Centers for Medicare & Medicaid Services (CMS)

QPP Participation Criteria Webinar

Held on May 22, 2017

>>Hello, and thank you for joining today's Quality Payment Program webinar. Today Adam Richards, Lisa Marie Gomez, Kelly DiNicolo, and Benjamin Chin, subject matter experts at CMS, provide an overview of the participation criteria used to determine inclusion in the merit-based incentive payment system and alternative payment models under the Quality Payment Program. During this webinar, CMS will provide an overview of MIPS participation requirements for individual clinicians and groups; participation requirements for advanced APMs and MIPS APMs; a new tool that allows clinicians to check if they are included in MIPS; the recent participation letter sent to the clinicians' offices. After the presentation, you will have the opportunity to ask questions. The speakers will answer as many questions as time allows. Any questions not answered on the phone should be directed to the QPP Service Center. You can listen to this presentation through your computer speakers and ask questions using the chat box. You can also use the phone number provided later in the webinar to ask questions by phone. The slides, recording, and transcripts from the webinar will be posted on the Quality Payment Program website in the next week or so. I would now like to introduce the presenter Adam Richards. Adam, you may begin.

Great, and good afternoon, everyone. Good morning to some. And thank you for joining us today. We have an action-packed agenda for you with several of our subject-matter experts ready to walk you through those criteria used to determine inclusion in the Quality Payment Program for what we are calling the 2017 transition year. But before jumping into the discussion, I want to open a poll just to get us all loose, get us interacting and thinking on this Monday, dust off some of the cobwebs from after lunch, and that poll is on screen right now, and the question is, prior to receiving the Clinician Participation Letter from CMS, how much did you know about the Quality Payment Program? And for those who may not have received the letter, let's say prior to May, how much did you know about the Quality Payment Program? And your polling options are available on screen. While you are polling, I want to take a minute or so just to set the context for our discussion today. Our focus is primarily on those criteria used to determine inclusion in both the Merit-based Incentive Payment System and the Advanced Alternative Payment Model tracks. This is meant to be a high-level, informative overview. We will not necessarily be getting into the how, as I like to call it. In other words, how do I choose measures? How do I submit my data? How do I pick my pace? We do have some really great resources available on qpp.cms.gov that can help answer those questions, and I highly suggest checking out the education tool section on the site where you will find fact sheets, downloadables. If you click on the webinars link, also under that tab, you will have access to previous webinar recordings. There are self-paced micro-videos, which are just short tutorials on many of the concepts of both MIPS and Advanced Alternative Payment Models. Generally they're 15 minutes or less. Most are 10 minutes or less. And we also have education modules out there that contain continuing education credit, so I certainly encourage everyone to check out the website. We're going to go ahead, now that that minute or two has expired, we're going to go ahead and close the poll and move on to our next slide. This is kind of where we're going to jump in, get dirty with the Quality Payment Program. So, the Quality Payment Program, as you can see on screen, is really comprised of two tracks. That is Merit-based Incentive Payment System and Advanced Alternative Payment Models. Those are the two tracks for the program. We're going to get into both of these tracks as we move through our discussion, so I won't spend too much time on this slide. So, I'll move on to the next slide, which is talking MIPS basics for the

2017 transition year and what you need to know moving forward. So, on our next slide. Great. So, what is MIPS? What does MIPS really do? And we have two graphics on screen here, and ultimately what the first graphic is speaking to is the fact that MIPS consolidates three of the programs that you all may be familiar with. Those include the Physician Quality Reporting System, or the PQRS program, the Physician Value Modifier, or VM program, and the Medicare EHR Incentive Program for Eligible Professionals. I do think it's important to point out and remind folks that the Medicare EHR Incentive Program for Hospitals and the Medicaid EHR Incentive Program will remain in place. So, in essence, MIPS keeps the focus on quality, cost, and use of certified EHR technology without having separate programs that ultimately do the same thing. This is one single improved program. And the second graphic you'll see on the screen is really just an example of how the PQRS program will phase out or how the legacy programs will phase out. Again, this is just looking at PQRS, and we will talk a bit more about this in a few minutes because there are some nuances that I want to make sure everyone understands as we move forward. Next slide, please. Great. So, for the Merit-based Incentive Payment System, there are four performance categories that make up MIPS, and each one of these performance categories carries a different weight for the 2017 transition year. So, quality is weighted at 60%. Cost is zero percent for this year, so clinicians won't be assessed on cost in 2017. Improvement activities weighs in at 15%, and advancing care information at 25%, and combined, these make up 100% for the MIPS final score. I think it is important to note that the Improvement Activities Performance category is really the only new category for clinicians this year. And if we move to the next slide, I can give you a good visualization of what that really means. Great. So, as you can see, when we talk about quality under MIPS, it's very similar to the PQRS program. Cost is very similar to the resource use or cost measurement side of the Value Modifier program with some elements of quality data mixed in, and the advancing care information performance category really deals with the usage of electronic health records, so ultimately the Meaningful Use program. It's very similar. And I think the key word here is "similar." Not necessarily identical. You will see some changes to the program, and you'll see more flexibilities at it under the Quality Payment Program and under the Merit-based Incentive Payment System. So, if we go to the next slide, please. So, with the legacy program, this is one area I mentioned we'd talk a little more about the legacy programs, which, as we mentioned, are going away. They are being sunsetted into MIPS in the transition year and beyond, in the future years. So one question that we have been hearing from everyone out there is, how will these changes impact -- and when I say changes, that's the transition toward the Merit-based Incentive Payment System -- so how will these changes impact the adjustments that I'm expecting from the legacy programs? And simply put, you will still receive those expected adjustments. As you can see from the points that we've bulleted on screen, for both PQRS, Value Modifier, and EHR Incentive Program, those adjustments are still expected in future years. I won't go through all this information, but I do want to touch on one very, very important nuance, and that's specific to the EHR Incentive Program for Eligible Professionals. So, if you move to the next slide, please. This is a special note that pertains specific to this legacy program. So, eligible professionals who are first-time participants in the EHR Incentive Program generally have until October 1st of their first year to attest and avoid payment adjustments in the subsequent year. So, what does that really mean? So, those eligible professionals who are first-time participants in 2017 have until October 1, 2017, to avoid the 2018 payment adjustment. We do note that 2017 is also the first year of the Merit-based Incentive Payment System, which carries similar EHR reporting requirements to those of the Medicare EHR Incentive Program for Eligible Professionals. I also think it's important to note here that we define first-time participants as being eligible to previously attest but never did, so this is really the first year they are participating to try to demonstrate meaningful use. Additionally, eligible professionals that are brand-new to Medicare are automatically exempt from the EHR Incentive Program. So, what is CMS doing? Now that we kind of know that this is out there, what is CMS doing? So, for first-time Medicare EHR Incentive Program participants in 2017, CMS is offering a one-time

