Overview of the Proposed Rule for Year 3 (2019) of the Quality Payment Program

Tuesday, July 17, 2018

Hello, everyone. Thank you for joining today's overview of the proposed rule for the Quality Payment Program Year 3 webinar. The purpose of this webinar is to provide an overview on what is included in the proposed rule for the Year 3 of the Quality Payment Program. Now I will turn the call over to Adam Richards, health-insurance specialist in the Center for Clinical Standards and Quality at the Centers for Medicare and Medicaid Services.

Great. Thank you so much and good afternoon, everyone. Good morning to those on the West Coast. I think it's an early start time. But thank you all for joining us today. We're excited to be here to talk about the Quality Payment Program and our proposals for Year 3 of the program. We do intend to cover both tracks, the Merit-based Incentive Payment System and Alternative Payment Models and Advanced Alternative Payment Models today. There's a lot of information to go through, so I won't spend too much time up front. I do just want to quickly jump on to slide 3. Just some important information, really some administrative information before we really get started today. Again, this is a proposed rule, and that means that we are in rule making, so there is an open-comment period. So, we do encourage you all to, after you hear our proposals today and certainly take the time to read through elements of the rule that may interest you, to send your comments to us. We want to hear from you. In developing these programs, we've gone through and we've gone to the front lines to really hear from clinicians and stakeholders, many of whom these policies impact. So, we do want to hear from you. There is an official process, as you can see, on screen. So, we do want to make sure that everyone is aware of that. We do need you to send in your comments in a written format so that we can certainly address them. So, as you can see, instructions on screen. I won't go through all of these, but I certainly encourage you to circle September 10th. That is the close date for this submission period on the Quality Payment Program Year 3 proposed rules and our proposals. So, definitely make sure that you've got that. And of course for additional information, you can always check out qpp.cms.gov. There's some great resources on there, certainly get you started. Jumping on to the next slide -- just quickly, the run of show for today. We're going to start with a high-level introduction of the Quality Payment Program, talk a little bit about our proposed rule. We have a very special guest with us today, who I'll announce in just a few minutes. We'll then jump right into the Merit-based Incentive Payment System, and we'll go through our proposals. We plan to cover the majority of our proposals. Of course, this isn't an exhaustive discussion today, but we will hit on the big ones, specifically around eligibility. I know a lot of questions have come in on our opt-in policy so far. So, we'll definitely touch on that. Talk a little bit about data submission, some of our performance -category changes, as well as the proposals for our performance threshold and payment adjustments. We also have a few areas that we are seeking some additional comment on, and we'll go through those toward the end of the MIPS section. Then we'll be sure to address Advanced Alternative Payment Models, again providing an overview of Advanced APMs. We'll also provide an overview of the All-Payer Combination Options, since we are offering some proposals in this area, as well. And then we'll wrap things up, just to go through some of our technical assistance, forms of supports. And then we'll open it up for a Q&A session. I do encourage everyone to focus specifically on the Year 3 proposals when asking your questions. Again, we'll try to provide as much clarity as possible. We
can't get into too much depth, again, because this is an open-comment period. So, we certainly encourage you to submit all of your comments to us following this webinar and by September 10th -- so, one last plug for that. So, at this time, it's my pleasure to introduce Jean Moody-Williams, our deputy director in the Center for Clinical Standards and Quality, to kick us off today. Jean?

Thanks so much, Adam, and hello to everyone on the line. And on behalf of our administrator, Seema Verma, and all the leaders here at CMS, we welcome you and thank you for joining this call. As you're aware, on this past Thursday, we issued the proposed Medicare Physician Fee Schedule and Quality Payment Program rule, and as, as the Administrator has mentioned from the beginning, her priority is to put patients first. The proposals that are issued in this rule really deliver on some of the initiatives that we've talked about -- Patients over Paperwork, MyHealthEData, Meaningful Measures, and lowering drug prices -- which together will work to advance innovation and efficiency in what we think is an unprecedented way. And this very much includes reducing provider burden so that clinicians and providers have more time to spend with their patients. So, I invite you to please read the entire rule. But today this webinar will focus on the proposals for Year 3 of the Quality Payment Program. And before we jump into the discussion on Year 3, I would be remiss if I didn't take this opportunity to remind everyone that we are closing out Year 1 of the Quality Payment Program, and we are in the review of feedback period, as well as the targeted review period. And so, we ask you to please go in and take a look at your feedback reports if you have not already and that targeted review request, if necessary, must be submitted no later than September 30th of 2018. And in order for you to be able to go in and take a look at your feedback reports, it's extremely important that you have your credentials -- your EIDM account -- which will allow you to access your reports and that those requests really need to be in by July 31st of 2018. Otherwise, it takes a while to process your requests, and you won't be able to, you may not be able to get in to see it in time in case you need to request a targeted review. So, we're asking you, if you are one that will be reviewing these reports or to spread the word to your colleagues if not. So, we are going to move on to talk about the Quality Payment Program. If we could move to the next slide, please. And as was mentioned, on last Thursday we did issue the proposed rule for the Quality Payment Program. And I think that probably everyone on this phone call I hope knows that this rule came about as a result of the Medicare Access and CHIP Reauthorization Act of 2015, MACRA. And as a result of MACRA, we are required to implement a program that has basically two tracks, one being the Merit-based Incentive Payment System, MIPS, or the Advanced Alternative Payment Models, which we call Advanced APMS. Now, as we began to look at Year 3, on the next slide, we will see our objective, the Quality Payment Program objective, which really have been the same since the beginning of Year 1. And we do reevaluate them every year, and we reevaluate them before we started the program policy-making and proposals for Year 3. I'm not going to read through them, but I think you can see the first thing is improving beneficiary outcomes and the very second is reducing burden for clinicians. And then we go on for excellence in other areas. So, as we prepared for Year 3 of the Quality Payment Program, we continued to take all the input that you provided into consideration. We looked at smoothing the transition where possible and offering targeted educational resources for our program participants. We did use, as I mentioned a little bit earlier, the Patients over Paperwork initiative, which evaluated many of the requirements under the Quality Payment Program, and we got to some of the proposals that we'll be talking about. Now, the other thing that we were able to incorporate was the Bipartisan Budget Act of 2018, which allowed...offered a number of flexibilities that we were able to use so
that we could take a slower path in ramping up the programs as it related to several of the thresholds. For example, in weighting of the cost performance category, instead of requiring this performance category to have a weight of 30%, which it really initially did require for Year 3, we are proposing 15%, and then we'll be able to ramp up for there. Another area of flexibility were the thresholds in that it gave, it allowed us program Years 3, 4, and 5 to gradually and incrementally transition to using the mean or the median for the final score. And we now have a little bit more of a ramp so that we're proposing to set the threshold for performance at 30 points for this Year 3, and we'll talk more about that. You'll hear about the quality measures in which we are reducing the number of quality measures that nearly, have little room for improvement, topped out, as we call it, and then we are adding 10 new quality measures that really address what we've heard from patients and families and clinicians. So, we have patient-reported outcome measures, high-priority measures, and many other clinical topics of importance. So, moving more and more toward getting away from those measures that have less relevance to clinicians. We'll, a highlight -- our promoting interoperability, one of the things that Administrator Verma said early on this year is that we were really going to move toward pushing interoperability so that patients could get access to their medical records and the clinician-to-clinician transfer could occur, and we have proposed that, an opt-in policy, and facility-based scoring. Many of the bonus points will remain, and we have some aggressive policies related to the Advanced Alternative Payment Models. So, those are some of the highlights that we want you to listen for as you go through and provide comments on. There are many other areas that we seek your comment on, as well, but I did want to highlight those particular areas. And, as always, we do have technical assistance that will be available to you as we go throughout implementing these programs. So, with that, again, thank you, and let me turn this back to Adam.

