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Please stand by for realtime captions.

Ladies and gentlemen, please standby. The conference will begin momentarily. We thank you for your patience and ask that you please remain on the line.

Ladies and gentlemen, thank you for standing by. Welcome to the Preparing for MACRA and MIPS: Where to Go for Help webinar. During the presentation, all participants will be in a listen only mode. Afterwards, we will conduct a question and answer session. At that time if you have a question, please press one followed by four on your telephone. If at any time you need to reach an operator, please press star zero. As a reminder, the conference is being recorded, Thursday, November 17, 2016. I would now like to turn the call over to Marcus Brown. Please go ahead, sir.

Thank you very much, Teah, and hello, everyone. Wishing everyone first of all a safe and enjoyable holiday season. We welcome you to the Atlanta quality innovation network webinar series. This is a joint venture between the quality improvement organizations of New York, South Florida and Washington DC. As Teah said, my name is Marcus Brown and I am the project manager here at Dell Melva foundation. We appreciate you taking time during your busy schedule to join us for this webinar. So, we are literally one month away from of the new payment quality payment program. So, Preparing for MACRA and MIPS: Where to Go for Help. Particularly, help for year one of the program in 2017. I would like to do a few things within this hour. The first is to kind of figure out where we are now, and do a high-level review of the final ruling which came out October 14. I would like to introduce a new dynamic tool, the quality payment program website. And talk about some of the changes that CMS has made in trying to hear your voice. And then finally, if I could offer maybe 5 to 7 tips to you of how I would suggest you prepare moving forward. Just a few housekeeping items before we get started. My colleagues, Neavah and Janet will be monitoring the chat. We will be compiling your questions and comments to address them during the question and answer period. Today's presentation is being recorded, and we will post this on our AQIN website within coming days. We will provide further details of how to access it from our listserv communications. And, we also have an exit survey that we are encouraging you to take two minutes at the end to fill out and provide feedback. We use this feedback to improve our webinars, and generate topics you feel are valuable. So, let's get started and have a conversation about . The Medicare access and -- chips reauthorization -- MACRA. The Medicare access and CHIPS reauthorization. We received a ruling and as a result of that, there were over 4000 comments from nearly 100,000 clinicians and community stakeholders. So, this particular program, the quality payment program, which you see on your screen is the result of your comments. And a result of CMS trying to accommodate the varying degrees of clinicians out here. And the patients that you serve.

So, what is a quality payment program? In 1997, we had the sustainable growth rate. And, we had a situation that was arising that the physician cost exceeded the Medicare expenditures, essentially, CMS had to do what we call doc fixes, and they had to cut Medicare payments. And

so, they wanted to really develop a better system that focused on quality care and patient outcomes. Rather than fee-for-service, we are now looking at fee for value.

So, the quality payment program will affect nearly 600,000 Medicare part B payers across the country. And they try to do this particular program in a way that gives you the option to participate, based on your practice size, specialty location, or patient population. So, there are two tracks to this quality payment program. That you should know about. The first is an advanced alternative payment model. And we will talk a little bit more about that moving forward. And then the other is a merit-based incentive payment system. Or, MIPS. The important thing I think that we need to focus on with MIPS is that this program is due to sunset, the legacy programs, of PQRS meaningful use and the value modifier program. Starting in 2017. So, who participates in the MIPS program? Because of your voice and some of the comments, there have been several changes from the proposed ruling and last spring, to the final ruling that just took is over one month ago. One of those changes was that they lowered the threshold for more providers to be able to participate in this program. So, as of today, the Medicare threshold to participate in MIPS is that you bill Medicare more than $30,000 per year, and, you provide care for more than 100 Medicare patients a year. I think the important thing to remember here is that the operative word is and. For instance, if you bill Medicare $29,000 per year, and had 101 patients, you still would not be eligible to participate in the MIPS program. In 2017, this particular group will be the group focused on MIPS. So, if you are a physician, and when I say physician, that includes doctors of medicine, podiatrists, optometrists, dental medicine. So, if you are a physician of Dr. medicine, this includes you. Physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurses and aesthetics. So, this is the group that will be affected by MIPS in 2017.