significant hardship exception for the Medicare EHR Incentive Program 2018 payment adjustments to provide eligible professionals ample time to collaborate with their EHR vendors and really to adjust to the new reporting requirements of MIPS, especially those found in the advancing care information performance category. Our goal is really to help those first-time participants successfully participate in MIPS for the 2017 transition year. If we move to the next slide, please. I do just want to call out the hardship exception. As you can see it here, we have a list of points bulleted out. So, a first-time eligible professional may apply for the exception if -- and there are those three points. I do want to call out that those three points are linked with "ands," so each point ands -- it builds on the other. And just to wrap this up concisely, if an EP meets these criteria for the one-time exception that are listed on screen, the EP must -- the eligible professional must submit the 2017 eligible professionals transitioning to MIPS hardship application no later than October 1, 2017. We've built a link directly to that form into the slide, so if you can't necessarily link to it, you can just copy and paste, and that will take you directly to that hardship application. One last thing to note here is if any eligible professional has previously participated in the EHR Incentive Program, you are not eligible for this one-time hardship exception. Okay, so, now let's move on. Now that we've talked a little bit about that nuance, we'll get back on track with the Quality Payment Program. So, let's talk a little more about MIPS, so these next few slides are really the orientation to MIPS participation. Next slide, please. And just as a refresher, we know that there are a lot of acronyms. Sometimes we call them acronym soup. So we do want to just explain a few of these acronyms that we're using throughout the presentation today. So, TIN is the Tax Identification Number, and this is just the identifier at the group or practice level. The NPI is the National Provider Identifier, the 10-digit numeric identifier that identifies individual clinicians. And for NPI, clinicians can always use the National Plan and Provider Enumeration System, or NPPES, and the NPI registry public search tool to verify their NPIs, so just keep that in the back of your mind as well. And then, of course, we have TIN/NPI, and that's really the association between the NPI, so the clinician and the practice in which they are connected. Some clinicians -- you may just have one NPI, one TIN. Some clinicians may have a single NPI plus practicing at two or three different TINs. So, if we move to the next slide. This will just lay out our discussion for today for the MIPS component. So, in 2017, in the 2017 transition year, you can participate in MIPS as an individual, as a group, or in an Alternative Payment Model. And this is how our discussion will be covered for the duration of the MIPS track. So, with that said, we're going to go to the next slide, and I am going to introduce my colleague, Lisa Marie Gomez, Health Insurance Specialist within the Division of Electronic and Clinical Quality here at CMS to talk us through participating in MIPS.

>>Great. Thanks, Adam. Now, I'm going to talk about participating in MIPS as an individual in the 2017 transition year. Next slide, please. Great. So, Adam provided you with all information relative to MIPS. Now I'm going to talk about who participates in MIPS. So, CMS describes a clinician who participates in MIPS as eligible clinicians. For the first two years of MIPS, through 2017 and 2018, we have a performance period. MIPS-eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and any clinician group that includes one of the professionals listed above. So, as you can see, these are the clinician types that are what we would consider those who meet the definition of a MIPS-eligible clinician. We also note that in order to participate in MIPS, not only meeting the definition of a MIPS-eligible clinician, but it's also ensuring that you exceed the low-volume threshold. Now, as you can see on this slide, we identify the low-volume threshold as clinicians billing more than $30,000 in a year in Medicare Part B-allowed charges and provides care for more than 100 Medicare patients in a year. Next slide, please. So, I also want to go into how we define a physician. So, a physician includes such as a doctor of medicine. It also includes dentists. It includes podiatrists and ophthalmologists and chiropractors. So, these are just- not only the clinician types, but the specific types of physicians who are required to participate in MIPS.

