

Dr. Vaile Wright: Good afternoon, or morning depending on where you are. Welcome to today's webinar entitled "Using the Mental and Behavioral Health Registry to Boost Quality and Reimbursement." My name is Dr. Vaile Wright and I'm the director of research and special projects at APA. I have the distinct pleasure to be introducing today's webinar and our presenters. So, if we go to the next slide...

Dr. Carol Goodheart is an independently practicing psychologist in Princeton, New Jersey. She's a former APA president and she now chairs the Advisory Committee for the APA Mental and Behavioral Health Registry or MBHR. The Advisory Committee defines, develops, and selects the measures of most importance to fill the gaps in currently available CMS measures that are relevant to mental health, and to capture the meaningful concerns of patients and clinicians which are the focus of treatment. Our second presenter is Mike Lewis; he's a quality program consultant and MIPS specialist for Healthmonix, who has worked exclusively with small specialty practices to help them achieve their quality goals. He has helped over 1,000 providers with MIPS reporting.

This webinar is being recorded and a link to the video will be available to everyone. Also, a copy of the slides used during today's presentation will be emailed to all who registered; hopefully we'll get that to you by this afternoon. At the end of the presentation, there will be an opportunity for the presenters and myself to answer any questions you may have. That portion of the webinar will be moderated by Nicole Owings-Fonner, who is the communications project manager at APA. Please use your questions box to submit questions at any time during the presentation and then we will get to as many questions as we can at the end. Questions that do not get answered will be addressed individually after the webinar. And with that, I will turn it over to our two presenters.

Dr. Carol Goodheart: Hello, I'm Carol Goodheart; welcome to the webinar. Well, the main question here is "Why should psychology get involved at all in reporting on the measurement-based care that we're doing?" And we think it's because we should be the discipline -- psychology should be the profession to determine what and how to measure good mental health care and to get paid for it. We all know that payment for services is now being based on value and not the fee-for-service model that's being phased out and all healthcare professions are being required to demonstrate their value and of course we are, too - if Uber drivers get rated, we get rated, too. If we don't participate, we won't be included in health care and imagine what that would look like. It's been ten years; there are no psychologists who are doing psychotherapy. Who is going to do it? This is our best chance to show the value that we can add as doctoral-level providers in health care; the master's level social workers and counselors cannot report. I've been saying for almost 20 years that the best way to show effectiveness is to show our outcomes, regardless of your own particular theoretical orientation, but we really have needed a way to do it successfully. In the beginning when - before the MIPS system and when there was an earlier system - a lot of psychologists got very discouraged when they tried to report via the claims that they submitted. The rejection rate from Medicare from CMS were at least 50 percent or higher on the national level and you didn't find out until the following year. That's an essential reason why we decided to partner with Healthmonix to build a registry for psychology and, of course, other mental and healthcare providers who want to participate also. Now, we've discovered if you use the registry, ninety-eight percent of the submissions filed through our MBHR registry are approved and so that puts us at the beginning of earning better pay rates, tracking our outcomes, demonstrating our care, and we can use it to market ourselves. Next slide.

Mike Lewis: Hi, I'm Mike Lewis; I'm gonna walk you through a lot of the technical side as well as the MIPS side of this presentation. First off, we're going to go over on how to take the next steps to make you a MIPS expert. Then, we're going to determine how you will report to CMS and also, we'll discover how the MBHR will lead you to success.

So, in 2019, clinical psychologists including those who... Medicare providers, clinical, and counseling psychologists were added to the list of those physicians that need to report for MIPS. A lot of it is very similar to three years ago when psychologists needed to report for PQS, but there is a lot more on the line in 2019 for you as providers. I'll throw it back over to Dr. Goodheart.

Dr. Carol Goodheart: Yes, these are the exemption categories. You only need to fit one category in order to opt out - only one. So, the lightbulb on your left says if you're newly enrolled in Medicare, you may not report in the first year that you are approved as a Medicare provider. After that you may. And if you look at the one... the icon all the way on the right, if you participate in an advanced alternative payment model system, you're also exempt but this category really

does not apply to most psychologists. The one in the middle is the low volume threshold: if you earn \$90,000 or less in allowable Medicare Part B charges or you see 200 or fewer Medicare patients or you deliver 200 or fewer covered professional visits, you are not required to report. You may opt out on any one of those. Next slide, please.