So, who is excluded from MIPS? If you are newly enrolled in Medicare during the 2017 performance period, you are excluded from MIPS and will join MIPS the following year. If you, like I said, are a clinician that does not meet the threshold, you are excluded. And then, certain clinicians that are significantly participating in advanced alternative payment models, you will be excluded. So, one of the concerns, or one of the comments that were made during the comment period was, there was a concern that small practices would be at a disadvantage to participate in MIPS. And again, CMS is doing a great job at trying to accommodate your comments and to make changes in flexibilities within the program. And, this illustrates that, so that small practices will be able to successfully participate in quality improvement programs. And, the reason why is the reduced time and cost to participate. The whole goal of MIPS is to streamline those three programs that I mentioned, so that you can spend more time actually working with your patients. It is providing and allowing -- providing and allowing physicians to pick their own pace, so to speak. During the first year, it is not all or nothing. You have the option to pick a pace, if you want to test the program, or if you are already a well oiled machine and have been reporting in PQRS and have certified EHR and you know the measures that you choose to select, you can actually submit a full year. So, it is giving you flexibility to pick your pace. Again, there are opportunities for advanced payment models, and then, there are going to be organizations who will directly be able to provide technical assistance and outreach to small practices. And, practices in rural and underserved situations. So, these are some of the changes that were made, to make sure that we have an all-inclusive program. So, how does the quality payment program work? Now, I'm really fond of this slide, because I think this is an easy way to really get

prepared for 2017. There are several ways that you can pick your pace, as I mentioned. If you are in an advanced alternative payment model in 2017, you may want to choose that option, and follow those policies and those rules within that alternative payment model. As I said, there is a test phase. The goal here is to submit something to avoid the negative down payment of 4%. So if you submitted some data after January 1, you will get a neutral or small payment adjustment. If you feel you have more of, you know, a fluid system, you are allowed to do a partial year, and to submit 90 days consecutively. And, you will receive a small positive payment adjustment. Or as I just mentioned, the option of fully participating starting January 1. Obviously, the goal over the next 5 years is to have everyone submitting full information through the electronic certified EHR.

So, choosing success. If you submit a minimum amount of 2017 data to Medicare, for example, if you submit one quality measure for one patient, for a 90 day period, you can avoid the downward adjustment, just by doing that alone. If you submit 90 days of 2017 data to Medicare, you can earn, like I said, a neutral payment. And so, the other adjustment is, let's just assume that you are not ready to submit data as of January 1. You are now given the flexibility to submit up to October 2, 2017, a 90 day. Oh. So again, another adjustment that has been made to give you ease into the program. And of course, the goal and best way to earn the highest and largest positive adjustment is to participate for a full year. The key take away here is that the score that you will gain is not based on the abundance of information that you submit, or the length of time. The positive adjustments are based on the performance data of the performance information. So again, we are back to concentrating on desired outcomes or improved outcomes for our patients. Again, it's based on data submitted. The best way is to participate for a full year, and again, we are encouraging you to pick your own pace. Based off of your staff, your workflow, and your EHR preparations.

Okay. So, we said there is another track that you can go on. The other track is alternative payment models. Essentially, what they are are payment models that were actually developed by your colleagues in conjunction with CMS, that provides added incentives kludge conditions -- to clinicians to improper provide high quality cost and care care -- care. They can provide to a clinician or -- episode. These payment models offer significant opportunities to eligible clinicians who are not merely able to prepare or take on additional risks and requirements of the advanced ACMs. Obviously, being in an advanced alternative payment model, where there are more stringent criteria, and allows the practice to earn greater rewards for taking on some risks related to their patient outcomes.

Now, CMS has approved six APMs for the 2017 year. So if you are in one of these APMs, we will show a little bit later on the website, if you need additional information about them, if you have a desire to join any of these APMs, we will be able to show you where you can access further information. And, CMS is working to develop additional APMs that meet the needs of the flexibility of providers. So, they are working really hard to come in the future, look at payment models that are in the private sector, payment models that are applicable to small and rural populations as all. So these are just a few of the future performance advanced APMs that CMS is working on unfolding in subsequent years.