Next slide, please. All right, so, now, I want to get into a couple of dynamics in terms of those who have to participate relative to some of the items you may have received or have seen on your participation letter. So, for example, we'll talk about participating at the individual level. So, there are two components relative to the low-volume threshold, as I mentioned. It's the dollar amount and the beneficiary count. So, in order to exceed the low-volume threshold, a MIPS-eligible clinician would need to exceed the dollar amount and the beneficiary count. So, in this example, there's Dr. A., who is a MIPS-eligible clinician. Billed $100,000 in Medicare Part B-allowed charges and saw 110 patients. So, Dr. A should actively participate in MIPS during the transition year to avoid the 4% reduction in Medicare Part B payments in 2019 and possibly earn a payment adjustment. Next slide, please. Okay, so, now let's talk about participation in the transition year. So, in order to participate in MIPS, CMS verifies if you meet the definition of a MIPS-eligible clinician, which includes the clinician types I just mentioned, then CMS reviews your historical Medicare Part B claims data from September 1, 2015, to August 31, 2016, to make the initial determination. If you are determined to be exempt during this review, you will remain exempt for the entire transition year. Later on in this year, CMS is going to conduct a second determination on performance period for Medicare Part B claims data from September 1, 2016, to August 31, 2017. If you're included in the first determination, you may request as exempt for the transition year during the second determination period. If you are initially exempt and later found to have claims or patients exceeding the low-volume threshold, you are still exempt. I just want to note that we've received several questions regarding if a clinician opted out of Medicare or received a letter stating that they should participate in MIPS, and they're asking what they should do. So we just want to say that we initially looked at Medicare Part B claims data, as I noted, from September 1, 2015, through August 31, 2016, to see if you and your practice meet the low-volume threshold for MIPS. And as I noted, if you billed more than $30,000 in Part B-allowed charges and you provided care for more than 100 Medicare Part B patients during the same timeframe, you met or have exceeded the low-volume threshold. But as such, you received a notification letter stating you are considered a MIPS participant. And as I mentioned just previously, a second review of claims will look at claims data submitted between September 1, 2016, and August 31, 2017. So, when we look at the second review, your information may be different. So, if you opted out of Medicare after August 31, 2016, you may receive a notification from CMS if you did exceed the low-volume threshold between this timeframe that I just mentioned. However, if you did not bill Medicare Part B between September 1, 2016, and August 31, 2017, you will not exceed the low-volume threshold, and you will not need to participate in MIPS, and no further action will be required of you. But if you did bill Medicare Part B at any time between September 1, 2016, and August 31, 2017, by opting out, you may be required to participate if you should, but again, if you have any questions, please do not hesitate to visit our website, which is qpp.cms.gov, for more information on how to get started if you are determined to participate in MIPS. Next slide, please. All right, so, if you are included, you should actively participate in the transition year to receive a neutral adjustment or possibly earn a positive payment adjustment. So, not participating will result in a 4% downward payment adjustment. Next slide, please. All right, so, now I want to get into who is exempt, and you've heard me talk about this low-volume threshold, which is one way in which a person would be exempt. But there are a total of three types of exclusions. So, as a clinician who's eligible for one of these exclusions, the clinician would be exempt from participating in MIPS. So, a clinician who is enrolled in Medicare for the first time during a MIPS performing period are exempt for reporting on measured activities until the following performance period. Also, qualifying EPM participants, which are also known as QPs, are not considered MIPS-eligible clinicians and are exempt from this participation. Also, we have partial QPs, who do not report on measured activities that are required to report it under MIPS for a performance year, are not considered MIPS-eligible clinicians and are exempt from MIPS. And as I also noted, there is the low-volume threshold. And I want to just get into just one dynamic relative to the low-volume threshold.

With the low-volume threshold, we make determinations at the individual level and at the group level, and so, this participation letter that you received, you will see information relative to your participation at the individual level and at the group level. The reason why we've established the low-volume threshold at the individual level and at the group level is for groups to determine how they want to participate in MIPS, because groups have the option to participate at the individual level or at the group level, and so we provided information for groups to make that determination. Next slide, please. Now I want to go into a scenario in which we talk about an exemption at the individual level. So, in this scenario, Dr. B is considered a MIPS-eligible clinician, billed $100,000 in Medicare Part B-allowed charges, and provided care to 80 Medicare Part B beneficiaries. So, in this scenario, Dr. B would be exempt from MIPS due to seeing less than 100 patients. And again it's because the low-volume threshold has two elements -- the dollar amount and the beneficiary count -- so in order to exceed the low-volume threshold, you have to exceed not only the dollar amount but also the beneficiary count, and in this scenario, Dr. B did not exceed the beneficiary count, which would then make this clinician exempt. Next slide, please. Okay, so, now I just want to talk about if you are exempt, you have the option to voluntarily submit data to CMS to prepare for future participation. But you will not qualify for a MIPS payment adjustment based on your 2017 performance. Also, if you voluntarily participate, this will help you hit the ground running when you are eligible for payment adjustments in future years. Next slide, please. Now I'm going to talk about participating in MIPS as a group in the 2017 transition year. Next slide, please. All right, so, as I previously noted, groups have the option to report at the individual level or at the group level. If your group participates in MIPS at the group level, the low-volume threshold will also be calculated at the group level. So, low-volume threshold determination for a group is conducted for a group as a whole. So if your group bills more than $30,000 in Medicare Part B-allowed charges and provides care for more than 100 Medicare Part B patients, the group as a whole is required to participate in MIPS at the group level. I just want to note that even though an individual clinician in a group does not exceed the low-volume threshold at the individual level, such individual clinicians will need to participate in MIPS because their group is participating in MIPS at the group level. Next slide, please. So now I want to go over a particular example. So, in this scenario, we have a group, or a TIN, with three clinicians. Dr. A exceeds the low-volume threshold at the individual level and is required to participate in MIPS at the individual level. Dr. B does not exceed the low-volume threshold because Dr. B did not provide care to more than 100 Medicare Part B beneficiaries and is not required to participate in MIPS at the individual level. Now, for the nurse practitioner. The nurse practitioner does not exceed the low-volume threshold because the nurse practitioner did not provide care to more than 100 Medicare Part B beneficiaries and is not required to participate in MIPS at the individual level. So now let's look at the group as a whole. So, for this group as a whole, the group exceeds the low-volume threshold at the group level, and if this group decides to participate in MIPS at the group level, all three clinicians will be required to participate in MIPS. If the group decides that it will participate in MIPS at the individual level, then only Dr. A would be required to participate in MIPS. Next slide, please. So, now I want to continue going on with what it means to participate at the group level. So, groups are required to register with the CMS enterprise portal if they elect to report utilizing the CMS web interface and/or administering the CAHPS for MIPS survey. The registration period is from August 1[1] to June 30, 2017. Only groups that are registered prior to June 30th are able to cancel their registration. And I also just want to note that only groups that are utilizing the CMS web interface or administering the CAHPS for MIPS survey are required to register, whereas if you're going to report via a qualified registry, a QCDR, or EHR, you are not required to register. Registration, again, is only for groups wanting to utilize the CMS web interface or administer the CAHPS for MIPS survey. Next slide, please. Now I want to go into participating in MIPS and these