Thanks, Jean. And thank you so much for getting us started today. I recognize that some folks are having some challenges right now with slides. They're a little bit delayed. We might also have some audio issues. We're trying to kind of work through those. Just wanted to call a quick time-out to try to get us all back up to speed and on the same slide. So, we're going to transition over to Molly MacHarris, our MIPS program lead, and we're going to be on slide 8. So, I do want to give a quick second to refresh and make sure we're all there. It sounds like it might be working at this point. If you are still having trouble with your slides, we have heard that you may need to just refresh the browser quickly. That seems to be working. If you can't see them or if you get stuck, I think we have the issue now resolved. So, with that, I'm going to turn it over to Molly.

Thank you, Adam, and thanks, everyone, for being here with us today. So, I'm going to go ahead and jump right in. So, moving on to slide 9, where we're talking about the MIPS program.

So, Jean mentioned this in her earlier remarks. I won't go into this in too much detail, and for those of you who have sat in on prior Quality Payment Program sessions in the past, this will not be new information for you. But just as a quick reminder, prior to the Quality Payment Program and the two tracks of MIPS and APMs, there were three legacy programs that clinicians had to participate in -- the PQRS program, the Value Modifier Program, and the Medicare EHR Incentive Program for Eligible Professionals. When MACRA the law passed, it consolidated those programs into one new program, MIPS, which, as slide 10 reflects, the measure performance under four performance categories -- Quality, Cost, Improvement Activities, and the newly renamed Advancing
Care Information performance category, which is now called Promoting Interoperability. I'll go into more detail on these four performance categories, as well as the weights associated with these in more detail in coming slides. The important thing to remember is that we do assess clinicians' performance on these four performance categories. There are specific weights associated with each of these categories, and how a clinician performs in each of these categories will determine their final score. And that final score will be compared to a performance threshold. What we propose the performance threshold to be at for Year 3 is 30 points. If their final score is above the performance threshold, they could get a positive adjustment. If it's below, they can get a negative adjustment, meaning money being taken away. Or if it's at the performance threshold, they would get a neutral adjustment. And then, just as a quick refresher on slide 11, because these are some common terms you will hear me and my colleagues talk about today. When I talk about a TIN, a Tax Identification Number, this is the identifier used by the IRS to identify an entity such as a group practice, and NPI, or National Provider Identifier, is the numeric identifier for clinicians. We talk under the Quality Payment Program about unique TIN/NPI combinations. That refers to the specific clinician that is associated with a specific practice that we, CMS, receive billing under. And then, also, you'll hear me and my colleagues talk about the performance periods and some of our corresponding payment years. So, we are currently in the, well, the proposals we're talking about here today are related to Year 3. The performance period for Year 3 is 2019, and the payment year that's corresponding to that is 2021. Again, I'll talk through all of these in more detail. Moving on to slide 12. Again, this is just a refresher for those of you have sat in on Quality Payment Program sessions in the past. Our general timeline for participation in the program is clinicians participate in the program during the performance period, which for the third year would be 2019. Data is submitted following the first quarter after that through the end of March. We then issue feedback in the summer, and then claims would begin being adjusted in 2021. For the 2021 year or the third year, there is a total amount of 7% payment at risk. So, that has increased over the first few years of the program, and that is defined by statute. In the first year of the program, there was a total amount of 4% we could distribute. In the second year of the program, there will be a total of 5%. And in the third year, it has increased to 7%. Moving on to slide 13. Again, Jean went over these in her opening remarks, so I won't go over these in too much detail. But just so folks are aware, one of the, many of the proposals that we made in this year's rule were to extend the flexibilities that were offered to us by the Bipartisan Budget Act, specifically related to how we apply the low-volume threshold, as well as how we apply the MIPS payment adjustment itself, and then further flexibilities on the weight we apply to the cost performance category and performance threshold. So, let's go ahead and move along to slide 14 and then 15 to start talking through some of the details of our proposals related to eligibility. So, starting on slide 15. So, as a reminder, those who are currently eligible to participate in MIPS include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. I do want to remind folks that when we talk about physicians under the Quality Payment Program, that includes not only MDs and DOs, but dentists, podiatrists, optometrists, and chiropractors. We have proposed for the third year of the program that those clinician types I just mentioned would continue to be eligible, but new clinician types could also participate in the program. That includes clinical psychologists, physical therapists, occupational therapists, and clinical social workers.
Moving on to slide 16. One of the other changes related to eligibility deals with our low-volume threshold. So, as folks will recall there are a couple ways that you can be excluded from participation in the MIPS program. One is if you become newly enrolled during the performance period. Another way is if you become a qualified participant, which is significant participation under certain Advanced APMs. The third and most common way that clinicians may be excluded from participation in the MIPS program is based off of our low-volume threshold. So, the low-volume threshold, as it stands today is based off of a dollar amount, specifically $90,000 in allowed charges, a number of beneficiaries, which, as it stands today, is 200 beneficiaries. And what we are newly proposing is to add a third criteria, which is a number of services, specifically 200. So, let's move on to slide 17. And this outlines the values I just went over. So, with the low-volume threshold, what we are proposing is to add a third criterion, and if finalized what that would mean is that clinicians would be eligible for MIPS if they meet or exceed all three of these criteria. So, you would be eligible for MIPS if you bill more than $90,000 annually and see more than 200 patients and render more than 200 services. Let's move on to slide 18, which describes the other element of our low-volume threshold proposal, which relates to the opt-in policy. So, we talked about the opt-in policy in last year's rule, and what we're trying to do with this is we understand that there are certain types of clinicians who want to participate in the programs that are not currently able to do so. So, the opt-in policy provides flexibility for certain clinicians who may be excluded for some of the low-volume threshold criteria but not for all. So, the way that the opt-in policy would work is that if you meet all three of those criteria I just went over -- so if you meet $90,000 in allowed charges, you have 200 patients, and you have 200 services, you are required to participate in the program. You are considered a MIPS eligible clinician. And this would apply for the currently eligible clinicians, and, if finalized, the new clinician types we have also proposed, as well. The same low-volume threshold would apply to all MIPS eligible clinicians if finalized. You'll also see on slide 18 at the top of the chart, if you do not meet any of these three criteria, you would continue to be excluded. So, if you fall below the dollar amount, the beneficiary amount, and the services amount, again, you would be excluded from the MIPS program. If, however, you meet one or more of the low-volume threshold criteria, but not all, you have the option to participate. So, you would have the option to opt in and become a MIPS eligible clinician. So, let's move on to slide 19, which gives an example of what this could look like. So, you'll see in this example, we have a physical therapist. Again, this is one of the new clinician types that we are proposing this year. Again, all of our policies would apply to all MIPS eligible clinicians. So, as you can see in this scenario, the physical therapist billed $100,000 in allowed charges. So, they met one of the criteria. You can also see that in the middle column, they only saw 100 patients. So, they didn't meet the third area. And then, in the right-hand side of the slide, this physical therapist did provide 201 covered professional services. So, that meets our criteria there. So, as you can see, since this physical therapist did not meet all three elements of the low-volume-threshold criteria, they have a choice to participate in the program. And as reflected on slide 20, we have solicited comment within the rule on ways that clinicians can provide this choice to us. One of the reasons why we didn't finalize this proposal in last year's rule is we didn't feel that we had a mechanism to implement this policy in a low-burden manner. We have done additional work, specifically working with our user experience teams and working with our human-centered design processes to ensure that the process is low burden to clinicians. What we have done is we have created wire-frame design examples, which describes visually how we anticipate that clinicians
would interact with us, CMS, on making this decision point. To be clear, this is a proposal. We do want feedback on all elements of this proposal, including the new value that we have set the third criteria at, of 200 services, as well as the opt-in policy itself, and then the mechanism of how clinicians can make that choice. One other piece I wanted to flag because this is a question that we've received since the rules have been issued, which is what the difference between patients and services? So, when we talk about patients and services, as you can imagine, if you are a clinician, and you have an office visit with a patient, you would just see the patient. That would count as one in sense of seeing a patient. But during the office visit itself, you could render multiple services to that given patient. Those multiple services associated with that one patient would contribute for your 200 count. And if there are other questions on this, I'd be more than happy to talk to that in more detail during the Q&A section. Okay, let's go ahead and move on to slide 21, where we talk about some of the other changes we have proposed regarding eligibility. Slide 21 talks about consolidation of some of our determination periods. So, when we initially constructed the program, we set up determination periods to determine a clinician's low-volume threshold, as well as various determination periods to determine things called "special statuses." Special statuses apply to certain types of clinicians, but I want to be really clear on this. As a clinician, if you do have a special status, you are still eligible to participate in the MIPS program. You may just have to do a little bit less or something different. What we've proposed to do in this rule is to consolidate the determination period for the low-volume threshold, as well as our non-patient facing, small-practice, hospital-based, and AFC-based special statuses. We've shifted the time frame from falling from a September through August time frame to falling on the fiscal year. So, I think that's everything that I wanted to cover here. So, let me go ahead and move on to slide 22 and then slide 23. So, one of the other proposals that we have made within this year's rule is regarding our submission terms. As folks will recall, in the first two years of the program, we generally refer to submission mechanisms as an all-inclusive term for how people collect their data, how they submit their data, and how they potentially partner with organizations. So, the submission terms we have in existence today talk about claims recording, registry recording, qualified clinical-data-registry recording, EHR recording, web-interface recording. As we have gained experience under the Quality Payment Program, and as we've been working with all of you through our user-research efforts and through our human-centered design approaches, we've found that the way that we have described these terms don't actually reflect the experiences that users have when interacting with the system. So, what we have done, as reflected on slide 24, is we have broken out this one all-inclusive term, "submission mechanism," to now have three separate terms, which we feel more accurately and appropriately reflects the experiences that folks have under the Quality Payment Program. So, just to talk through these briefly, the first new term we've proposed is collection type, and that references a set of quality measures with comparable specifications and data-completeness criteria. Those include our ECQMs, our MIPS CQMs, which were previously referred to as registry measures. The measures that were previously referred to as registry measures are not limited to usage just by registry. So, that is why we have renamed those measure specifications to be called MIPS CQMs. We also have QCDR measures as a collection type. That refers to the specific measures that QCDRs offer to their clients that work with them. We also have Medicare Part B claims measures. Those would be the measures where clinicians would append a quality data code to a claim. We also have the web-interface measures, the CAHPS for MIPS survey measure, and administrative claims measures. So, again, the term "collection type" specifically refers to the
