and tell you exactly where the errors are so that you can go fix them up and resubmit your file.

But once again, if you do have any issues, please take advantage of our help desk and they are available by phone and by e-mail. They have been extremely responsive to any and all laboratories, just meeting an extra hand to get through this process, which everyone is walking through for the first time. So we understand that there are some (symbols).

Lastly, we do have several other sources online to assist laboratories walking through this new clinical laboratory fee schedule requirements. The best way to find the page honestly is either to just Google PAMA and CLFS, or I as said, we will send link out after this call.

In addition to the sources online specific to the data collection system, we also have several resources related to more policy guidance around PAMA. For example, there is a long list of frequently asked questions. These have been created based on inquiries that we have received through an e-mail box that we have setup.

This e-mail is clfs_inquiries, I-N-Q-U-I-R-I-E-S, @cms.hhs.gov. This mailbox really is used for the policy type question such as, am I in a applicable lab or what information counts as applicable information that you need to (me) collect and submit?

Unfortunately, CMS is not able to answer the specific question of whether it is applicable or not for a given laboratory. This is meant to be a self-determine designation. But the FAQ sheet does outline several different scenarios that we received through this inquiries mailbox and does an excellent job that walking through how a laboratory in that scenario would determine whether it is applicable or not.

So, once again, I do encourage you to take a look at that – that frequently asked question list. And if you do not see a solution to your question, feel free to e-mail that mailbox I mentioned. Again, it is clfs_inquiries@cms.hhs.gov.

On our Web Site it's also a series of past presentations we've given about the implementation of PAMA as well as the data collection system. There's a very detailed walkthrough of the system.

So please reach out to us if you feel that your laboratory maybe included in PAMA and we very much appreciate your time today. Thank you.

Jill Darling: Thank you, Sarah and Craig. Next, under the IPPS NPRM, we have Sid Mazumdar who will go over the RCH Demo.

Sid Mazumdar: Thank you very much Jill. This past Monday, April 17th, CMS released a solicitation for applications for additional hospitals to participate in the rural community hospital demonstration. The due date for submission of applications is May 17th, 2017.

Under this demonstration which CMS began conducting in 2004, selected rural hospitals will be paid under a reasonable cost methodology for Medicare inpatient hospital services. To be eligible for the demonstration, a hospital must be located in a federally designated rural area, have fewer than 51 acute care inpatient beds, make available 24-hour emergency care services, and not be eligible to be or not have been designated as a critical access hospital.

The demonstration was originally authorized for a five-year period by Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA. And it was extended for another five-year period by the Affordable Care Act.

Section 15003 of the 21st Century Cures Act, which was enacted December 13, 2016, again amended Section 410A of the MMA to require another five-year extension period.

In accordance with the Cures Act statute, CMS's solicitation is open to hospitals in all states that meet the eligibility requirements. Also in accordance with the statute, hospitals that were participating in the demonstration at the end of the initial five-year period or as of December 30th, 2014 will be able to continue participation in the second extension period and will not need to submit an application.

The statute imposes a limit of 30 hospitals participating in the demonstration. However, priority will be given among the highest going applications to those from hospitals in the 20 least densely populated states. These states are identified in the solicitation which is on the webpage for the demonstration.

The easiest way to get to it is to go to the CMS Web Site, click to tab that says Innovation Center and there there's a search feature and if you just put in rural, you will get the Rural Community Hospital Demonstration webpage.

Alternatively, the URL is (<https://innovation.CMS.gov/initiatives/rural->

[community-hospital/](#)). We can send out that link after this call but it's just easiest to find the innovation center webpage.

(Pre-staging) substantial information that Carol referred to and that we represent later in this call. This solicitation is one of two documents that CMS has released about the demonstration in the past week. The IPPS proposed rule which went on display last Thursday also includes a segment on the rural community hospital demonstration. As in previous years this piece in the regulation provides detail on the status of the demonstration as well as our proposal for budget neutrality. So, again the due date for applications is May 17th.