But you may also opt in and you only need one to opt in. It's important to know that originally, we knew we... we wanted to give people an option to opt in if they wanted to. We do not want to be frozen out of health care or stuck with payment rates that would never rise. APA actually worked with CMS to give psychologists an option to participate and earn the higher reimbursement if they choose. So, if you can meet one of the variables on this slide, you can opt in. For many of us, the best option is the 200 number or covered visits per year - the last one. For example a small so... small practice solo practitioner who saw just five Medicare patients a week and works 46 weeks a year: that equals 230 covered services delivered if, say, you do an individual evaluation and a, you know, a beginning evaluation and then you deliver psychotherapy or you deliver health and behavior codes – whatever it is and you can do that more than once, that all adds up to more than 200. Of course, if you... it's enough to report, but your overall score chances will be better if you report more. But the key point to remember for these two slides is it only takes one category to opt out or one category to opt in. Next slide, please.

Mike Lewis: So, I'm gonna go over an example of what your options are for opting in and how it can help you. So, the benefits are there's a potential increase on your investment as little is... there.... This gives you the opportunity to work with MIPS in 2019 as an introduction to the program at very little to no risk. So, we used numbers on this list of showing what it looks like for a solo provider that's looking at Medicare charges of about \$80,000. Using an estimated incentive of 3% – and we'll get it to that soon about how psychologists are actually in great position in 2019 to do very well in this program – take out the vendor costs and then you have your total. As you can see here, the estimated return on investment is a little over \$2,000. This... actually, if you take the next step shows you that if you do this in a group setting how much larger this can be.

There are a lot of benefits to group reporting. There's a potential for an increased return on investment the same as your solo provider; however, you can also use measure optimization by avoiding the 20-instance minimum, which can really help when accounting points and we'll take a look at that when we get to our quality section. High performers are not penalized as well as low performers will benefit from the team score. Basically, what that means is that if you're a high performer above your group average, we can... you will get your individual score. We will report for both their individual as well as the group score and CMS takes the higher of the two scores for you. So, you can see with this example here now we're including all of those providers that may not have reported due to their eligibility and we're able to get the incentive for the entire group. And a \$25,000 incentive is a nice touch to a program that I believe can become easy for psychologists.

So, on this next screen this shows you that if you have 30 points, you'll avoid the penalty. Anything below 30 points will get you a penalty up to 7%. So that starts out at as the number gets smaller the penalty gets larger. The upper two categories will give you an opportunity for some incentive as well; on top of that, the maxed incentive for 2019 reporting could be up to the three and four range.

So, now we're going to take a look at performance category weights. For psychologists, what we're saying here is that there are only two performance categories. We have your quality as well as your improvement activities. You are exempt from the other two which are promoting interoperability and costs due to your specialty as well as your status as being new to MIPS in 2019.

So, quality reporting basics for 2019 is that you have to report on six measures, and one must be either an outcome -- and if that's not available, a high priority measure. You need to report data – and this is very important – on at least 60% of ALL patients seen in 2019. That includes all payers and not only Medicare; that is a very important difference from the days of PQRS. Now that you're moving into MIPS is to understand that this is for all of your patients. And practices larger than 15 providers cannot report via claims and need to report using a registry system.

Dr. Carol Goodheart: This slide shows the recommended high priority and outcome measures. I'd like to give you the larger context of where we're headed. The advisory committee that worked on getting these measures approved and

into our registry started with four guiding principles. We said that measures needed to be free, elegant, and brief and include process outcome and structural measures that followed what was then called The Institute of Medicine Recommendations for all of healthcare. We thought there had to be at least four domains for potential measures: role functioning, drop out as a structural measure or proxy for the alliance, symptoms or disease management including chronic health conditions, and patient's perception of care. We thought that measures needed to be linked conceptually or empirically to the aspects of care which we need to know - not just nice to know - because otherwise it just burdens them to clinicians and patients. Most critically, we were guided by the vision that measures should capture the change that is meaningful to the patients themselves as well as to clinicians and health systems. So, if you look at the slide and the actual measures that are on it, you will see that the first measure - we wanted to add a measure that was much more relevant to common mental health problems and there was not one approved CMS measure in any registry for anxiety. And anxiety is ubiquitous -- we see it all the time in mental health whatever the diagnosis and of course it's very common in primary care and other specialties as well. It is the first measure we submitted to CMS, stepped it out, and received the approval and we're still the only registry to have it. So, you can use that measure to measure it... your baseline; it's been coded as a process measure, and then anxiety response at six months for outcome. But we also know in the real world that there has to be some leeway because what if your patient finishes up in three months? Well you have plus or minus three months on that anxiety and actually we have leeway for the amounts of time for most of these. We also wanted transdiagnostic measures for problems that occur across diagnoses. We submitted and now have approved measures, as you can see, for sleep -- people report sleep problems with a lot of diagnoses -- and for people who have pain - chronic pain. We also wanted to take a lifespan approach, so we wanted measures that are suitable for children and for teens as well as adults. So, you're now going to start to see them here as well; in other words, what we're trying to do is take the lead on defining, developing, and selecting the measures that are of the most interest to our vast pool of practitioners and most important to our patients and our clinicians.