[1] Registration period is from April 1 to June 30, 2017

special rules and considerations that we have and that we've outlined in the rule. So, we'll go on to the next slide. And now I'm going to talk about clinicians participating in Rural Health Clinics and Federally Qualified Health Centers. So, if you're a clinician that participates in an RHC or FQHC and billed under the RHC or FQHC payment methodology, it would not be required to participate in MIPS and would not be subject to a MIPS payment adjustment. However, if clinicians in RHC or FQHC bill under the Physician Fee Schedule and they meet the definition of a MIPS-eligible clinician and exceed the low-volume threshold, they are then required to participate in MIPS and are subject to the MIPS payment adjustment. Next slide, please. So, for clinicians who meet the definition of a MIPS-eligible clinician and practice in Critical Access Hospitals, specifically in method 1 Critical Access Hospitals, such clinicians would participate in MIPS and the MIPS payment adjustment would apply to payments made for items or services that are Medicare Part B charges billed by the MIPS-eligible clinician. The payment adjustment would not apply to the facility payment to the Critical Access Hospital itself. For clinicians who meet the definition of a MIPS-eligible clinician and practice in a Critical Access Hospital, specifically a method 2 Critical Access Hospital and assigned the billing rights to the Critical Access Hospital, the MIPS payment adjustment would apply to the method 2 Critical Access Hospital payments. For clinicians who meet the definition of a MIPS-eligible clinician and practice in a Critical Access Hospital, specifically a method 2 Critical Access Hospital and they have not assigned their billing rights to the Critical Access Hospital, the MIPS payment adjustment would apply similar to the method 1 Critical Access Hospital. Next slide, please. So, further, we define a hospital-based MIPS-eligible clinician as a MIPS-eligible clinician who provides 75% or more of his or her professional service and site service identified by the place of service code used by the HIPPA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting based on claims for a period prior to the performance period as specified by CMS. Hospital-based clinicians who are part of a group practice and have assigned their billing rights to the group TIN will be scored as part of their group and will not have their advancing care information score re-weighted to zero. The group has the option to include or not include their data and the group data that is submitted to CMS, but their payment will be adjusted based on the group's MIPS final score. If all clinicians of the group are hospital-based, the performance score for advancing care information will be re-weighted to zero, and the 25% weight would be assigned to the quality performance category. We want to note that the group, despite being entirely hospital-based, would have the option to include or not include their data and the group data that is submitted to CMS, but their payment will be adjusted based on the group's MIPS final score. If a clinician within the group are hospital-based and some are not hospital-based, the advancing care information performance category will not be re-weighted. Next slide, please. So, now in regard to clinicians that have an employment contract with a hospital or healthcare system, such clinicians are required to participate in MIPS if they meet the definition of a MIPS-eligible clinician and the Medicare Part B services that they furnish are billed on their behalf by an entity such as a hospital or health system. Also remember that such a clinician, if they do not exceed the low-volume threshold, then they would not be required to participate in MIPS. Next slide, please. Now I want to get into non-patient facing clinicians. So, non-patient facing clinicians are included in MIPS as long as they meet the definition of a MIPS-eligible clinician, exceed the low-volume threshold, are not newly enrolled Medicare Part B clinicians are not enrolled as Medicare clinicians, and are not either a Qualifying APM Participant or a Partial QP that elects not to participate or report data to MIPS. Also, an individual MIPS-eligible clinician is considered to be non-patient facing if they have 100 or fewer patient-facing encounters in a designated period. A group is non-patient facing if more than 75% of its clinicians under the group's TIN during a performance period are identified as non-patient facing. There are more flexible reporting requirements for non-patient-facing MIPS-eligible clinicians. Next slide, please. So, these are just examples of non-patient-facing clinicians that are identified in the 2017 final rule -- pathologists, radiologists, nuclear medicine physicians. So, these are just examples that we have. But

again it's all based on the number of patient facing encounters that determine whether a clinician is determined patient facing or non-patient facing. Next slide, please. So, now I want to talk about our participation for clinicians in small practices, rural areas, and Health Professional Shortage Areas. So, special rules exist for the Improvement Activities performance category under MIPS for MIPS eligible clinician types in practices with 15 or fewer clinicians and solo practitioners; MIPS-eligible clinician types in designated rural areas; and MIPS eligible clinician types working in Health Professional Shortage Areas. The points for both medium-weight and high-weight activities are doubled, so this means medium weight equals 20 points and high weight equals 40 points when we're thinking about Improvement Activity performance category. Next slide, please. Then I want to talk about participation with a Type 2 National Provider Identifier, as Adam noted, an NPI. So, if you have a Type 2 NPI, do you have to participate in MIPS? Well, only MIPS-eligible clinician types with a Type 1 NPI need to participate in MIPS during the transition year. Type 2 NPIs, such as a hospital, home health agency, lab, or DME supplier, would not participate. However, if you have both a Type 1 and Type 2 NPI and exceed the low-volume threshold, you will need to participate in MIPS. Now I'm going to transition the presentation over to my colleague Ben. Ben, I turn it over to you.