I will not be able to stay following the (substances) call to answer questions. So if you have any questions or would like further information, please visit the webpage. Alternatively, you can send an e-mail to the following address -- Jill will have this in case there's a question -- that is RCHdemo -- that's all one word -- @cms.hhs.gov. Or you can call me -- Sid Mazumdar -- at 410-786-6673. That's Sid Mazumdar at 410-786-6673.

Thank you and back to Jill.

Jill Darling: Thanks Sid. Next we have Don Thompson who will go to the rural provisions under the IPPS and CRM

Don Thompson: Thanks. So, (I'm going to talk a little bit about) some of the payment provisions highlighting some of the ones that would impact rural areas, the (rules, primary law) also contains a number (quality) provisions. So, I'm not going to sort of going into depth on those but I'm going to sort of talk a little bit about this as well as (Renate) will talk a little bit about the CAH 96-hour certification information (that was in the IPPS document).

So the rule is published in April 14, 2017. And as Carol mentioned the comment period was on June 13th, 2017.

One of the center pieces that's in the rule is a request for information and we're looking for ideas, whether they be regulatory, policy, practice, procedural changes, (matching) changes -- in order to sort of promote

transparency, flexibility, (for simplification), innovation. It's a quite of broad net we're trying to cast here. So we're looking for ideas. So, hopefully, people will be able to submit those by June 13th and we consider those for future regulatory action – or (sub-) regulatory action for inpatient and long-term care hospitals.

In addition to that sort of broad request for information, we also sort of have the usual rate increases (that) occur under the IPPS. And so we expect that the update for fiscal '18 currently (that stands to be) approximately 1.6 percent for people that participate in the hospitalization (quality reporting) program and are also meaningful (at trying) health record users.

That is the derived by taking the hospital (marketing update) -- that's 2.9. There's a (four-tenths of a percentage) point reduction for multifactor productivity, then there's a six-tenths of a percent adjustment that's related to some rule making that we had done last year related to the (two midnight) policy.

There is a 0.4588 percentage points -- and that number is very precise because it's actually in the (statute) -- that's required from the 21st Cures Act. And then there's also a 0.75 percentage point adjustment that's required by the Affordable Care Act. And when you put all that through, you end up with an update of (about 1.6) percent.

We anticipate that together with all the other proposed (policy changes) in the rule that the operating payments will go up by approximately 1.7 percent. And then on top of that, we anticipate that changes in (un-comped – any care) payments that I'm going to talk about a little bit in a second -- are going to increase by an additional 1.2 percent on top of the 1.7. So, we anticipate total increase on operating payments of 2.9 percent.

And then when we take sort of all the inpatient hospital services including capital we expect about a \$3.1 billion increase in IPPS spending in fiscal 2018. (I mentioned a little bit about) Medicare uncompensated care payments and it said we expect compared to what's happen the last few years of pretty sizable increase in the size of the pool – the size of the amount of money, the

amount of money that we can distribute in uncompensated care payment in fiscal '18 of about \$1 billion.

And that comes from the statute now provides us with the ability to update some of the uninsured numbers -- the (uninsured rate) from past years. And that's one of the primary drivers of that \$1 billion. As well as we anticipate sort of a certain amount of growth in what would have been spent -- would have been spent under the (DSH) payments to this (portion shared) hospital payments for next year. And that also factors in to the total amount of money that's available to pay hospitals (from uncompensated care).

So that's sort of about the side of the amount of money that we have. But in addition we're also proposing to begin to distribute that money to hospitals a little differently than we have in the past. In the past, we've been using insured low income (data) in order to distribute that money. And starting next year, we are going to begin to phase in the worksheet S-10 uncompensated care data.

So remember from last year and prior years we've had this discussion before in the rule about sort of when the appropriate time was to begin using the worksheet S-10 data. And for a reason that are laid out in the rule, we determined that we sort of reached a tipping point and that fiscal '18 is the first year to begin the appropriate (rush) to adopt the worksheet S-10 data to distribute that uncompensated care (forward).