All of the... the measures marked MBR... MBHR on this slide are only available on our registry. And just to give you a heads-up about what's coming this year, we're submitting for approval - or we've actually already submitted - measures for PTSD for both children and adults and also alcohol use disorders measures. Going forward, we are starting to tackle "How do we best measure function and quality of life?" because these are central to our patients' concerns. Next slide.

Here you see the survey tools and outcome measures that are available as resources on the APA resource link, which you should be able to see at the bottom of this slide. However, on my screen, it's blacked out so I hope that it will be included in your handouts; I'm sure, if it's not, we'll get it to you. So, you may go and download any of these tools; these are the actual outcomes measures and you may download them for free. They're at no cost. Next slide, please.

You may also download this logo or badge for marketing on your own website or any other marketing material. The point is to stand out from other local providers. We think that marketing the fact that you track outcomes is beneficial and we have at least anecdotal evidence from the people who are doing it to say that it makes a difference and they are using it to stand out. Apart from marketing benefits of participating in the registry, we are anticipating clinician needs in the future and although it doesn't really fit with the marketing slide, I forgot to say it earlier so I'm going to say it now: we think it's going to be increasingly important for providing for all your other data needs. So, you're going to need CE credit and of course you'll get CE credits for participating in the registry, also for board certification or maintenance of competence standards - for example, ABPP - also, for credentialing or for adding licensing jurisdictions if you happen to move. So, we anticipate that these will go on in the future; we also expect to provide more resources for you and the APA page and Healthmonix of course will too as this project continues. Next slide.

Mike Lewis: So, I'm gonna talk to you about how the MBHR is gonna help you report for your quality measures. The first area that concerns most providers is that they want to know "Well, how are you going to get my information into the MBHR?" There are multiple ways to get information into the MBHR, all the way from being able to manually put the information in to uploading a spreadsheet that might be just an Excel spreadsheet downloaded from either your EMR, your practice management system, or it could be a spreadsheet that you've created on the side from your billing organization. We support all the MIPS CQMs and ECQMs, as well as, as you saw, the QCDR measures that we've created along with the MBHR and the APA. We have the ability for you to upload even special spreadsheets delivered directly from your EMR system through an HL7, a QRDA One file, or a CCD file as well as your billing files that you are probably

very used to. We also do have direct integrations with certain EMRs and, as psychologists are now coming on, those are becoming even more prevalent with what we are trying to do here at Healthmonix.

Now to take a look inside the MBHR registry. As you can see on this page, what this is showing are the measures that you have chosen from our list of measures that we have and showing you the complete instances as well as those measures that are met and not met. You have the ability from this screen to separate your providers to take a look at which providers are performing well, which are not if you're in a group; otherwise, you can look at this information as an individual off-base and from off-base of every single one of your measures that you want to look at. We also pride ourselves on the ability for you to take a look at this throughout the entire year. So, as 2020 is approaching, we highly recommend getting as soon as possible so that you can track your performance from January on. Our system is up and running usually after the first weekend of the new year.

We also give you the opportunity to take a look at your top six measures. So, with MIPS, you can track as many member... measures as you'd like within our MBHR system; however, you only want to report - in most cases - your top six quality measures, giving you a... the highest possible opportunity to get the largest score and the highest incentive. We also give you the opportunity inside the system to take a look at individual patients and dig into their visits. See which patients are not meeting the measures; use that gap analysis that now you have at your... at your fingertips to create performance improvement activities to make sure that the next time this patient comes in, you ask the questions that are needed to be completed. This gives you the opportunity once again to score the highest.

The next area that we discuss is the improvement activities and reporting the basics. I like to tell everybody that this is almost like a free 15 points and you need to go get it. It's a 90-day minimum reporting period, so October 1st is coming up at the end of this week and your... beginning of next week, I apologize - and needing to have 90 days will start right after that. So, there's more than a hundred improvement activities within the system and we can track it right inside your MBHR so that you have everything in one location. Forty points are required for large practices of 15 or more and 20 points are required for rural HPSAs, non-patient facing clinicians, and small practices: those with less than 15 providers.