Hey, Ben. This is Adam. Just before we transition to you, I just want to take a minute to thank Lisa Marie for covering the MIPS portion of our discussion today. I just want to touch on a few things very quickly, maybe a minute or two, that we saw coming up throughout the chat. Definitely the question of "and" versus "or" when it comes to the low-volume threshold. So, just to kind of elaborate on this, it depends on how you're looking at it, either from the inclusive or exclusive perspective. So, if a clinician is included in the Quality Payment Program, in MIPS for the transition year, we would look at it from the "and" perspective. So, to be included in MIPS, you have to bill more than $30,000 in Medicare Part B-allowed charges and provide care for more than 100 Medicare patients. So the "or" is really just a way of exempting folks from the program within the low-volume threshold. I hope that helped clear that up just a little bit. I know that can be a little confusing, but it does start to make sense when you look at it from that different perspective. So with that, I am going to turn it over to Benjamin Chin now, our Health Policy Analyst with the Center for Medicare & Medicaid Innovation, to talk about MIPS, APMs, and then eventually Ben will be back to talk about Advanced APMs in just a little bit. Ben?

>>Thanks, Adam, and thanks, Lisa Marie. So, switching gears here, I want to talk a little bit about MIPS APMs. So, next slide. Just as a refresher, MIPS APMs are a subset of APMs, Alternative Payment Models, and they're another type of subset different than Advanced Alternative Payment Models. So, participation in MIPS APMs applies to MIPS-eligible clinician types who participate in specific APMs. And just to note here, we have posted a complete list of all APMs, noting which models are MIPS APMs and which models are Advanced APMs on the website at qpp.cms.gov, so that's a good place to go and check to see if an Alternative Payment Model you may be participating in is also a MIPS APM. And so, if you're participating in a MIPS APM, this is the way that you are participating in MIPS if you are not exempted for another reason. Participants in MIPS APMs benefit from the APM scoring standard, which uses APM-related performance to aggregate data and streamline affording, and this is to ease the burden of clinicians who are participating in MIPS APMs. And just to note, CMS identifies clinicians participating in MIPS APMs on three different snapshot dates, which are illustrated by these calendar dates above. A MIPS-eligible clinician must be on a participation list or an Alternative Payment Model on at least one of the three snapshot dates to be considered a participant in a MIPS APM. Next slide. So, how does the low-volume threshold apply to MIPS clinicians in MIPS APMs? Similar to how the low-volume threshold applies to MIPS-eligible clinicians at the group level, for MIPS APMs, CMS will calculate the low-volume threshold at the APM entity group level. What this means is that if the APM entity group exceeds the low-volume threshold, they will be required to participate in MIPS, and if they

don't, they will be exempt from MIPS, similar to regular MIPS groups. And now I'll turn the presentation back over to Adam.

>>Great. Thanks, Ben. And if we go to the next slide, please. So, now we're going to just switch gears a little bit and talk about the clinician participation letter as well as the look-up tool that is now available online- NPI look-up tool that is available online. I'm going to turn it over to Kelly DiNicolo, Senior Technical Adviser with the Office of Communications here at CMS.

>>Thanks, Adam. Good morning, or good afternoon to everyone, depending on what part of the country you're calling in from. Next slide, please. So, I just wanted to talk about ways to determine if you need to participate in MIPS or not. So, a couple things have recently happened. One is CMS, through our MAC contractors recently sent out a letter that indicated whether clinicians needed to participate or not. So, a couple things about the letter. The letter began hitting the street, so to speak, on April 27th, and that probably continued for about 1 1/2 weeks, through the end of that first week of May, so by then everyone should have gotten the letter, so let me talk about what I mean by everyone. The letters were sent at the Tax Identification Number that a clinician or a group bills through, and so in some cases, and I'll use my neighbor as an example. He's in a practice where there's only him, another doctor, and I think they have one nurse practitioner, and they asked him over the weekend, "Did you get your letter?" He's like, "No, I just checked, and we didn't." And the issue is that all their billing is sent to the hospital, so a huge hospital with thousands of doctors, probably, has all of their information. So that's one thing to note. The other thing that is unique is, let's say you are a clinician and you have an individual practice, but then maybe you work at a group practice as well, separate. So you probably are billing to two separate TINs. One is your individual and one to the group, so you will have a different status at each TIN, and therefore could have had received notification through two separate mailings, so I just wanted to make everyone aware of that. Next slide, please. And one more thing I wanted to mention just before I review the letter itself is that for this particular mailing, MSSP Track 1 ACO, we did not include those organizations in this letter, and that is because with MSSP Track 1, if you're participating in that, you likely still need to participate in MIPS under that ACO model even if -- when Lisa went through the low-volume threshold -- if you don't meet that low-volume threshold and you're in that particular ACO, that is an exception where you still need to participate in MIPS, and if you have questions about that, you should contact your ACO administrator directly. So, what you should be seeing on the screen now is Getting Started. The letter itself is four pages. This is what it looks like. I know the slide might be hard to read at this point. But the slides are posted on the website qpp.cms.gov. If you go under the Outreach and Education section and click on that, it's down toward the middle of the page, so we've included a sample letter here. One, we start out by thanking everyone for participating in the Medicare program and then provide a brief overview, very similar to what Lisa and Ben have walked through just before me about the program, what you need to do and where to go for help. So if you can go ahead and skip to slide 45, please. Thank you. This, I would say, is probably the most important piece of the mailing and probably, likewise, the piece of the mailing that can cause some confusion. This is the page -- it's Attachment A -- and this is where we list by TIN as well as each NPI, National Provider Identifier, under that TIN what their participation status is. So we're telling you if you're exempt because of your clinician type, if you're exempt because you don't meet the low-volume threshold, or rather if you should participate because you were meeting those. And so, it can in some cases -- we have very large practices where this information is page after page after page of NPIs, which I think can be confusing. But if you wanted a written record, a paper copy, that would be where you would want to go, and again, it was sent to the most current address of the Tax Identification Number. So I'm going to plug that you should be updating your e-mail address -- I'm sorry -- your correct mailing and billing address often. So that's how it was mailed and sent there. Let me go ahead