So the purpose here is to not necessarily provide all of the answers to you, but more importantly, to be able to give you some resources for where you are able to get additional information. So I'm happy to let you know that CMS has worked really hard at covering their bases to make sure that providers and different health systems and different geographic areas with different resources have the ability to receive technical assistance. And so, there is a very significant initiative that is called transforming clinical practice and initiative. This was nearly $1 billion that was invested by CMS. It was an initiative to provide more than 145,000 clinicians over the next 4 years, in sharing, adapting, and further developing the quality improvement strategies in the practice. This initiative is well on its way and if you're interested in participating in it, the website will provide a link that you can get additional information. The quality innovation networks, QIOs, have been around for some time now, 30 years. So they have built relationships within local communities and provide technical assistance and educational support as it relates to quality measures and quality improvement activities. In this particular quality payment program, QIN-QIOs will be focused on practices who have 15 providers are more. So if this is a category that you fit in, this is a resource that will be able to help you moving forward. And certainly as I said, if you're in an APN, CMS innovation center for learning has a plethora of information and resources that will provide you and help you with questions and concerns. And, as I said before, which is not on this slide, CMS has invested nearly $20 million over the next 5 years for small practices in underserved and rural areas. To be able to provide one-on-one technical assistance to help with your EHR, staff, workflows, to be able to bring you up to speed and move toward alternative payment models.

So again, the final ruling was October 14 of this year. We are nearly one month out. There is a 60 day comment period that ends December 19. And, one of the things that we encourage you to do is to make comments because this program, while it is the bedrock of the future, it is definitely evident that CMS is open to flexibility, and to tweaking the program, based off of your concerns and your needs. So, with that, I think that right now, if we take a tour of the website, there are some tidbits that I think will be valuable for you.

So, the URL for this wonderful program is qpp.cms.gov. And, from my perspective, and when I have looked at this several weeks ago when it came out, is that, I think CMS has done a tremendous job in branding this as to my first and naked eye, plain English. The texture is very visible. The branding as you will see among the different variety of marketing mediums is very consistent. This site is complete with interactive tools that are at your fingertips. It is designed to help with information retention. I think it's a good thing. The messages are consistent from one medium to the other. And there are a variety of learning options, including, you just need information at a glance, there are executive summaries, there are webinars, and, for the to or many that are involved -- interested in reading the 224 page legislation, that is almost available to you as well. So, let's take a look at the website. Immediately speaking, the first thing that I would do, and I know that I am talking to practice managers out there, and providers that may take the lead, I would bookmark this particular site. Because I know that this will be the hub for further information to come. The great thing about this site is that it's going to be updated on a constant basis as things change with this program. So, you would be able to access this quickly and check to see if there are updates. So, I would add this to my bar right here so that I would have easy access to it. That's one of the first things that I would do. Second, I would definitely

scroll all the way to the bottom. And, I strongly encourage you to subscribe to the list serve for the quality payment program. I'm going to put in my information.

Once you put your email in and submit, you will come up to a page that verifies your email. And, it will also give you a list of the variety of listserv's that are available at CMS. I highly recommend PQRS, physician quality reporting system. The ML Connect provider news, and for the purposes of this presentation, I would definitely go down to the quality payment program. Once you select these, you just simply submit and you will receive an email confirming that you are now part of the listserv. So if there are any changes or webinars upcoming, you would definitely have that at your disposal.

So, if we could take a quick tour of the website, there are a few things that I would like to point out. Again, on the first page, when you learn about the program, -- let me go back. You get a quick synopsis of what I just went over. That is where we are, what is MACRA, what are the two tracks that you can actually decide to participate who is in a quality program. This is just a quick snapshot. The visual design to show you the timeline. Now, something right here, the performance year for the quality payment program begins in 2017. But, I would just like to remind you that you still should be prepared to submit PQRS and Meaningful Use for the 2016 performance period. That is very important. Because that is still in play, and will not sunset until after the performance period. When you submit by March 31, 2018, there will be a fee back period available and the 2017 performance measures that you submit, there will be an adjustment. That will be realized in 2019.

Again, important dates to remember. You have the flexibility of starting on January 1. You can report a full year, 90 days consecutive, and you have until October 2. Again, the same visual streams that you will see in much of the marketing pieces will be the same and so that will reinforce the intention of knowing how to prepare for what's coming forward. If you participate in an advanced APM this year, you will automatically receive a 5% bonus. And, these are the payment adjustments, up and down, for 2019 through 2022.

So the interesting thing about this tutorial is that at the end of the page, you can go to connect. I would recommend that you go to this page that really addresses some of the questions that we received, or they received in the comments section. We have already been over how to participate. The important thing to note here is that you can see that there are four new categories, of which underneath, you can see what they replace. Important here is that the cost category will not be factored in in terms of the composite score for 2017. Although, CMS will use your claims data to provide feedback reports. But, the cost section is not included in the 2017 composite score. As illustrated here. Again, if the alternative payment model is your means of participating, this is a quick snapshot of what it is and again, the sixth model that CMS has approved for the 2017 year. You can see, if you are in one of these APMs, you can easily go to the link, as I will go right here, and get additional information about the model, the background, or details on how to apply fact sheets. So just again, a wealth of information. That you can access. If you are interested in joining an advanced APM, you can simply click here and get additional information.