Quality performance category only, and it references the different collection types for our different quality measure specifications. We also have proposed the new term "submission type," and this is the mechanism by which a submitter type would submit data to CMS. That could include a direct mechanism, log-in and upload, log-in and attest, Medicare Part B claim, and the web interface. Again, to further clarify what we mean by these terms, we have also partnered with our UX design colleagues to create some wire frames here. You can take a look at those wire frames, and that will demonstrate visually what we mean by a direct submission, a log-in and upload submission, and a log-in and attach submission. The submitter type would refer to the MIPS eligible clinician group, which does include APM entities and virtual groups, or a third-party intermediary that would be submitting the data to us, CMS. The other piece I want to note with these new terms is these were the terms that we, CMS, were able to come up with, but we definitely welcome feedback and suggestions for other terms that may be more meaningful to all of you. So, we definitely welcome your feedback there. Moving on to slide 25. This references one of the tables within the proposed rule that breaks out exactly what the submission types, the submitter types, and the collection types are for the four performance categories. A couple things I want to note here. As you can see, under the Quality performance category row, we have proposed to restrict the Medicare Part B claims method only to those clinicians who are part of a small practice. That will include clinicians that are part of a small practice that participate in MIPS as individuals or as part of a group. And remember that we define small practices as any practice that has 15 or fewer clinicians. And as you can see on slide 26, these are the examples that are available for groups. This is also referenced from the rule. I will flag that within the Quality performance category row, we are missing the reference to Part B claims for small practices here. So, we will go ahead and update that in the transcript to reflect what is within the proposed rule. Okay, let's go ahead and move on to slide 27 and then 28 to start talking through the reporting options. So, as slide 28 reflects, we have the same basic options for participation in MIPS as we've had in prior years. You can participate as an individual, which is unique to an NPI. You can participate as part of a group, which is a TIN with two or more clinicians who have reassigned their billing rights over to the TIN, or as an APM entity. And then we also have virtual groups, which is a combination of one or more solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually to form a group. As reflected on slide 29, we've only made a few minor proposals related to the way that virtual groups work. The same overall requirements exist. The only changes that we have proposed here is that TINs would be able to inquire about their TIN size prior to making an election during a distinct time frame, prior to the performance period, and that those inquiries would be made to the Quality Payment Program service center. Okay, so let's go ahead and move on to slide 30 and 31 to start talking through the performance categories. So, as reflected on slide 31, the performance period for Year 3, we have not made any proposed changes here. This was finalized in last year’s rule. So, as you can see on slide 31, the performance period for Year 3 will be for quality and cost, a 12-month performance period, and for improvement activities, a 90-day performance period, as well as a 90-day performance period for promoting interoperability. For those of you who have made it through the rule, you will note that we do have a proposal related to performance periods. That proposal is specifically related to Year 4 and beyond of the MIPS program. As folks know, we have tried to provide as much advanced notice as possible on what the requirements would be for clinicians. So, what we have proposed within the rule is related specifically to Year 4 of the program and beyond. So, let's go ahead and move on to slide 32, the performance category weights.
Jean referenced these again in her opening remarks, but the major change here is that we have made a proposal to weight cost at 15%, with quality being weighted at 45%. Again, this is based off of the flexibilities offered to us under the Bipartisan Budget Act. One of the other areas that we are specifically interested in folks' feedback on is what should that gradual and incremental approach be to get the Cost performance category to be at 30%? So, that's another area that we are looking for specific feedback on. So, let's go ahead and move on to slide 33 so we can start talking about each of the performance categories. So, for the Quality performance category, one of the proposed changes here is that quality would not count for 50%. It would count for 45% of your final score. Overall, the Quality performance category, there haven't been too many changes here. We still have the requirements for participation clinicians. We need to select six measures. One would need to be an outcome measure or a high-priority measure. You also can participate using a specialty set of measures. We have proposed to add opioid measures to the list of high-priority measures. We also are continuing our bonus points that we offer under the Quality performance category. A couple of changes that I do want to flag here -- one is that we have proposed to discontinue the high-priority bonus points for web interface users, and we have proposed to move the small practice bonus from the final score level down to the Quality performance category for those small practices who participate by submitting at least one quality measure. Moving on to slide 34, our Data Completeness criteria have remained the same. We did not propose any changes. It's still at 60% for the majority of our submission mechanisms. Measures that do not meet Data Completeness would only earn one point. Small practices would continue to receive 3 points for failing Data Completeness. Slide 35. The information reflected here, these are new policies that we are proposing this year. So, based off of our experiences, again, to date, under the Quality Payment Program, a couple of unique instances have come up that we wanted to ensure that we had ways to address them. The first is that we recognize that updates to clinical guidelines can happen outside of the rule-making cycle. And what can happen when a clinical update would happen outside of the rule-making cycle is we have proposed to indicate that a measure that has a clinical-guideline change, if we feel that it is substantive in nature, we would make folks aware of that change, and the total measure-achievement points would be reduced by 10 points. So, that associates to one measure for those clinicians who would be submitting upon that given measure. We also have proposed that for groups who register to report the CAHPS for MIPS survey, we have found that sometimes when groups sign up for this survey, they may not have a sufficient sample size, and, unfortunately, due to our sampling time frame, we are not able to notify them of that lack of sample size earlier in the year. So, what we would do in these circumstances is that we also reduce the number of achievement points available by 10. Again, what that means is that essentially, those clinicians would have to do one less measure if they are impacted by these very distinct scenarios only. Moving on to slide 36, our Improvement scoring policies. Those have remained the same, no changes there. And then on slide 37, our topped-out measure policies. As folks will recall, we did finalize in last year's rule an approach for identification and then ultimate removal of topped-out measures. What we have discovered is that certain measures may reach an extremely topped-out status, which is based off of average performance within the 98th to 100th percentile range. If we find that those measures have reached that extreme topped-out status, we would propose that they would be removed in the next available rule-making cycle. Those measures would not fall subject to the 4-year life cycle that other topped-out measures would have. We also have proposed that QCDR measures would not fall under our topped-out measure policies. Again, this refers to the specific measures that QCDRs seek approval from us, CMS,
on and that they offer specifically to their clients. We believe that QCDRs have a lot of innovation and flexibility on developing measures, and so they don't need to follow the same toped-out measure life cycle as all other measures. That's it for the Quality performance category. So, let's move on to Cost on slide 38. For the Cost performance category, the major changes here is that cost is being proposed to count for 15% of your final score. We also are adding eight episode-based measures, which generally would apply to cardiologists, orthopedic surgeons, ophthalmologists, among other clinicians. We also have kept our case minimums. We also have added a case minimum of 10 for procedural episodes and 20 for acute inpatient medical condition episodes. The episode measures are referenced in Table 33 within the proposed rule. Slide 39, our Measure Attribution policies. These generally are the same, but we have proposed policies on how we would attribute clinicians for the procedural and acute inpatient medical condition episode. Let's move on to slide 40, where I will briefly talk through the facility-based measurement option. So, facility-based measurement is an option that we've proposed to have available beginning in the third year of the program. We did finalize this in last year's rule, but there were additional details that we needed to propose, which are reflected in this proposed rule. Facility scoring allows certain clinicians to have their performance under their facility that they work at, but that could be applied for the Quality and Cost performance categories. Let's move on to slide 41. There is the ability for clinicians to participate under facility-based measurement, either as an individual or as part of a group. As an individual, to be eligible for this option, clinicians would need to furnish 75% or more of their covered professional services associated with Place of Service Code 21, 22, or 23. For groups, the facility-based group would be one in which 75% or more of the eligible clinicians' billing under that TIN meet the definition of being eligible as an individual. Slide 42, our attribution policies. We have proposed that the clinician would be attributed to the hospital where they provide services to most patients. The group would be attributed to the hospital where most facility-based clinicians are attributed. If we are not able to identify the facility associated with the Hospital Value-based Purchasing score to attribute the clinician's performance, they would not be eligible for facility-based measurement and would need to participate in MIPS through one of our other methods. The election process -- this was an area that we did not finalize in last year's rule. What we have proposed, based off of additional user research, is that we would automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible. We are not anticipating that separate submission requirements would be required for facility-based measurement for the Quality and Cost performance categories. However, for groups, they would need to submit data for another performance category so we would know to assess them as part of a group. Slide 43, the measures and benchmarks that we have proposed to use is the set for the fiscal year HVBP program. The benchmarks are also those that are associated for the HVBP program. And then, lastly, on slide 44, we would assign the category scores for the Quality and Cost performance categories and then some of the special rules that we've proposed for those hospitals that do not receive a total-performance score, we would be unable to calculate the facility-based score for that hospital, and they would need to participate through another method. Okay, so, let's move on to slide 45, the Improvement Activities performance category. Not too many changes here. This category is still proposed to count for 15% of a clinician's final score. We have proposed to add six new Improvement Activities. We've proposed to modify five of the existing Improvement Activities and propose to remove one existing Improvement Activity. We also have proposed to remove the bonus for Improvement Activities where you use certified EHR technology. That is
contingent upon our finalization of the Promoting Interoperability policies. So, I'm going to go ahead and move to slide 46, and I will turn the presentation over to Elizabeth Holland to talk through these proposed policies.