It will not be entirely based on the worksheet S-10 under our proposals; it would roughly be -- we're going to use a three-year average of (three) cost reports. Two of those cost reports (where we've used the insured low) income days from that cost report. And then for worksheet S-10, one of the years would be from the fiscal 2014 cost reports -- we'd used the worksheet (S-10 data).

In addition there is also sort of different from it in prior years. In most years, the changes that we make to the DRG weights, (they're) sort of -- influence the payments that we make (to individual) DRGs -- generally, there is a drift or has been over time a drift toward surgical DRGs instead of medical DRGs.

And you'll notice when you read the rules, this year for the first time, we actually have a bit of an increase in the weights for the medical DRGs. And this has a benefit to rural hospitals but they tend to perform medical DRGs (sort of in a proportional sense) more than urban hospitals. So, that's somewhat of interest and you can comment on that rule.

And as well as this as any proposal what we just wanted to remind folks that the (MDH) hospital program and statutory Medicare (ten) hospital program, which provides additional funding for Medicare (to ten) hospitals -- that program under current law is expiring at the end of fiscal 2017. Those payments under current law will be going away beginning fiscal 2018.

And now I'm going to turn over to (Renate) to talk a little bit about the 96-hour certification requirement and the discussion that we had in the (proposals).

(Renate): Hi everyone. So, just a little background under the 96-hour certification requirement for inpatient critical access hospital or CAH services to be payable Medicare Part A. The Social Security Act requires that a physician certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Since this certification requirement is statutory it cannot be modified through the regulation. However, based on feedback from stakeholders, CMS has reviewed the CAH 96-hour certification requirement to determine if there are ways to reduce its burden on providers.

So we are providing notice in the proposed rule that CMS will direct Quality Improvement Organizations, Medicare Administrative Contractors, the Supplemental Medical Review Contractors and the Recovery Audit Contractors to make the CAH 96-hour certification requirement a low priority for medical record reviews conducted on or after October 1st, 2017. This means that absent concerns of probable fraud, waste or abuse, these contractors will not conduct medical record reviews.

Reviews by other entities including but not limited to zone program integrity contractors, the Office of the Inspector General and the Department of Justice

will continue as appropriate. Quality and (automated) reviews -- those reviews that do not involve medical records -- will also continue as appropriate.

Thank you.

Jill Darling: Thanks, (Renate).

And last we have Bruce Spurlock who will go to the top 10 questions about QPP that small, underserved and rural practices of facing are where to get the answers. Bruce?

Bruce Spurlock: (Thanks very much and) good morning, good afternoon, everybody.

My name is Bruce Spurlock. I'm the President and CEO of Cynosure Health. We are part of the National QPP SUR support team that helps to support this transition for small, underserved in rural practices in the QPP. I understand that you've all or at least familiar with the QPP to quality payment program that CMS is launching and how it affects physicians.

And we will go to some of the common questions. I thought about trying to describe some of things we're doing for small, underserved in rural practices. And some of the questions that we're hearing from the people that are talking just about what the practices themselves are facing. So, let me organize around that.

Now launching to my question number one, what is a small underserved in rural practice? Pretty straightforward. And small is define as a group of 15 or fewer practitioners that need to meet certain criteria. So not all people that bill Medicare or bill CMS or fee-for-service basis are considered as participating practitioners, but many of the ones that you would think about predominantly physicians, nurse practitioners P.A.s and others are included in that group. And if you're group of 15 or fewer you meet that small area definition. It's small as agnostic to location so it could be rural, it could exurban, it could urban.

You can imagine that ophthalmologist or orthopedist might be in a group of 15 or fewer in large urban environment. But you might also have other practitioners that are in group smaller in 15 in a rural environment as well. The underserved is defined by the health profession shortage area. And then as you know it's rural, it's a HRSA defined category. Some docs may or may not know if they meet some of the criteria and they will be notified in a letter coming up from CMS in the near future whether they qualify under this area. So that's an important distinction for this.