Here's an example of a couple of the measures that we have within the system that can help you and we show you everything you need to do for each one of these measures. The important part about improvement activities is that you're not tracking any individual data; you're not tracking individual patients; what you are doing is changing an action within your practice that shows that you are doing improvement activity. You need to have documentation that it was being done; however, at the end of the year when you go to report this information the only thing you're going to have to do is say, "Yes, I did this one measure or these two measures" to report for improvement activities.

Now I know I hit on a little bit ago the cost requirement and where the cost requirement comes in. Most psychologists are going to be exempt from this measure; I anticipate all psychologists will, but I want to explain it to you since you probably are questioning about it because it comes up a lot in the conversations when we're talking about MIPS. It is automatically calculated from administrative claims data; there is nothing that you can do during the year to... to mitigate or to increase your performance on this without having actual information from Medicare regarding your claims. Your performance period is the entire year; there are two Medicare measures that are Medicare spending for Part A and Part B beneficiaries as well as eight episode-based cost measures for those who may qualify, and as I said it is another category that most psychologists are exempt from and that this is mainly a primary care provider program.

So, how are we going to help you? We're gonna offer you those real-time dashboards I showed you, giving you the ability for performance improvement to take a look at your gaps in care – find out which providers may not be living up to the rest of the group so that you can help them. You have the ability to email those providers their scorecard as well as give them the chance to improve their measures. We have all MIPS categories available for you to report in; while quality and IA are important for psychologists, if there are psychiatrists on here, they need to report the PI and some may qualify for costs. You need to adapt this program to your practice; we are here to help you do that. We're here to show you... to work with you to come up with the best situation so that you are performing well and are successful with this program. We have an entire support team here at Healthmonix that is available to help you understand, not only the MIPS program, but understand your data, understand the information that you're putting in, and help you

circumvent this ever-changing difficult program. You can choose your own pace; we didn't hit on this early, but there are many opportunities for in 2019 to just avoid the penalty and going into 2020 that becomes more difficult, so getting on board in 2019 is extremely important. And once again, we are able to work with a number of your EMRs and practice management systems to bring information in.

So, now I'm going to turn it over to Nicole who is going to go through some of the questions for us.

Nicole Owings-Fonner: Thank you to all of the presenters and thank you to those of you who have submitted questions. I'm going to go through them, and I will ask specific presenters to answer them, but please if any of the other presenters have information to add, you can do that at this point, too. So, the first question is - and a couple varieties of this question have come up a couple times and - but it's... here's one version for Vaile: what are all of the specific MIPS measures that neuropsychologists can use? What quality and improvement activities measures can neuropsychologists use that correspond to their actual CPT codes such as nine six one one six, nine six one three six, nine six one three seven, and nine six one three eight?

Dr. Vaile Wright: Yeah, absolutely thanks for that question. So, there are currently four sort of traditional MIPS measures that are available for a neuropsychologist. They're 130, documentation of current medications in the medical record; 131, pain assessment and follow-up; 134, preventive care screening, screening for depression and follow-up plan; and 181, elder maltreatment screen and follow-up, and those aren't specifically linked to a particular diagnosis. So, those are what we would consider trans-diagnostic measures. There are also the four dementia measures; that's 282, 283, 286, 288. One of the challenges, of course, with the dementia measures is that you have to have a dementia diagnosis or a related diagnosis with delirium or alcohol dependence with induced dementia. So, those can be limiting for neuropsychologists, but those eight are the MIPS measures that are available. What we've been able to do with MBHR, however, is propose additional measures and when we write our own measures and put them in the MBHR and get them approved by CMS, we can include the CPT codes that neuropsychologists use. So, all six MBHR measures include CPT codes that you named: nine six one one six etc. So, all six of those measures are available to neuropsychologists who use MBHR to report their quality data and if you're a neuropsychologist who does... who is not using MBHR - either using a different registry or just using Healthmonix's traditional MIPSPRO - those aren't going to be available for you. You have to go through our registry in order to access them and that's the same for everybody. So, we are working hard to include CPT codes that are relevant to neuropsychologists. We know that this is a significant issue for people and it's something that we're working on; so, again so there's currently... that would put us at eight traditional MIPS measures plus the six, so there's technically 14 measures right now that if you use MBHR, neuropsychologists would be able to report on quality.