Thank you, Molly. So, I'm going to talk about the Promoting Interoperability performance category, which was formerly known as the Advancing Care Information performance category. Our proposal is designed to focus on interoperability, health information exchange, and providing patients access to their health information. I'm going to reiterate that last year we finalized that clinicians are required to use 2015 edition CEHRT in 2019. So, this is our policy, and there's no policy related to the addition of Certified EHR technology in this proposed rule. We are proposing alignment with the Medicare Promoting Interoperability program for eligible hospitals and CAHs. You may remember that program used to be called the Medicare and Medicaid EHR Incentive program. We're trying to align the measures as closely as possible. We are retaining the performance-based scoring methodology, but it's changed from what we had in 2017 and 2018. We are eliminating, proposing to eliminate the base performance and bonus scoring. We also are proposing to eliminate the security-risk assessment as having a score. It will still be required, as is having Certified EHR technology and the information blocking attestation statement. They're required to earn a Promoting Interoperability score, but they will not be scored. Next slide, please. Some of the other changes - we are, because we are only requiring a 2015 edition CEHRT, we only have one set of measures and objectives. We are reducing the number of objectives from six to four. And there are six required measures. We are proposing to eliminate some measures, combine some, and rename some. Next slide. So, this gives you a sense of the measures. We have a few new measures that we are proposing. As you see, the Query of Prescription Drug Monitoring Program, the PDMP, is new. Verify Opioid Treatment Agreement is new. Those are two brand new measures, and because of that, we are proposing to offer bonus points in the first year or two of their inclusion in the program. We also combined a couple measures to create the Support Electronic Referral Loops by Receiving and Incorporating Health Information. That is new. For several of these measures, there are exclusions. There are exclusions available for e-Prescribing, for the Support Electronic Referral Loops by receiving and Incorporating Health Information, and for the Public Health and Clinical Data Exchange measures. All of the measures are required except for the bonus measures. And if you claim exclusions, those points would get reallocated to other measures. You must score at least a 1 in the numerator to fulfill a measure, but your scoring will be based on the numerators and denominators that you submit. Next slide. So, I think we already talked through most of this, what you need to add for the yes/no measures. You need to submit a "yes" or a "no." And next slide. So, on slide 50 you'll see we're walking through a scoring example. And so, your score is based on the numerator/denominator to get converted into a performance rate, and then you have a score. In this particular example, you earn 83 points. Next slide. That 83 points is out of the total for the category, which is 25 points. So, if you score an 83, you would score a 20.75 out of the total performance category points. Okay? So, now I'm going to turn it back over to Molly.