So does it really make a difference if you are in a small, underserved or in a rural area. That's question number two. And the reality is, yes it does. And it does because the requirements and the transition are different. In fact the burden is a little less than it is for people in large groups or in more urban environment where they have usually more resources.

Let's go back and historically look at the legacy systems that MACRA replaced and that QPP now operationalizes. It's removing PQRS and Meaningful Use and related activities in. And the rural, underserved and small groups were already not deeply involved. They didn't really join in to many of those programs on a regular basis. And so, we think that this is going to actually improve because the transition burden is less over time. So, it's going to be – make a difference if you are categorized in the small, underserved or rural area.

So, question three. And this is the one that I care a lot. What are my options in a small, underserved or rural area, especially in the rural areas? What are my options meet the requirements? And here's what I've heard docs and other practitioners talking about. First of all, they can retire. And believe it or not I am hearing people saying that if I just hang on for a couple of more years the penalty is not going to be that big, I can tolerate it and I'll close my practice and call it quits. That's a very small minority but they're very vocal and very loud because they don't like change and it's time for them to move on. And they are certainly capable.

But if you're not of retirement age or you don't have the income or you just want to keep practicing medicine because it's something you love doing, what

are your other options? And you can relocate and we are hearing about people that are joining a large of practices maybe moving to do that because of the resource that they have and the – the fact that they don't have to change their practice unless they can focus on caring for patients to have all some of the other infrastructure things happening.

There are some opportunities especially for the small groups to participate only in Medicare Advantage. So this in Medicare fee-for-service type activities and a few contract only with the Medicare Advantage Plan you can avoid that, but again, that's very, very small group that would want to do that. And especially if you have a lot patients in the fee-for-service world you don't really want to do that.

So, those are the sort of three big category responses. But what can I do if I don't want to do any of those. And that's question number four. Should I join or should I affiliate with a larger organization? As you can imagine, some of things I'll be talking about that are the requirements for the QPP program, even though there streamlining and the burden is less for small practices are still pretty substantial infrastructure and practice changes. And so, can I try to find that from another resource that I'm actually have to do all of that on my own?

And we are hearing about rural practices and urban and some small practices that are also being approach by ACOs or patient-centered medical homes which qualify under the APM category, the advance payment methods. And so, if you are in a practice that want to consider doing it you could. The challenge is that just because you're in an ACO doesn't mean you are in the APM version of the QPP program. So there's a lot of requirements that you need to look into to make sure that you qualify for the APM to be able to do that.

And the APM requirement had data submission and I.T. capabilities that also need to be considered. It's just that in most cases the large organization that's creating the APM, the ACO or the PCMH are building those things into the infrastructure that they're already working on.

Another thing that we're hearing a lot of rural practices in particular talk about is integrating with the hospital or health system. And we do – we are saying this wave of integration going on whether there either a contractual-financial relationship or some other kind of affiliation. Sometimes it's shared practices or shared infrastructure like I. T.

So, in electronic health record that is purchased in the first place by a hospital or health system that then can go out into the individual practices. And we are seeing those things happen and there is a variation in the level and spectrum of what people are doing from an integration standpoint. So that is certainly an option.

The other thing that affiliation might provide help for some practices are the Q.I activities and a lot of the docs and practitioners don't actually have experience with improvement in their practice and so this can be obtained when they look with other larger organization, so that certainly a possibility but not a requirement. And many – we'll find many individual solo practices will be participating in the QPP especially on the MIPS side of the equation.

OK. So that's questions one to four. Question number five and this is what we're hearing a ton of especially because people don't necessarily understand. It's a very complex rule. It's a very complex set of requirements that we have doing that. Believe it or not it's even more streamlined from what things were in the past.

I'm overwhelmed, where should I start? Where should I get begin? And that's question number five. And so, where I tell people to go first is to go to the qpp.cms.gov Web Site. There are a ton of resources right there that you can learn a lot about the requirement. And on there, they have all the measures, the quality measures right now, there's like a 271 quality measures that people can look at and choose from and their measures from efficiency to process measures, to outcome to measures. So a whole bunch of things that people can look at that might be appropriate for their practice and interesting to consider.