Nicole Owings-Fonner: Thank you. My next question, I believe, would be for Mike but please feel free, like I said, for others to chime in: it says, "You indicate that I have to report on 60% of all patients seen. I am using the dementia measures, but a significant portion of my patients don't meet criteria for those measures; do I still have to enter their data into the MIPS?"

Mike Lewis: Thank you very much and I probably misspoke, but what it is is it's sixty percent of eligible instances for each of the measures. So, if you only have 25 patients with... that fit the denominator for the dementia measures, the only things you need to enter in for those patients are those 25... or the only thing you need to enter in are those 25. So, that brings me to where we can actually improve your score is that the least amount of work would be to do the patient... the the measures with the least amount of patients. Over... I'm sorry: let me add a caveat to that. Over 20, you need to have over 20 patients per measure for you to be able to get the max score for that many.

Dr. Vaile Wright: I suppose that the part that I would add is, to be quite frank, I would probably just report measures on all my patients and then... not just so that you can maximize your score but, you know, I think as Dr. Goodheart was talking about earlier, I think there are ways that we can use this data to improve our practice. We should be measuring our care; this is a way to measure care and you can look at your data and you can see where improvements can be made and then, sort of on the backend with Healthmonix, figure out you know what needs to actually be reported to CMS to get you that best score. But I think if we try to calculate ahead of time who to enter where and... and where and how I think it's pretty complicated and I don't know that we're setting ourselves up to be very effective.

Nicole Owings-Fonner: Thank you and I'm gonna skip around quite a bit because the questions skip around quite a bit. so, I believe this is for Mike: for quality reports, who defines if quality is met or is not met?

Mike Lewis: Sure, thank you very much, Nicole. For quality reporting in regards to MIPS, the important part is that each and every measure has what is a numerator and a denominator. The denominator section tells you if you are eligible for that specific measure and the numerator would be the answer to that measure. So, what you are attesting to is that you did the numerator section of that measure, whether that is asking patients certain questions, enter them... entering them into certain regiments for your practice, or it could be that you are just entering some of the demographic information that gives you credit. For instance like if you ask them about certain vaccines that they took. They could get you that will put you in the numerator for that question.

Dr. Vaile Wright: Yeah and I think I can maybe help flesh this out a little bit. So, how your performance is met or not met really depends on the measure itself; so, for example, with a process measure it's really a measure of did you do a thing, or did you not do a thing. So, did you screen for depression and if you screened for depression and they were positive, did you come up with a follow-up plan? Your performance is met; that's how you meet that measure. If you failed or if... another way to meet it would be you screened for depression, they were negative, and you didn't do... and so there was no follow-up, but you documented it – that's how you meet your performance. How you don't meet performance is if you just never screened for depression, didn't say why you didn't screen for depression, and just failed to not report it: that's how you not meet that performance. So, that's sort of how it works. With outcome measures, it's a little bit different; with outcome measures, you meet performance by showing some reduction, typically in a score. So, let's take the depression example again; so, with depression you would take a baseline score and you would take a follow-up score and you would look at how much did that person improve in that amount of time and that determines whether your performance is met or not. So, these are sort of it... so it depends a little bit on the measure and that why it's really helpful to use things like the registry because they have the technology to help determine whether or not performance is met on these various measures.

Nicole Owings-Fonner: Thank you. We had a very specific question about psychiatry - this is for Mike: what determines whether or not psychiatry has to report on cost?

Mike Lewis: Sure, thank you once again. So, you do not need to report on costs; you're either going to be automatically in the program or not in the program, based on eligibility. In most cases, as long as psychiatrists aren't seeing patients as their primary care holder – which I've seen a couple times: not many, but a couple – then they will be exempt as well, but there is nothing currently that you need to do; it is all done by CMS.

Nicole Owings-Fonner: Thank you, and two more very specific questions for you, Mike: does the MBHR integrate with Qualifacts EHR or Advanced Med EHR?

Mike Lewis: Sure, thank you for that. We are working on integrations with all of those EMRs. We do work with them and we do have the ability to take in their information; however, currently we don't have an API direct integration with those EMRs, but that should be coming down the line. But in most cases, they're able to send us the information that we need that the direct integration is not necessarily a hundred percent important at this time, especially as we're going into the end of the year.

Nicole Owings-Fonner: Thank you. Again, I'm going to direct this at Vaile, but others feel free to chime in: can you tell us how patient confidentiality is protected?