and go on to the next page. We're not showing Attachment B, but there is in the mailing something called Attachment B, and again, this is available on the website. That has a list of our most commonly asked questions, and we've provided answers on participating in MIPS, so if you haven't looked at that yet, go ahead and take a look at it. So, right after we sent the letter out, we were really excited to launch a tool, and I'm forgetting the date. I want to say it launched the first -- I think it was the first Friday in May, or it may have been the last Friday in April. First Friday Adam is telling me. What we're calling is the MIPS Participation Look-Up Tool. And this is really, I think, a more user-friendly way to look at information. I think it's a way you can confirm information that's on your letter, if you're like my neighbor and you can't find your letter. This is a quick way where you can enter your NPI, or for that matter anybody's NPI -- it's not authenticated -- and find out your participation status. So, if you look on this slide, this is what the homepage of qpp.cms.gov looks like now. If you were to click on the green Check Now button, you'll go on to the next page -- next slide, please. And here is where you -- So, assuming that you've entered your NPI once you click on Check Now, you'll get to this page, "AM I included in MIPS?" You enter an NPI number. Click on Check Now and go to the next page. Or next slide, please. Sorry. And on this page, you will see -- or sample slide -- you'll see a sample physician, Jane Sample, M.D. We talk about she has enrolled in Medicare prior to January 1, 2017, so we know there that she can participate. We also know by her provider type. She's a doctor of medicine, so she can participate. If you go down below, we list the group practice that she's part of. As an individual, she is included in MIPS, so obviously likewise she'd also be automatically be included in MIPS at the group level because the threshold's not changing. Next slide, please. Okay, here's an example, and this gives you an example of some of the things Lisa Marie was talking about earlier. This is an example of another clinician. They are a certified nurse midwife. They have one associated TIN, and they participated in Medicare prior to January 1, 2017. However, this nurse midwife is exempt from MIPS -- you can see this is exactly what the screen would look like -- because she's not a participating provider type. However, if she's part of a practice that bills as a group, the practice overall, and they just decide to participate that way, then the practice does meet the low-volume threshold and would therefore be included in MIPS. Next slide, please. I'm going to turn it back over to Adam. He's going to walk you through quick tips on getting started.

Great. Thanks, Kelly. And as you can see on screen, we are a little short on time, so I'm going to go through this fairly quickly because we have a lot of questions coming in about Advanced Alternative Payment Models, so we want to get to that section. But these are just some tips for getting started if you are in the MIPS track. One thing I want to point out that later in this week, hopefully in the next week or two, we will have a quick start guide that we anticipate publishing that will help to get you started in this program. It will cover a lot of the points that are listed out on the screen. So look for that resource. That's all the more reason to keep checking back with us at qpp.cms.gov. Again, these are just some tips for getting started. I do want to move to the next slide so we can get into the Advanced APM participation, and I'm going to welcome back Ben to talk us through this next section.

Thanks, Adam. So, switching gears, and you can move on to the next slide. Switching gears, I want to talk about the Advanced Alternative Payment Model track of the Quality Payment Program. As I mentioned before, there are general APMs, there are MIPS APMs, and then there Advanced APMs. Advanced APMs meet three specific criteria to be considered Advanced Alternative Payment Models, and I won't get into those criteria here, but I will, in this slide, talk a little bit about the benefits of participating sufficiently in an Advanced APM. So, for payment years 2019 through 2024, clinicians who become qualifying APM participants, or QPs, through Advanced APMs are excluded from MIPS adjustments, and they also receive a 5% lump-sum incentive payment for their Part B professional services furnished during the calendar year immediately prior to the payment year. And I know that's a