And there's also an improvement activities and on things like advancing information that's HIT component of the QPP program. So, there's lot of information on that. In fact what I'm seeing is that most other organizations that are providing support are pointing people to that as the very first place to start. So, that's answer number.

Answer number two and this where we can come in are the SURs contractors. So that's a small, underserved and rural support contractors and there's 11 of them. On the agenda that sent out it's the second item that I listed under there as far as a link. You can find the names and contact information for all 11 regional SURs contractors. So we're calling them SURs support contractors. There are – some familiar names that many of you may know that a provider resource to their rural community and in the past. Many of the QIN-QIOs are also located on there.

There are some folks that deal with larger practices and there is this transforming care at the practice initiative that's also going on. It's also providing support. But for small, underserved and rural practices, I would go to those SURs contractors. They have a lot of information on their Web Sites, have a lot of information that providing additional resources and know to answer questions. They will be able to refer you to the right place and point people to getting specific individualize help that's meaningful for them. So that's where I would look.

It's amazing as I start digging around in this area over the past several months. A lot of other resources are out there. Key places like national specialties societies are providing resources, information, guidance, and how to think to about where you fit in to all of that. Where finding some regional collaboratives that are popping up especially in rural areas. We're looking at – seeing some of the EHR vendors and some of the data registries are starting to provide support to physicians on how to be able to access that information. So lots of places to learn. I would start with qpp.cms.gov and inform our technical questions I would call and contact the SURs contractors.

OK. And that's number five.

Question number six. Here this one, do I need to purchase an EHR? Probably the bane of most docs' experiences is this topic. All the work and all the discussion going on with the need for electronic health record, electronic medical records, how it distracts from the patient interaction and all of this kind of things and the causes associated with it. And the straight answer is, you don't have to do that. But there are advantages to implementing one. And some people are seeing this as the handwriting on the wall. But the rule and the process allows for variety of different ways of submitting your data that do not require electronic medical records.

You will have to provide some activities, like, e-Prescribing and other things that might be advantageous to use. Streamline your life a little bit that you could consider. But to submit data, to submit some of these activities, you don't actually have to have an EHR. But I do think for the vast majority of folks the handwriting is on the wall whether it's a two-year or five-year transition period for you is depended upon what's happening in your individual practice. And that's again a technical question that some of the support contractors can help you with.

Ok. Question number seven. Kind of downer question. I heard this again a couple of weeks ago from some docs. It's just the reality that we're facing. Here is the question. I provide quality care why are people challenging me on this? So you might say, why is the government or anybody else challenging me on the quality of care? And I don't think this is the thrust of the whole QPP program. And I tried to talk to people about this is saying MACRA and QPP does streamline some of this legacy programs that were growing and becoming mandated on a variety of different levels.

So, it is an attempt to try to make your life easier. There is this notion that the "on-ramp" or pacing that allows you to pick what's right for you and the speed or pace you're comfortable with. And the downside penalties early on are not that significant at least for most practices.

That being said, people will still kind of grumble about having to this. What I discovered is that as people start submitting data and start collecting information, start participating in these things actually realize that they can

actually do a better job with their care and they want to do a better job with a practice that they are providing to their patients.

And so, collecting some of this information is hard for them. They discovered that. Then I thought I was doing all the right things for my patients. And I realize it's just I forget everyone small and I want to make sure I have systems in place to be able to help me be able to provide that. So, I do think that, we're hearing that a lot, part of the grumbling that goes on with any changes and eventually it will go away too.

Question number eight. I want to take care of my patients, I really am committed professionally to the world that I do in the community and the patients I served. How do I learn more about quality improvement? How do I get some practice? Because most docs and most practitioners didn't have any training on this in their professional work. Post professional career is about how to do Q.I. And again, there are number of resources especially societies are putting a lot of information out there for folks in this area.