I think this last box is important to know. If you lead an advanced APM during the 2017 year, you should make certain that you have received enough payments and meet the thresholds to qualify for the 5% bonus. If you haven't, then it is strongly urged that you submit data toward the downward payment adjustment. The other thing I would do is decide how you want to report. You problem I have -- you probably have an idea of how to participate. But if your individual practice is based on one identification number, recording as a group, [Please stand by]

Six measures from the list below. One has to be an outcome measure. The way I would use this is determine which way you decide to submit. Let's just say you have the option of submitting through your EHR, and he wanted to know what were the measures that you could choose from this particular filter. Well, you will see that there are 269 measures available submitting through that EHR our residency. The thing that is important here is that when you click on measure, it gives you the definition of what will be successful submission. It gives you the domain which in 2017, the domains are not needed. Gives you the type of measure type and lets you know if it is successfully measured. This is good information, high-priority measures have a higher weighting within each category. So if you want to post or make certain that you received as much adjustment reimbursement, then you can select measures that are high-priority measures. Once you have selected your filter, or your specialty, based on your practice, I would then either select the individual measures that you now that you utilize in your EHR or practice. Let's just say for instance we at all of the measures. You can see them over here on this right-hand side, all of the measures that you have selected are available, and you would simply just download this Excel report. And come up with something that looks like this. If you open the section, again, you get the measure name. If you wanted to determine -- let's just say I wanted to do all registry, you could highlight a particular column. Go to sort. It will be A to Z. And out to sea, this is now queried based on all of the measures or registry, and then EHR. So, there are several things that you can do. I would print this out and use it as a topic of discussion. With my staff, or with the other providers. So, this is a very, very nice tool that you can use to identify your measures.

I'm going to speed up a little bit here. For the advancing care information session, there are an option of tools. Is an option, based on the certification. If you have an EHR certified for 2014 you can use the measure objection care which has a total 15 measures, if your EHR is 2015 certified, you can use these 11 measures under this category. Or, you can use a combination of both. But again, as I just demonstrated, you would use this tool as a discussion with your team to see which are required for the health information exchange. And then, some idea of those. The same can be done for the improvement activities. And again, I would filter by subcategory, the waiting, if you're going for higher weighting to bolster your score, you can do that as well. The final section that I think is really for the person who wants either a snapshot or you want to go all the way up to reading the full legislation? In here, you can see there is an actual link to the final registration. And I actually used this sometimes to go and for me, it is good to see what your colleagues are saying. So, I actually used this in my technical assistance and being able to understand the dynamics of the providers that I work with. Again, you can submit a formal comment here, by December 2019.

From here, there is a summary, and again, this is a summary that shows you where to submit comments. It also, as I read it, a good tool, to get an idea of how CMS interpreted your comments and concerns, and the different things that they have done to make this program as

seamless as possible, such as the pick your pace change. And again, if you are a small practice and want to know where you can get additional information, this is some verbiage about CMS invested to help you get into speed with joining an advanced APM.

There's information on how to design the APM, information about learning more about the improvement activity , measures, specifications, if you want to go and get the strategy in terms of how to maximize the measures that you choose, you can go there as well. There's a lot of information and tools that you can go to. And again, where to find help.

Demanding of different materials all are based on each other so if you want to learn about the PPI initiative, click here. Obviously, the QRLs, who many of you have been working with for years, can provide some technical assistance for practices of 15 or more. And if you are not, we can definitely get you contact information for other boots on the ground. And of course, we encourage you to visit the video library. There are past webinars, the links that will direct you to some websites that had a really good webinar on the 15th. You can access those, if you have the time. If you just want the slide, you can access them as well.