Okay, thanks, Elizabeth. So, I'm going to go ahead and jump to slide 53 and 54. Just a few more from me on the MIPS side, and then you can hear from Corey to talk about APMs. So, on slide 54, the performance-threshold and payment adjustments that have been proposed. Again, Jean mentioned these earlier. I have shown them earlier, as well. But just as a reminder, we have proposed to increase the performance threshold, as reflected on slide 54,
from 15 points to 30 points. We have also proposed to increase the exceptional performance bonus, which is currently set at 70 points, to 80 points. Also, again, the payment adjustment has increased for the third year of the program. This is statutorily required. It's increased from 5% to 7%. One other piece I do want to note, which is also authorized by the Bipartisan Budget Act, is that the payment adjustments, when we actually go to apply the payment adjustment to your claims, that will be applied to claims rendered under the Physician-Fee Schedule, not all of Medicare Part B. Moving on to slide 55. As you can see in comparing Year 2 to Year 3, we have a similar breakdown of the thresholds that clinicians would need to meet to either receive a positive adjustment, a neutral adjustment, or a negative adjustment. I do want to call folks' attention to the very bottom of the chart. You can see that if your final score ranges from 0 to 7 1/2 points, clinicians would receive the maximum negative-payment adjustment of negative 7%. Again, this is required by statute. And then the last item for me on the MIPS side of things -- as folks who have made it through the entire rule will have noted we are continuing to solicit comment on some of our policies that we would be addressing through future rule-making. So, I do want to call these out, and I really would encourage folks to give us feedback here. We are interested in receiving feedback from folks on furthering the expansion of our facility-based measurement option, specifically for clinicians who may practice in ESRD settings or post-acute care settings. We also are soliciting comment on a number of different ways that we could restructure the Quality performance category and the way that that category is scored. What we're looking to do there is really to simplify and streamline participation in that performance category. We have a number of different approaches on how we could accomplish that. One would include assign different values to different types of measures. Another option would be creating measurement sets. We're also interested in other approaches or feedback that folks may have on ways that we can continue to streamline and simplify the Quality performance category. We also are soliciting comment on the concept of subgroup reporting. We've received feedback from folks in the past that while they like participating in MIPS as a group, some of these really large groups may have further subgroup participation approaches that they would like to use. We have come up with a handful of different ways that we think that this could work, but, again, we're really interested in folks' feedback on what this could look like so we could implement this conceivably in a future year. And then the last item that I want to call out that we are soliciting comment on is Cross-Performance Category Measurement Sets. Again, as one of our efforts to reduce burden to clinicians, we want to see if folks are interested in the concept of having measures and activities that could stand multiple performance categories. We are also interested in feedback on what those measures or activities could look like and how that could work. So, at this point, I'm going to go ahead and turn the presentation over to Dr. Corey Henderson to talk through APMs. Corey?