So I would say that's a big one. There are a lot of national programs that are available. Lot of national societies that have created Q. I programs for example a minute long podcast type video things that are out on YouTube, another place to learn about Q.I. It's just takes of a little bit of looking around. And again you can go to the SURs contractors and they can point to things that are going on in your region, in your locale, but there are just so many resources that if you just look a little bit on web search you'll find plenty of places to learn about quality improvement.

And then I also say boy, so for those of you practitioners that have any affiliation or you're close to a rural hospital, they have a lots of experience in Q.I and probably be able to support you and make sure you understand some of the basics of what it is mean to do improvement practice in your field. So that's question number eight.

Question number nine, what is the role of cost and how much people spend on their practices? What is that mean for me in the current period. And it's important to let people know that the fourth component of the MIPS program

in particular the cost equations, the cost calculations are not part of this transition year in 2017, that there will be work on this and eventually evolve and include cost measures and cost calculations in the future. Those will be shared and will have more resources on that. Again that will be at the qpp.cms.gov Web Site for people to evaluate. But right now in 2017, those calculations, those measures are not part of the equation of the current time.

And finally, I am going to be doing this but I think there are other people out there that may have been successful with implementation and how they are being working in this area of QPP. I mean, importantly, this is not a zero sum game. This is not we have to have some people winning and some people losing. All of the practitioners can have positive bonuses on their payment from the calculations if they participate fully in these programs.

So how can we collaborate and learn from each and sharing, have the early adaptors that are making success. And this is where the SURs contractors are probably going to be the most supportive and the most helpful. So all of the regional SURs contractors will be having webinar and activities. Some of them are actually having local workshops. I've heard about local workshops in some of the regions where they're going to bringing practitioners together to talk about how do; they meet somebody's requirements and how can we learn from each other and share ideas and collaborate and make it easier on everybody involved.

I think that's one of the great things that the SURs program is going to doing with the contractors. And at the national level, we will also be having national webinars, national resources. We're talking about podcast, tip sheets, all of this things that can help people understand where they can go. And we'll also be providing places for people to have technical questions where they can get specific answers. The measures will evolve over time. The implementations strategies will evolve over time to EHR and advancing information components will change over time. And all those will be supported at the national and regional level by the SURs program.

So, it is going to be exciting to watch this develop – is going to have a little bit of roughness for people who do not like change, who do not want to go this

direction. But eventually I think we'll find that most practitioners will start to improve and actually start embracing many of this – many of these concepts that are come up – coming in the QPP program.

And with that I'm going to stop and see if there's any questions or comments.

Jill Darling: All right. Thanks Bruce. We have about 10 minutes left for question. So we'll try to get as many as we can. And so, (Amy) will open up the line for Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on the telephone key pad. If you would like to withdraw your question please press the pound key. Please limit your questions to one question and follow up to allow other participants time for questions. If you require any further follow up you may again press star on to rejoined the queue.

Again, that's press star then the number one on your telephone keypad to ask a question.

And at this time, there are no questions on the phone line. I turn the call back over to Ms. Darling.

Carol Blackford: This is Carol Blackford. And I want to thank everyone for participating on the call today. As I've said at the beginning it was a very full agenda. Lot's of information. And again, I want to put in a plug is as Don talked about in the IPPS rule, we included a request for information to solicit ideas for regulatory policy, practice and procedural changes to better achieve transparency, flexibility and programs simplification and innovation.

So, I would encourage everyone to please take advantage of the public comment period. Please take advantage of the request for information and send in your ideas and your thoughts and your comments on the rule. We do read every comment that we receive and we do considers comments as we develop proposals for the final rule. So, we look forward to hearing from you.

And as always, I'll end the call with request for your ideas and suggestions on how to make this call useful for you. Please send me your ideas. My e-mail is Carol.Blackford, B-L-A-C-K-F-O-R-D, @cms.hhs.gov. And I want to thank everyone for participating on the call today.

Operator: Thank you for participating in today's rural health open door forum conference call. This call will be available for replay beginning today, April 20th, at 5:00 p.m. eastern through April 24th at midnight.

The conference ID number for the replay is 57728700. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

END