Dr. Vaile Wright: Well, sure so – and Mike want to... you might want to jump on this, too – but when you go in to enter your data into the MBHR, you can determine how you want to identify your individuals. So, you could give them a unique number or ID number if that's how you wanted to identify them, but of course then you have to remember that unique ID. You can put in their names as well; it is a HIPAA-protected program, so nobody else has access to your data unless you give them access to your data. So, it's how it's protected, similar to how you might work within your EHR. Mike, do you have anything to add to that?

Mike Lewis: Sure, Vaile. We actually have worked with CMS on a number of programs pretty significant within their abilities and we are a hundred percent HIPAA-compliant. Every person at our company is HIPAA-trained; our programs have more firewalls and ways to secure your information; so that is not an area that you should have any concern working with us. We have helped report over 50,000 providers in the last year to report for MIPS and we continue to strive to be the most secure company in the country when it comes to Medicare and registries.

Nicole Owings-Fonner: Thank you. And Mike, could you answer how are scores entered into this system? Are these assessments paper-based or computerized?

Mike Lewis: Sure. So, scores are entered, based on all of these numerators and denominators that are loaded into the system, whether that's through any of the ways that we have integrations with current EMRs, whether we are getting your QRDA-1 files, or you are uploading a spreadsheet, and finally the ability to actually do this manually. Once you enter in all that information, immediately with our real-time access to our dashboards you'll see your numerator and denominators build a score, based upon the numbers that CMS has given for each one of the measures and the scoring. So you'll see from there what your predicted score would be CMS always holds the right to change that a little bit on the decile. However, we are... we are pretty accurate with our numbers as the year is finishing up.

Nicole Owings-Fonner: Thank you. I have a question – I'm not sure who to direct to but I'm still gonna answer... I'm still gonna ask it and hope that you guys will chime in: when I used PQRS measures, I administered them as part of a therapy session and thus did not receive extra reimbursement for doing them, scoring them, documenting them. Is there a way to charge Medicare and other insurance companies for the time it takes to do these measures?

Dr. Vaile Wright: So, this is Vaile; so, there is technically a CPT code that is set aside for some administration of these types of tools or scales. One of the challenges with it, however, is that you cannot bill for it and also bill your psychotherapy code. They consider that a bundled code right this moment. Which doesn't obviously help us anyway because if you're administering say, the GAD-7 or the PHQ-9 as part of your therapy session, obviously you're also going to bill your therapy session code. So, APA has been working with some government organizations and some research groups to try to come up with a solution that we could recommend to CMS as well as other options for how we could get reimbursement for giving out these measures. Because they're absolutely right, you know. We should be paid for measuring [unclear word] and... and we need to remove the barriers to being able to do that. So... so, no – as of right now it's... it's it's not you can still bill... bill the CPT code and see if you get reimbursed, but generally what we've seen is that it often gets rejected.

Nicole Owings-Fonner: Thank you. Again, probably Mike should answer this question: when doing quality measures, when and how many times do we have to record for the same patient?

Mike Lewis: Sure, thank you. That actually depends on the measure; if you look on our page once you're signed in, you'll see that you'll be able to select "View details" for each measure and under each measure in the first paragraph, it will tell you once per reporting period, once per visit, once per occurrence. So, each one is a little bit different in how they're going to do that. For instance, if you're looking at some of the measures that have follow-up, you're going to need to do that at every visit; however, some of the measures that you're looking for a distinct answer. You will only have to do that once per reporting period and, in this case, the reporting period is a full 365 days.

Dr. Vaile Wright: Yeah, exactly – so... so, another way to think about that is, you know, as your initial intake, you could have part... as part of your initial intake that you just already do as part of your best practice. Maybe you screen for tobacco; you screen for alcohol; you screen depression and anxiety. There are measures that correspond to all those; you've already just knocked out four measures that you only do once a year. So then, for that patient, you might have one or two additional measures that you might track over the course of their therapy that would maybe track their symptoms or track their functioning. So, you know, similar to what Mike said, it really depends on the measures. Some measures are once-only; some measures you track over time and you just want to think about what measures make the most sense for your practice and the people that you're working with.

Nicole Owings-Fonner: Thank you. For Mike: if we are exempt and we opt in, is there a risk attached to that?

Mike Lewis: Sure. There actually is; it's very small because being a psychologist, there's a good opportunity that you won't receive less than 30 points. Just by participating in our program and if you enter at least one patient in a positive numerator for each of the six measures that you choose as well as do the improvement activities, your minimum score is guaranteed to be over 30, if you're in a group practice less than 15 or as an individual. So, the score... the... the... there is very little risk involved in it, but the reward could be at a min... at a minimum one or two percent on your Medicare as well... all the way up to over four percent for your high performers.