Good afternoon, everyone. Thank you for dialing in again. I will go straight to it. Thank you for getting to slide 58. So, under the Alternative Payment models, we wanted just to do a quick overview for you, share a few pointers here. An Alternative Payment model is an approach or a payment approach developed in partnership with the clinician community that provides added incentives to clinicians to provide high-quality and cost-efficient care. It's also important to note that APMs can apply to a specific clinical condition, a care episode, or a population. And APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on additional risk in requirements of Advanced APMs. Next slide, please. So, what are the benefits of participating in an Advanced APM? For
payment years 2019 through 2024, clinicians who meet these requirements are excluded from MIPS adjustments and receive a 5% lump-sum incentive payment for their Part B professional services, furnished during the calendar year immediately prior to the payment year for payment years 2019 through 2024. Please bear in mind that there is not an explicit incentive in 2025. However, qualifying APM participants will be excluded from MIPS reporting requirements and payment adjustments and would, as always, have the potential for rewards under the Advanced APMSs in which they participate. Now, for payment years 2026 and later, an eligible clinician who meets these requirements is excluded from MIPS reporting requirements and payment adjustments each year and receives a higher physician-fee schedule update than those clinicians who are not qualifying APM participants. The physician-fee schedule update following, beginning in 2026, will be 0.75% annual update for services furnished by a qualifying APM participant and 0.25% annual update for services furnished by non-qualifying APM participants. And we'll talk a little bit more about what it means to be a qualifying APM participant shortly. Next slide, please. So, here we're going to talk about Advanced APMSs. So, to be an Advanced APM, the following requirements must be met. The APM requires participants to use Certified EHR technology, provides payment for covered professional services based on quality measures, comparable to those under the MIPS Quality performance category, and either one, is a Medical Home Model expanded under CMS Innovation Center authority, or requires participants to bear a more than nominal amount of financial risk. Be aware that the final rule updated the risk requirement for an Advanced APM so that it can be defined in terms of either total Medicare expenditures or participating organizations' Medicare revenue, which may be significantly lower for small practices. This update provides needed flexibility to allow for the creation of more Advanced APMSs tailored to small practice participation. And we want to just note that there. Next slide, please. Here, just wanted to touch on a few quick terms that's important to note. We talk about the APM Entity. The APM Entity is the payment arrangement that participates in the APM. It is actually the organization that you would belong to. It's the entity that is in the APM. We talked about the Advanced APM definition. The Affiliated Practitioner and the Affiliated Practitioner List are the practitioners who participate in contractual relationship with the actual participants who are on or in the APM Entity. So, for instance, there are practitioners who support the work of the actual participant who is assigned to the APM Entity, who is actually doing the work. But these are the supporter practitioners who help to keep the work going. So, we just wanted to make sure if you saw those terms, you saw that. MIPS APM -- we talked a little bit about that, but a MIPS APM actually supports or works under the Advanced APM in a sense that most Advanced APMSs are also MIPS APMSs. So, that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM, in order to become a QP, or Qualified APM Participant, thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM. And we just talked about the Participation List. This is the list of participants in an APM Entity that is compiled from a CMS-maintained list. And then the QP again we discussed earlier. Next slide, please. Again, that was just an overview of APMSs. If we can go to the proposed rule for Year 3 Advanced APM criteria. Thank you. Next slide, 63. Advanced APMSs for 2019 proposal. So, this is the CEHRT use. Currently, Years 1 and 2, years 2017 to 2018. The final rule, actually qualify -- to qualify as an APM, the participants had to or to participate in the payment arrangement, you must satisfy the criteria requiring that at least 50% of the eligible clinicians in each APM Entity use CEHRT. So, that's
just Certified EHR Technology. For Year 3, we propose that we increase the CEHRT use criterion so that an Advanced APM must require at least 75% of eligible clinicians in each APM Entity use CEHRT. Next slide, please. Here we're going to talk about the MIPS Comparable Measures. Apparently, the MIPS Comparable Measures are defined as quality measures upon which an Advanced APM bases payment must be reliable, evidence-based, and valid and meet one of the following criteria: on the MIPS final list, endorsed by a consensus-based entity, NQF, submitted in the annual call for quality measures, developed using QPP Measure Development funds, or otherwise determined by CMS to be reliable, evidence-based and valid. We propose for Year 3 2019 MIPS Comparable Measures will be defined effective calendar year 2020 that streamline the quality measure criteria to state that at least one of the quality measures upon which Advanced APM bases payment must be on the MIPS final list, endorsed by a consensus-based entity, or otherwise be determined to be evidence-based, reliable, and valid by CMS. Next slide, please. Here I want to talk about the outcome measures. Currently, for Years 1 and 2, 2017 and 2018, the final rule outcome measures -- the quality measures upon which an Advanced APM bases payment must include at least one outcome measure, unless CMS determines that there are no available or applicable outcome measures included in the MIPS quality measures list for the Advanced APMS’ QP Performance Period. For Year 3, 2019, we propose outcome measures -- effective in 2020, amend the Advanced APM quality criterion to require that the outcome measure used must be evidence-based, reliable and valid by meeting one of the following criteria: on the MIPS final list, endorsed by a consensus-based entity, or otherwise determined to be evidence-based, reliable, and valid. Next slide, please. Here we talk about the revenue-based nominal amount standard. For Year 2, 2018, final, the revenue-based nominal amount standard was for performance years, for performance periods 2019 and 2020. The revenue-based nominal amount standard is set at 8% of the average estimated Parts A and Part B revenue of providers in participating APM Entities. For Year 3, we propose that we maintain the 8% revenue-based nominal amount standard through performance period 2024. Next slide, please. That's it for those proposals. Now we'll go to the overview of All-Payer Combination Option and Other Payer Advanced APMs. Next slide. Here, just to give a quick overview, All-Payer Combination Option. The MACRA statute created two pathways to allow eligible clinicians to become Qualifying APM participants or QPs: Under the Medicare option, it is available for all performance years, and eligible clinicians achieve QP status exclusively based on participation in Advanced APMs with Medicare. Under the All-Payer Combination Option, this is available starting in Performance Year 2019. Eligible clinicians achieve QP status based on a combination of participation in Advanced APMs with Medicare and Other Payer Advanced APMs offered by other payers. Next slide, please. So, these are the Other Payer that combines into the All-Payer Combination Option and other Other Payer Advanced APMs. So, Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs under Medicare. Payer types that may have payment arrangements that qualify as Other Payer Advanced APMs include Medicaid, Medicare Health Plans, including Medicare Advantage, payment arrangements aligned with CMS Multi-Payer Models, and other commercial and private payers. Next slide, please. Here we also like to just give a brief definition. The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used for Advanced APMS under Medicare. One, requires that at least 50% of eligible clinicians to use CEHRT, or the certified EHR technology, to document and communicate clinical care information. Two, [inaudible] base payments on quality measures that are comparable to those used in the MIPS Quality performance category. And three,
either, one, is a Medicaid, Medical Home Model that meets criteria that are comparable to a Medical Home Model expanded under CMS Innovation authority or, two, requires participants to bear more than nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures. Again, actual aggregate expenditures exceed expected aggregate expenditures. Next slide, please. I'm going to talk a little about the proposed rule for Year 3 under the Advanced APMS All-Payer Combination Option and Other Advanced APMS Criteria and Determination Processes. Next slide. So, apparently, under the Advanced APMS 2019 proposal for CEHRT for Other Payer criteria, for Year 1 and Year 2, minimum CEHRT use threshold. To qualify as an Advanced APM across both Medicare and other payers, a payment arrangement must satisfy the criterion of requiring that at least 50% of the eligible clinicians in each APM Entity use CEHRT. For Year 3, the 2019 proposal, we propose that the minimum CEHRT use threshold increase the CEHRT use criterion threshold for Other Payer Advanced APMS so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must be 75%. Next slide. Here we will discuss the CEHRT use for Other Payer Advanced APMS. For Years 1 and 2 under the final for 2017 and 2018, CEHRT use requirement previously finalized that CMS would presume that an other payer arrangement would satisfy the CEHRT use criterion if we receive information and documentation from the eligible clinician through the Eligible Clinician Initiated Process showing that the other payer arrangement requires the requesting eligible clinicians to use CEHRT to document and communicate clinician information. Under Year 3 proposal, we propose for 2019 that CEHRT use requirements that we modify the CEHRT use criterion for Other Payer Advanced APMS to allow either payers or eligible clinicians to submit evidence that CEHRT is actually used at the required threshold rather than it be a requirement of Other Payer Advanced APMS. Next slide. Here we’re talking about the revenue-based nominal amount standard. For Year 2, 2018, the final revenue-based nominal amount standard. The revenue-based nominal amount standard for Other Payer Advanced APMS parallels to the revenue-based nominal amount standard for Advanced APMS. Payer arrangements would meet the revenue-based nominal amount standard for performance periods 2019 and 2020 if risk is at least 8% of the total combined revenues from the payer of providers and supplies in participating APM Entities. For Year 3, we propose that revenue-based nominal amount standard maintain the revenue-based nominal-amount standard for Other Payer Advanced APMS at 8% through performance period 2024. Next slide, please. The payer-initiated process for Other Payer for Year 2 in the 2018 final -- the Payer-Initiated Process: CMS established a process to allow select payers to submit payment arrangements for consideration as Other Payer Advanced APMS starting in 2018 for the 2019 All-Payer QP Performance Period. Also, we finalized the intent to allow remaining other payers, those not incorporated in the process for 2019, including commercial and other private payers, to request that CMS determine whether other payer arrangements are Other Payer Advanced APMS starting in 2019, for the 2020 All-Payer QP Performance Period and annually each year thereafter. For Year 3, our proposal for 2019, we propose that the Payer-Initiated Process allow all payer types to be included in the 2019 Payer-Initiated Process for the 2020 QP Performance Period. Next slide, please. Here, for the multi-year other payer determinations. For Year 2 2018 final the multi-year other payer determinations -- payers and eligible clinicians with payment arrangements determined to be Other Payer Advanced APMS to resubmit all information for CMS review and redetermination on an annual basis. For Year 3, we propose that the multi-payer other year determinations maintain annual submissions but streamline the process for multi-year arrangements such that when initial submissions are made, the payer and/or eligible clinician would provide
information on the length of the agreement and attest at the outset that they would submit for the redetermination if the payment arrangement underwent any during its duration. In subsequent years, if there are no changes to the payment arrangement, the payer and/or eligible clinician would not have to annually attest or resubmit the payment arrangement for determination. Next slide, please. Under the QP determinations for Year 2, the multi-year other payer determinations conduct All-Payer QP determinations at the individual eligible clinician level. For Year 3, we propose that the multi-payer other year determinations, beginning in 2019, allow for QP determinations under the All-Payer Option to be requested at the TIN level in addition to the APM Entity and individual eligible clinician levels. This was a change made as a result of public comment and subsequent listening sessions with the payer community about how contracting is executed in the commercial, non-Medicare space. Next slide, please. We're going to talk finally about the proposed rule for Year 3 Advanced APMs, MIPS APMs, and the APM Scoring Standard. Next slide, please. Here under the MIPS APM criteria, Year 1 and Year 2, 2017 and 2018, final, the MIPS APM Criteria: Currently, one of the MIPS APM criteria is that an APM bases payments on cost/utilization and quality measures. We did not intend to limit an APM’s ability to meet the cost/utilization part of this criterion solely by having a cost/utilization measure. Year 3, 2019 proposed -- we propose that MIPS APM Criteria: Reorder the wording of this criterion to state that the APM bases payment on quality measures and cost/utilization. This would clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure. Next slide, please. Here under the MIPS APM Aligning PI under the APM scoring standard for Year 1 and Year 2, the final, MIPS APM criteria: Under previously finalized policy for the APM scoring standard, Shared Savings Program ACOs are required to report Promoting Interoperability, or PI, at the participant TIN level. This differs from all other MIPS APMs, which allow MIPS eligible clinicians to report PI in any manner permissible under MIPS, i.e. at the individual or group level. So, for Year 3 we propose that MIPS APM criteria align the Promoting Interoperability reporting requirements under the APM scoring standard so that MIPS eligible clinicians in any MIPS APMs, including the Shared Savings Program, can report PI in any manner permissible under MIPS, either at the individual or group level. Next slide, please. We will now pass things over to Adam Richards.