little bit confusing, so as an example, if an eligible clinician reaches QP status in 2017, he'll be paid an APM incentive payment in 2019 based off 5% of their Part B professional services furnished during the 2018 calendar year. Next slide. So, to add some additional context on what it means to be a Qualifying APM Participant, as that top box shows, clinicians must become Qualifying APM Participants to earn the Advanced APM rewards. Qualifying APM Participants, or QPs, are clinicians who have a certain percentage of their Part B payments for professional services or patients furnished Part B professional services through an Advanced APM Entity. I just want to reiterate that it's not sufficient to simply participate in an Advanced APM. Your participation needs to reach a sufficient threshold by way of your APM Entity in order to achieve QP status. Next slide. So, how do clinicians become Qualifying APM Participants? The first thing here is to note that all QP determinations that CMS makes are made at the Advanced APM Entity level, and there's only really two exceptions to that. The first exception is that individuals participating in multiple Advanced APM Entities in which none of the APM entities they are participating in meet the QP threshold as a group, and the QP thresholds will be done at the individual eligible clinician level. The second exception is clinicians on an affiliated practitioner list, which are used in the Comprehensive Care for Joint Replacement Model. Those determinations will also be done at the individual eligible clinician level. Next slide. So, CMS calculates a percentage threshold score for each Advanced APM Entity in an Advanced APM using two methods -- the payment amount method and the patient count method. CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity. The general formula that we use to do the QP determination or to calculate the QP threshold scores are attributed beneficiaries over attribution-eligible beneficiaries. And I know the attribution-eligible construct is a little bit confusing, but essentially it's all beneficiaries who could have potentially been attributed to an Advanced APM Entity in an Advanced APM. So, next slide. So, this slide is more illustrative as to the two different methods that we use to do the QP threshold calculations. One, on the left-hand side, you'll see the payment amount method, and then on the right-hand side, you'll see the patient count method. And like I said, we will generate threshold scores using each of the two methods, and then we'll take the more favorable of the score in making the QP determination for a given Advanced APM Entity in an Advanced APM. Next slide. So, the threshold scores that we calculate for each method are compared to the corresponding QP threshold table, and CMS, like I said, takes the better of the two results. For 2017 and 2018, and this is performance years 2017 and 2018, the payment amount threshold is 25% of payments through the Advanced APM, and the patient count threshold is 20% of patients furnished services through the Advanced APM. As you'll see, starting in 2019 and 2020, the thresholds go up to 50% and 35% respectively, and then again in 2021, the thresholds increase to 75% and 50% respectively as well. Next slide. And so, this last slide here showed that all clinicians in the Advanced APM Entity become QPs for the payment year. So, like I said, the Advanced APM is at the model level, and then we do QP determinations at the Advanced APM Entity level, and then if the Advanced APM Entity meets the QP threshold, then all the eligible clinicians in that Advanced APM Entity will be QPs for that year. One thing to note here -- there's one other exception. For a model such as CPC Plus, there could be an APM Entity which is a single provider or a single eligible clinician. Next slide. So, how are QPs determined during the performance period? So, during the QP performance period, which is January 1 to August 31st, CMS takes three snapshots or makes three different QP determinations to determine which clinicians participating in Advanced APM Entities, in Advanced APMs, meet the threshold to become QPs. These snapshots are on March 31st, June 30th, and August 31st. So, reaching a QP threshold at any one of the three determinations will result in QP status for the eligible clinicians in the Advanced APM Entity or that given performance year. And like I said, these snapshots are also used to determine participation in MIPS APMs as well. Next slide. So what if clinicians do not meet the QP payment or patient thresholds for a given year? So, clinicians who participate in Advanced APMs but do not meet the thresholds may become partial QPs or partial Qualifying APM Participants,

and partial QPs have the option to choose whether or not to participate in MIPS. So they can choose to elect to participate in MIPS and receive the MIPS adjustment, or they could not and then they would receive no MIPS adjustment and be exempt from MIPS. It's important to note that partial QPs do not receive the 5% APM incentive payment. And this slide shows the thresholds for partial QPs. I will note that there's a difference in this slide from the previous slide in that this slide is in payment years, so for payment years 2019 and 2020, which refer to performance years 2017 and 2018, the thresholds for partial QPs are 20% of payments or 10% of patients, and similarly to the thresholds in the other slide, they increase in performance years 2019 and 2021 as well. And so that's a brief overview of the Advanced APM track of the Quality Payment Program. We'll be happy to answer any more questions on this in the Q&A. And now I'll turn it back over to my colleague Adam.

Great. Thanks, Ben. If we can go to the next slide, please. Just a note -- we did extend by about 10 minutes, so please hang on the line if you have some questions. One more slide, please. I just want to quickly mention that there is quite a bit of support available. We do have the technical assistance for clinicians that many organizations out there working right now, as you can see on this slide. The Transforming Clinical Practice Initiative, the Small, Underserved and Rural Support, which provides technical assistance to those practices with 15 or fewer clinicians, and then larger practices we have the Quality Innovation Networks and Quality Improvement Organizations. Those are for practices of greater than 15 clinicians. Additionally, you can also contact us at the Quality Payment Program. The number and the e-mail address are both on this slide, and we're going to bring that back up in just a few minutes, just so you have that number as well. Any questions related to letters, policy just call in, e-mail us, contact one of the technical assistance organizations. That information can also all be found on qpp.cms.gov. So, if we go to the next slide, please. And I believe at this time we're going to open it up for Q&A. So, if you do have a question, we do have the information on screen right now. Please dial in to the number you see on the slide and use the passcode. Again, for anyone who doesn't get through at this time, we have the Quality Payment Program Service Center at qpp@cms.hhs.gov or the phone number is also available there. Let's take the first caller on the phone, please.

>>Our first question is from Inquirer.

>>Hi, Inquirer.

>>From the Ohio State University Western Medical Center. Thank you for taking my question. I understand that we can report via different methods for each category. Example, like through our EHR for the ACI, but then we can do a registry for our quality. But my question was, can we report different reporting periods? So, our quality, we could do a full calendar year, but our ACI and our Improvement Activities we do 90 days?

>>This is Lisa Marie. So, for let's say a particular performance category, you can determine what that timeframe would be, and so every clinician would be reporting for that specific performance period listed that you select. Let's say you choose part of the transition year, if it's a 90-day timeframe. It has to be that exact same timeframe for all the clinicians for a performance category. But let's say for a different performance category, it could be a different performance period. But I think the critical thing relative to this is that for the performance period, it has to be the same performance period -- The performance category, the performance period has to be the same for every clinician, and you have to report on the same measure or activities relative to that performance category. Does that make sense?