Dr. Vaile Wright: The other thing to remember is that if you decide to opt in for the year, you can't opt back out in that calendar year. So, if you opt in for 2019 and you're like a month into it and you're like "I'm over it", you can't opt back out. You have to stay opt in... opted in for the rest of 2019, but then you wouldn't... but then every year you make the determination whether or not to opt in.

Nicole Owings-Fonner: Thank you. If I'm a psychologist and I – this is for Vaile – if I'm a psychologist and I'm just interested in tracking our own performance and I really don't feel like I'm in a position to submit to CMS, is that an option? How would this work?

Dr. Vaile Wright: Yeah, that is an option. So, when you... when you sign in to join the MBHR, you're presented with two options: two tracks, if you will. One track is to report to MIPS and that will take you to that payment page and sort of what your options are or you can select "Report from My Practice" and that'll set you on a different path with different pricing options. They're also available on our website, so you can take a look at what those two options are. Our website will come up after this slide, but yes. So, you... you can use the registry to track your own personal practice without any intention of submitting to MIPS, but you still have access to your own data, and you can track your own personal quality improvements. And yes, there at the bottom the slide is APA's website, which has a wealth of information including as Carol mentioned earlier access to all the tools for free. We have additional resources, including this and other webinars we've done. There's a tab for all the measures that are in the MBHR, including descriptions. You can see who exactly is on the Advisory Committee and steering it and there's other... and the badge logos are there as we mentioned earlier. So, there's really a lot of information on the website; we encourage people to go visit it if you haven't done so yet.

Nicole Ownings-Fonner: Thank you. I have a few follow-up questions from earlier questions; first, for Mike: I'm concerned about the guideline that I have to report on 60% of my patients; yet you just mentioned that I can meet the requirements by reporting six measures on one patient. Could you clarify the 60% guideline?

Mike Lewis: Sure – so, the 60% guideline is to give you the ability to maximize your score; the minimum work that you would need to do is reporting one patient. That will help you avoid the penalty, but that does not give you the opportunity to receive anywhere near the maximum incentive. So, you need to report at least one patient for each measure to receive the points for that measure.

Nicole Owings-Fonner: Thank you. Vaile, we've had several requests that you repeat the measures that are available for neuropsychologists. I know that you listed them off; would you mind reading those again?

Dr. Vaile Wright: Sure, and it might be easier for me to just give the numbers, but they're 130, 131, 134, 181, 282, 283, 286, 288, and then MBHR one through six. But again, those are only available by joining MBHR and using the MBHR to report your data to CMS.

Nicole Owings-Fonner: And Vaile, could you speak just a little bit further about the measures that are only available on the MBHR that you just mentioned?

Dr. Vaile Wright: Yeah. It would be easier if we could go back to that slide because I don't have all of them memorized off the top of my head. But basically, what we have are... we have six measures that include a combination of process and outcome measures. So, again, process measures are "Did you do a thing?" Did you screen or not, for example, whereas an outcome measure is a patient-reported tool that you give to your patient over a series of sessions, you

know, maybe at week one and at week six and at week twelve as an example? Again, as Carol mentioned, we started with anxiety because there were not any MIPS measures related to anxiety and we all know we see a lot of it; there are a lot of individuals that come to us with anxiety, so that's where we really started. And then we started really looking at some other measures, so we have a pain interference measure: so, you know, looking at individuals that you might work with chronic pain. You know, using non-pharmacological psychotherapies to treat chronic pain. Can you, you know... do you see their pain score improving over time? That would be that one. Social role functioning is really focusing on the things that often matter the most to patients, right? Like, are they better able to function at work, in their relationships? That's what that really gets at. For number five, it's again our tool looking more at children and youth, and it's looking at externally and... externalizing and internalizing problems using the pediatric checklist. And then the last one is sleep quality... quality screening, so, you know, as part of your intake possibly you asked about sleep. What the requirement is with a measure like this is that you used a standardized tool to do so; we don't specify the standardized tool for the screening. We do, however, for measuring outcome. But these are the types of... and again all of these include the CPT codes that neuropsychologists use; we're very specific about making sure that we include every possible code that could be used by psychologists. That's really the benefit of us being able to have this MBHR and have this registry because it's not always... it's not always easy to go back to these other measure developers and say, "Look, you didn't include the neuropsychologist codes; will you include them?" That's a much harder sell or pull than it is for us to be able to create measures that we think are the most meaningful, are the most useful, and that won't feel hopefully like such a burden to... to use, but will actually provide you with information on how to demonstrate the quality care that you provide.