All right, well, thank you, Corey and Molly. We appreciate you going through all this information, certainly all of the proposals. This is a lot of information certainly to consume. So, in just a few minutes, we're going to have a Question and Answer session. I do just want to mention quickly some of you may be familiar with our free technical assistance that is out there. So, this may be a refresher, but for those who are not, right now we are offering free support to clinicians who are participating in the Quality Payment Program. As you can see on the screen to the infographic, there are a multitude of networks that you can certainly reach out to, really depending on your practice size. That way we can tailor the supports specific to your practice and patient population. Also encourage you certainly to check out our website, qpp.cms.gov. Another plug for our Quality Payment Program Service Center. They are fantastic. If you have questions, either on our proposals or on anything related to the Quality Payment Program, they are an excellent source for getting these questions answered. And then for those who are participating in APMs and Advanced APMs, we encourage you to reach out to your model in-boxes for support. I'll also say that if you have not signed up for the Quality Payment Program listserv, highly encourage that you do so. We are going to send out notification that the slides, recording, and transcript are all posted probably in about a week or so's time. We'll get all that
information available to you. But if you haven't signed up, please do so. It's a great source of information, not just for webinar information but for everything related to the Quality Payment Program. If you visit qpp.cms.gov and scroll to the bottom of the page, you can find the link to sign up for the listserv. Okay, so, moving forward, onto the next slide. Again, I do just want to remind folks that this is a rule-making period. We are entering into comments. We are currently in an open-comment period. We do need all of your comments by September 10th. Of course, these are the methods on screen by which you can submit your comments to us. Please submit them in writing. Unfortunately, we can't take anything out of the chat today. So, if you have some comments, please get them to us through these mechanisms. If you move on to the next slide... This is -- and I think we can actually jump one more to get to the Q&A slide. So, again, just some of the ground rules. We're going to enter into our Q&A session -- just a couple of ground rules. Please focus your questions on Year 3 proposals. Anything related to Year 3 we're happy to try to answer. Folks, please try to limit your questions to one per person. We want to try to get as many through as possible. Finally, we'll try to answer as best we can, but also remember this is a rule-making period, so we ask that you do submit all formal comments through the official process. Again, we'll do our best to clarify, but we do need your comments to come into us through the official process. I do want to also note quickly that we are going to extend our webinar today by about 10 or so extra minutes just to compensate for the technical difficulties that we had. So, we'll have about 20 minutes for Q&A. I'm going to turn it back over to the moderator to announce how folks can get into the cue for phone questions.

At this time, if you would like to ask an audio question, please press *1 on your telephone keypad. Again, that is *1.

Okay. I know folks are dialing in right now. We'll just give you a couple more seconds because we do want to start kind of trying to address some of your questions on our proposals. A lot of good questions coming into the chats. I will say there's a lot of questions coming into the chat. There's about a handful of us in the room trying to answer as many as we can. So, if we haven't gotten to your question, you know, we'll do our best to get to it in the chats or try to address it through the phone. But if you have any additional questions, the Quality Payment Program Service Center is a great mechanism to have your questions on any of our proposals answered. Turning it over to the phone, do we have anyone online?

You do have a question from the line of Jason Shropshire.

Hi, Jason.

Hi. Can you hear me?

Yes, we can.

Hi. So, can you please explain if you can a little bit more information from the MIPS quality component? There's a language about if a measure is somewhat clinically no longer up-to-date that there's going to be points subtracted, but, I mean, that's a very ambiguous statement. What does that mean, that the clinical relevance isn't quite up-to-date? Who is going to determine that and what is that going to be based on?

Sure. Great question -- this is Molly. So, if folks want to refer back to slide -- let me just find it. 35 -- thank you, Adam. So, this refers to our
proposal related to measures that are impacted by clinical guideline changes. So, as I was mentioning earlier, we recognize, as much work as we do to try to have really close alignment with our measure stewards and measure developers that provide the majority of measures under the Quality Payment Program, sometimes clinical guideline changes, so updates to recommendations for actual clinical actions at various specialties should be taken. Those don't always fall within our specific rule-making cycles. So, one of the ones that I remember from a few years ago was there was revisions to some of the mammography-screening guidelines. So, for example, if we have a measure within the program that during the performance period, a clinical guideline has changed, depending upon what the clinical guideline change is and what the impact is to the measure, we wouldn't necessarily want to still have people reporting and having their performance assessed on a measure that is no longer clinically up-to-date. So, what this proposal is getting at is that in that specific scenario -- so, when we receive information from the measure steward, that the measure that we have finalized within the program is no longer relevant due to a clinical guideline change. What this proposal does is that for that measure and for clinicians that would be submitting data on that measure, they would have to do one less measure, essentially.

So, as you know [interrupted]

So, basically, you're saying at the end of the day, it's up to the measure steward whether or not they want to adopt any clinical changes and make changes to the scoring. Is that a fair statement?

I wouldn't necessarily frame it in that manner exactly. I would say that based off of the clinical guidelines that may come about that may impact a measure, we, CMS, will be working closely with the measure steward, as well as any of the organizations who may issue those clinical guidelines to understand the full impact to the measure. If we determine in that coordinated effort that the measure does require a significant impact...update -- and, again, we would no longer want to encourage reporting and performance on a measure that is out of date -- then the policy would go into effect. Does that help?

Yes. Thanks.

Thank you.

Okay.

All right. [Laughter] We'll take the next question on the line, please.

Your next question comes from the line of Shirley Ryan.

Hi. This is Maxine Doolittle with the Shirley Ryan Ability Lab. I had a question about the proposed changes to the scoring for the PI measures. It seems like you're going from having -- what you're proposing is going from the base score and some optional measures to being all required measures. Will there be a minimum score that you need for each measure, or, for example, could you send in a score of zero for a particular measure?

You cannot send in a score of zero. You need at least 1 in the numerator for all the required measures. The measures are scored by numerators and denominators, so the higher numerator is used then, based with your denominator, the higher score you can submit. So, I think if you submit 1s in
all your numerators and "Yeses" for the public health, you'll earn a score of about 3 for the performance category.

Okay, thank you.

Thank you. We'll go to our next question. We'll just keep powering through.

Your next question is from the line of Kim Sweet.

Hello, everyone, and thank you for this time today. In the proposed rule, there are some terminology changes, and two of them sound like they pertain to each other, but the terminology is completely different. I was wondering if you could help me identify or define what the difference is. So, for the MIPS level, you've got the new terminology called direct, log-in and updates or uploads, log-in and attest, and then the Medicare Part B claims, correct?

Yes, that's correct.

Are you with me there?

I am.

Okay, now, when you get to the quality level of that, they changed that to say "MIPS CQMs" and then there's ECQMs and then QCDR and then Medicare Part B claims. Can you tell me what the difference between these two are, or if they're the same thing?

Sure, yeah, it's a great question. This is Molly. So, we have different terms because they mean different things. So, again, when we look at the way we talked about things in the past, we tried to create a one-to-one-to-one relation between how data comes into us, who submits it to us, and specific measures that can be used. What we are reflecting now within these policy proposals that clean up these terminologies is that there is no longer that one-to-one requirement of how people can choose to participate in the program. So, for example, if you're looking at slide 25, again, this is a table that's pulled directly from the proposed rule. This reflects the data-submission types for individual clinicians. We have the submission types for quality of direct, log-in and upload and Medicare Part B claims. For the submitter types, we have individual and third-party intermediary. What we're reflecting here is that the individual and third-party intermediary options, those are available for the submission types that are reflected in that column. The same would go for the collection types. We...we're trying to reduce some of the constraints that we've set on clinicians in the past on that certain types of measure specifications, which refers to the collection type, can only be submitted in certain ways. Does that help clarify?

So, for the terminology of submission type, other word, direct, that would be, that's face-to-face, so it's computer-to-computer. So, that would be like an EHR going directly to CMS, correct?