>>So, yes, as long as we report at the TIN or, if it's individual, for each TIN, then you can have different reporting periods but they all have to have the same reporting periods for that category. So, if all of our eligible clinicians under our one TIN did 365 for quality and then 90 days for ACI, then that would still be appropriate.

>>Yes.

>>Okay. Thank you.

>>Okay, I just want to answer a few questions that we're seeing, a few common questions that are coming up in the Q&A. If you did not receive a letter and you thought that you should have received a letter or if there are errors on your letter or any of the above, if you just have questions about your letter, again, please reach out to us directly. As you see on screen right now, we have both the e-mail address and the phone number for the Quality Payment Program, so if there's any questions about the letters, just want to talk in general, please give us a call. We're happy to help, sort through any issues that there may be with the clinician participation letter. One other thing that I did notice -- for folks who have received a letter and they say individually you are exempt, that holds true. If you are exempt, you are exempt from MIPS for the transition year. Now, if you opt to report as a group, that is entirely up to you, if that's one way that you want to participate in the MIPS track this year, but as far as individual clinician goes, you are exempt if that's what the letter or the NPI Look-Up Tool states. So, let's take another question from the phone line.

>>Your next question is from Inquirer.

>>Hi. Thanks. And I think I have a letter question. It was just about the last line, where there was a final line below all of the individual providers that had the TIN and said that the TIN itself was eligible. So was that there simply to say "here's what would happen if all of these providers reported as a group"? Is that why that line is there?

>>Yeah. And CMS isn't mandating whether or not a practice should participate as a group or not. That's up to each individual practice. So that's why on the letter we included the TIN level information so the practice could decide to submit as a group as well as individual NPI information associated with that TIN in case they wanted to report individually.

>>Thank you.

>>You're welcome.

>>I'm going to pull a question from the Q&A, and this is for Ben and the CMMI team. For the snapshot June 30th and August 31st, to qualify as a QP, is this the time we need to register or should we have already been reporting measures by this time period or snapshot?

>>So, thanks, Adam. So, the answer to that question is you would have already been participating in the Advanced APM during the QP performance period, so you would've been reporting any measures associated with participation for that Advanced APM that were required by that Advanced APM, so you would be participating from the start of the performance period through the end of the year.

>>Great. Thanks, Ben. Back to the phone lines.

>>Your next question is from Inquirer. Inquirer, your line is open.

>>Hi. Yes, I just had a couple of -- I think it was a few questions. So, we are a Track 1 MSSP ACO and that includes some FQHCs. So, because we're at a group level, are they required to participate in MIPS? And then the second question I had -- I think I sent it through the Q&A on the website -- was that if -- you said that we all didn't receive the letter -- I can't remember my question, so that one's forgotten, so just the FQHC then the MIPS, because someone told me last week that FQHCs can participate, so we just need some clarity around that.

>>So, this is Lisa Marie, and I'll answer...it's like being an FQHC. So, for an FQHC, it depends on the billing methodology. So, if you're billing under the FQHC billing methodology, a clinician FQHC would not be required to participate in MIPS. However, if there is a clinician in the FQHC that is billing under the physician fee schedule and if that clinician, based on the amount that they bill, if it exceeds the low-volume threshold, then the individual clinician would be required to participate in MIPS.

Okay, so, as an ACO, we could have half of our participants, because we have various TIN numbers, so we could have half of our participants doing MIPS and then the other ones would still stay with our meaningful use or PQRS for 2017, correct?

>>So, Adam, do we have other folks from our team on the line who can address the ACO portion of this question?

>>We don't have a MSSP Track 1 expert on the line today. For next time, we definitely will. I wanted to --

>>Sorry, this is Terri Postma from the Shared Savings Program. And I think that -- So, what I'm hearing from you is if you have FQHC or HC in your ACO and there are practitioners that are billing through that facility TIN, are they included or excluded? And I actually have to kick this back to the QPP folks because my understanding is -- and the QPP folks can correct if I'm wrong -- but my understanding is that a Shared Savings Program ACO and the group as a whole will be assessed on low-volume threshold. We don't anticipate that any ACOs will not meet that low-volume threshold, so that means that all the clinicians that are participating in the ACO will be MIPS-eligible clinicians. So, I guess we'll start there. QPP, can you validate that statement?

>>Hey, it's Kelly. I've heard that, too. And the one statement I did want to make, because we tend to get a lot of questions on MSSP, particularly track 1, this week we will be posting two new fact sheets on qpp.cms.gov that focus on MSSP in particular, so look for that. Most likely it'll happen Tuesday or Wednesday, and for sure we will provide a link in the external newsletter, which is mailed on Fridays, and if you're not signed up for that, just go to qpp.cms.gov and sign up to be our list. That way you'll be alerted as information is posted.

>>Okay, thanks, because that makes a big difference about trying to figure out okay, we have to tailor half of our organization for MIPS, and then the other half, we're telling them, "Okay, you all are going to continue doing what you're doing because FQHCs are not eligible for MIPS." But no one has told us that at an ACO level how that impacts us, so we just kind of split them half and half. Okay, so that's good news.

>>Thank you for your question. Well, ladies and gentlemen, that is going to conclude our discussion today. If you didn't get a chance to get on to the line or didn't have one of your questions answered, please, please, please, please send them to the Quality Payment Program, again, at qpp@cms.hhs.gov. We will do our best to try to get your questions answered. There were a lot of folks on the line today, and we certainly appreciate every single one of you participating in this discussion and for asking questions. I want to thank all the subject-matter experts for being here today, and we will see you in the future. Thank you.

Thank you. This concludes today's conference.