So, we are coming to the top of an hour and I wanted to just take some time to really navigate this tool, as you can see, there is a lot of information and a lot of avenues to assist you. I think the take-home is again that CMS is trying to make adjustments, so that this program is one which will be successful over the years to come. Just to recap. Some of the tidbits that I would suggest, I suggest that you bookmark the web address, scratch the QPP list serve and explore the interactive tool with your staff to identify measures and activities that best fit your practice. Verify your EMR, to make sure that it has certified status. Download and print the fact sheet. It could be a great tool for the discussion for the rest of your staff. Because, this is an all-inclusive initiative and the success of it is really not hot heavy, it really needs to include everyone on the staff. Know how and where you need to get to go for assistance. And I think that we provided several avenues here on the website where you may not get all of the answers from the website. But, at least, you will be equipped on being able to know where to go to get assistance. And, my last, I guess, comment would be don't panic. We are all learning together. This is a huge initiative. And, the success of it depends on all of us being able to work together. Which ultimately provides optimal care for the patient population. So, with that said, we are at 10 minutes before 1:00. I wanted to see, Teah, if we could open up the question line and see if I'm able to assist any questions or concerns that may be out there.

Ladies and gentlemen, if you like to register a question, please press the one followed by the four on your telephone. You will hear a three tone pumped -- prompt to acknowledge your request. If your question is answered and you would like to withdraw, press one followed by three. One moment, please. Once again, if you would like to ask a question, please press one followed by four on your telephone.

While we are waiting -- go ahead, TF. -- Teah.

Oh, that's okay. We have a question. Please proceed.

Hi. I wanted to know if it would be beneficial after this program for a small group to be part of a larger IPA.

You know, that's a good question. And, I guess it just depends on your resources that you have, and the benefits that joining a larger system would be. I know that in the future, there are going to be some opportunities for virtual connections, so that you will have the opportunity, like if you are a solo practice or a small group practice, to virtually submit with other practices. But again, that would be based off of, I would say, your practice atmosphere, and your resources. In making that decision.

Okay. Thank you.

We also have some questions in chat. The first one is, I thought all APMs were closed for enrollment in 2017. Is this not correct?

I believe you are correct. They are close for 2017. There are going to be options for an increased APM involvement moving forward. But yes, for 2017, it is my understanding that they have been closed.

And another question, is the MIPS criteria of $30,000 in Medicare charges and 100 or over Medicare patients, is this per individual provider? Or is it a group practice?

Yeah. To my knowledge, this is for an individual provider. So, if you are submitting as a group, my understanding would be that based on that group's tax identification number, that if the tax identification number is billed more than $30,000 and has 100 patients in that group, that would be including criteria. If you are a solo practice, again, that solo practice threshold would be specifically for you. I hope that answers the question.

Another question. For the quality factor that is replacing PQRS, do we have to submit that through our certified EMR? Or can we continue to submit independently through an outside registry, like Current? Our EMR charges $1100 per year to submit through PQRS so I use an outside registry and pay $199 and submit myself to them for 20 patients.

Yes. So if I understand the question correct, the mode or way in which you were to submit is entirely up to you. The modes do not change in 2017. I have heard just in my own travel with providers that one of the most efficient ways would be what you just said. The latter part. And that they pay a small nominal fee for a third party to submit on their behalf to a registry. So yes. That option would be available.

And, one last question in chat. Do you get credit for bonus if you try to engage in syndromic surveillance? But, your state does not offer it?

My answer to that question would be, that is something that if you are, like I said, need to work with whatever organization, if you are in PCP or with the QIO, quality information network, that would be one that I suggest be tackled on a case-by-case specific. Because I don't have a specific

answer for you on that. But I would really yield to whoever you are currently working with now, to flesh that out a little bit more.

Okay. There is another question coming through. And they wanted to clarify. To clarify, individual providers in a group practice, billing under the group 10 who have greater than $30,000 in Medicare charges and greater than 100 Medicare patients, will they meet the MIPS criteria?

That is a good question. Now, I would probably need to get further clarification because I don't want to be wrong on this. But, my knee-jerk response is that if the -- has more than 30,000 in Medicare billing collectively and more than 100 patients, but I would really need to clarify that one. I don't want to feed you bad information. So, that is one in which I will further investigate and through the New York and South Carolina will be able to have a follow-up clarification for you on that. I do apologize.

We have no questions from the phone lines.

Okay. All right. Well again, I want to thank everybody for coming out today. I hope that this has been informative, or at least giving you some idea of the new quality improvement payment plan website, and, given you some avenues of where you can get additional information. Again, we encourage you to take a few seconds to complete the survey that comes out. We use these, again, to make our webinars more efficient, and to provide topics that are of interest to you. With that said, I again wish all of you a wonderful holiday season, and thank you for coming out today. Thank you.

Ladies and gentlemen, that does conclude the webinar for today. We taught -- thank you for your participation and ask that you please disconnect or line. -- Your line.

[Event concluded]