Not exactly, and it's a great question. So, what we mean with a direct-submission type is really usage of our API. We have an automatic or -- I don't know that I'm using the correct terms -- but it's our automatic programming interface. This is way where there can be a computer-to-computer exchange of information. It can be coming directly from your EHR, but it doesn't have to come from your EHR. It could be from working with a third party, such as a registry or a QCDR. We also have found that many practices
themselves have the ability to submit data to us directly, as well. I would recommend that you take a look at the wire frames that are referenced within the rule and also on the bottom of slide 24 because they provide a little bit more information on what these different terms mean under the submission-type column.

Okay, because we don't have the slides, and I don't have any wire frames within the proposed rule, and, like, ECQMs to me is very confusing. Does that mean the same thing as direct? But you can go onto the next question because even though you're changing the terminology, you're still being very confusing, but you can move on. Thank you very much.

Okay, thank you for the feedback. I did just want to call out that if you reference table 29 and table 30 within the proposed rule, that does provide the same information that's available on these slides, and there is the reference to the wire-frame designs there. For the comment regarding the terms and how they're confusing, thank you for that feedback here, but as my colleague Adam mentioned, please please submit that comment to us through the formal process, and we would very much welcome any recommendations or feedback on other terms that maybe more meaningful. Again, as I said, these are terms we've come up with. CMS are not always known for the best usage of our terms. So, we really would be interested in receiving feedback on other words that would make these terms more meaningful. Thank you.

Okay, thank you. We have time for a few more.

Your next question comes from Brittany Walden.

Hi. This is Brittany Walden, and I was calling to see if you guys were able to release the scaling factor for the 2019 payment year.

Yeah, I don't think we have that available yet. I'm getting head shakes in the room, so I don't think we have that available yet.

Okay, thank you.

Your next question comes from Emanuel Gonzales.

Hi. Thank you for taking my question. Hopefully, my question falls within the purview of this presentation, though it wasn't touched upon directly. But my question is, under the proposed rule, is it possible to qualify under the MAQI demonstration if a clinician has zero participation in Medicare fee-for-service Advanced APM, provided that the clinician satisfies the QP threshold and either the payment manner or the patient count? It's not clear in the rule.

We can't really talk about the actual models specifically because until the details are available for all, we can't give too much information about that. What I will say is just stay tuned, and as Adam spoke earlier, make sure you're on all the listservs or the different communication pieces where we release information. There may be some announcements about that if you go to innovation.cms.gov. But I know that there are communications about that that are being developed. So, don't want to kind of tip the hat.

Okay, thank you.
Thanks.

Your next question comes from the line of Jennifer Gasperini.

Hi. I was wondering if ACOs continue to earn full credit automatically for the improvement activities performance category.

A concept of Medicare Shared Savings Program. So, for the improvement activities, APMs are assigned points to that category. And at the beginning of the performance year, there will be information providing the total points assigned to each APM. So, for years 2017 and 2018, all Medicare Shared Savings Program ACO tracks qualify for full points for the improvement activities.

Thank you, Rabia. Next one, next person on the line, please.

Your next question comes from the line of Michelle Illitch.

Hi. Thanks for today's webinar. I have two questions. One, when will you be releasing the application-cycle period for new Advanced APMs or MIPS APMs for the 2019 performance period? Usually, the deadline was 7/31 of the calendar year, and we're looking to get clarity on that application period. And secondly wanted to ask a question about the APM bonus and thresholds and how this is calculated for specialists who do not bill ENM codes.

All right, we're going to start with the first question. Turn it over to Rabia.

So, for the Medicare Shared Savings Program, the notice of intent to apply, the NOIA submission period, has not begun. The 2019 application materials are not available yet, and there's no deadline for submission of the NOIA that's been announced. I would urge you to continue to monitor the Shared Savings Program application types and timelines website for updates regarding our application cycle.

And as it relates to Advanced APMs, each APM, Advanced APM has their own time period and time frame. The different models have different open-application-period time frames throughout the year. But as we release more Advanced APMs and other MIPS APMs, those time frames we're hoping to align. But there is not any one alignment of that yet. I know the Shared Savings Program, as Rabia just mentioned, has their own time frame. So, that may be what you're referencing.

Yeah, I was specifically looking about Track 1-Plus, when the application period for that will be open.

Right, but that coincides with the Shared Savings Program application types and timelines. So, we can definitely provide additional information when it is available, but I have nothing at this time, unfortunately.

Do you think it's going to be in the month of July?

I don't have the information to be able to share at this point regarding that -- my apologies.
But we will make sure that as soon as it's released, we make sure everyone has that information. And I'm sorry. What was the second part of your question?

Yeah, if you could provide more clarity about how the APM bonus will be calculated for participant TINs that join an APM and Advanced APM and if they're a specialist that does not bill evaluation and management codes, how will their APM bonus be calculated?

So, the second part of your question is very specific. So, we ask that if you could go to our resource page under qpp.cms.gov, we have interaction guides there, and we have other resources that help with scoring specifically because that is a very detailed question. We don't want to take up the time on this call. But the first aspect of your call again depends on whether or not you are a QP, if you're eligible for QP status. And then all of those things happen at the TIN level or the entity level. So, the calculation that's done, if you go to qpp.cms.gov, there are performance-feedback reports available there, and we have information available. And if you have any questions or concerns about that, then we also have other options available for you to be able to have more detail given about your score. But both questions are very specific. If you reach out to our help desk, we can get you more detail and/or if you're unable to find the answer on the resource page, please reach out to us -- again, that innovation.cms.gov page. And my name is Corey Henderson.

Thank you.

Thank you so much. We have time for one more, one more caller. Who's it going to be?

Your next question comes from the line of Mary Ann Ferlazzo.

Hi. This is Mary Ann Ferlazzo. My question is about the consolidation of determination periods on slide 21. I'm trying to understand what is proposed to be changed in Year 3.

Sure. This is Molly. So, there's a couple things that have been proposed to be changed. First, we have proposed to change the time frames. So, right now it runs from September through August. We're proposing to change the time frame of analysis instead of from September through August through October through September. So, running on the fiscal year. We feel that that's a lot easier to communicate and to explain to people. People generally understand what the fiscal year is. We will still have for the determination period, the two segments or the two looks that we currently do for our low-volume threshold determination or special-status determination. The second piece that we did is really again a bit more of a terminology clean-up and consolidation. Previously, we had specifically defined separate terms for each of the determination periods. We had a low-volume-threshold determination period, a non-patient-facing determination period, an AFC-based determination period, et cetera. And we felt that it was just really cumbersome and clunky. So, based off of feedback that we have received from folks when we took a look at it and we saw that all of these time frames, or that all of these determination periods are using the same time frame, let's just create one period. So, in summary, that's what we've done. We've modified the time frame to fall on the fiscal year, and we've also created one MIPS determination period, which applies for the low-volume-threshold determination, as well as the majority of the special statuses. I do want to
flag, and I think I forgot to mention this earlier, so apologies for that, is that we do still have distinct determination periods for virtual groups, as well as for clinicians that participate in facility measurements. Those determination periods are distinct because we only use one of the determination periods. So, you will still see separate definitions for that. I hope that helps. Thank you.

Thank you.

Thank you so much. Well, folks, that's going to wrap it up for today. We appreciate you all being here with us today and joining us for today's webinar. Please, a few takeaways -- review the proposals. We will get the slide deck out to you so you'll have quick access to it. Also check out the wire frames that Molly mentioned a few times throughout our discussion today. Submit your comments through the official comment process by September 10th, and certainly sign up for our QPP listserv on qpp.cms.gov so that we can get all of this great information out to you. With that said, we thank you again for being here with us today, and we'll talk to you all again soon.