Nicole Owings-Fonner: Thank you, Vaile. I have a question for Mike now: what would folks have to do to set up by Monday to get the full 90 days?

Mike Lewis: Sure. So, you actually do not need to sign up by Monday to receive the full 90 days; all you need to do is report that you have done the work for 90 days. You don't need to do anything in our system for that... the... by October 1st; however, if you would like to sign up, our contact information will be included in the email as I send out this video as well as the slides to you by this afternoon and you could contact anybody here at Healthmonix to sign up or you can visit the web page, the MBHR: M-B-H registry dot com.

Dr. Vaile Wright: Because, you know, honestly for a lot of the improvement activity measures - which is a 90-day measure that you're talking about - there are some things you might already be doing in your practice. They're often things around improving access to care. So, you know, do you have a feedback loop set up for when you're reporting test results back to the referral individual? That, you know... if that's something that's already a part of your practice, then you can attest to "yes, I'm doing that." So, it doesn't necessarily - as Mike was saying - it doesn't necessarily have to mean that you have 90 days still left in the reporting period. Often, they're... they're things that you're probably already doing that CMS wants to know that you're doing.

Nicole Owings-Fonner: Another question for you, Mike: is there a way to report MIPS measures directly to CMS?

Mike Lewis: There is a way to directly report to CMS through your claims data; however, there are a number of reasons why that isn't optimal. Number one: most of the measures that we show you here are actually not available through claims or almost 90% and a hundred percent of the MBHR registry measures are not available through claims. The other area is that you are totally dependent on someone else picking up that information when you report via claims, giving them the option of missing said information, if it's on the bottom of one of your claims as well as you can never track how well you are doing for that. Most cases, the average person who's working through claims scores much lower than those that report through a registry.

Nicole Owings-Fonner: Thank you. I have another very specific question for Mike: where can I find more information on pricing?

Mike Lewis: Sure. So, for pricing, you can go directly to the MBH registry website, as well as I'll send out links this afternoon with information directly to go there. We have a per provider... per provider cost as well as we offer programs for you to submit both basic which would qua... which would be quality only, and our standard program which would be quality and improvement activities. And then if you wanted to add the spreadsheet upload option or data integration

through your EMR, there is a small extra cost that is included with that. But we are very upfront with the costs and we have everything directly there for you to look through. And you can also call any one of our account executives here at Healthmonix to walk you through the cost of the program.

Dr. Vaile Wright: And as I mentioned earlier the costs are also can be found on APA's website as well.

Nicole Owings-Fonner: Thank you. We're starting to run out of time here, but I do have one follow-up question from someone that hopefully maybe Mike you can address before we wrap up. To clarify, the current threat is a seven percent decline in pay; combined with doing MIPS to avoid the MIPS seven percent penalty, we end up even. Can you talk about that a little more?

Mike Lewis: Sure. It actually is; there's a swing. So, there is an even... there's a penalty and there's an incentive. So, there can be a penalty up to seven percent as well as an incentive officially up to seven percent, but we're looking more at a max score somewhere in the four percent range. So, there is an ability to get extra or incentivized and if we take a look... if I slide back to that slide, it will show you... might take me a minute to get back there. It will show you that in 2019, you need to report on... here you go – if you get thirty-one to a hundred points, there is an opportunity for an incentive on top of that break-even point at 30.

Nicole Owings-Fonner: Thank you; I think that that is all the time we have for questions now. Would one of you guys like to close things out?

Dr. Vaile Wright: Sure, I can do that. So, again here's our contact information; you can see the top information is contact for Healthmonix directly, putting... looking directly at the registry site. The contact information below is for us at APA; if you have any questions for APA staffers about what we're doing, either related to the registry, the Advisory Committee, or just in the field in general about measuring care and working with CMS, you can always email us there at MBHR at APA dot org. Again, our website's at the bottom. I want to thank all our attendees today; thank you so much for being present and asking these great questions. And I will finish off by thanking our presenters Mike Lewis, Dr. Carol Goodheart, Nicole Owings-Fonner, and myself. So, thank you very much and I hope everybody has a good rest of their day.

Mike Lewis: Thank you, everybody; enjoy.

Dr. Carol Goodheart: Thank you; bye bye.