MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
MACRA Listening Session: Quality Payment Program Proposed Rule
MLN Connects National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode. If time allows, we will open the lines for feedback. This call is being recorded and transcribed. If anyone has any objections, you may disconnect.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements and Introduction

Nicole Cooney: Good afternoon, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS. And I'll be your moderator today. I'd like to welcome you to this MLN Connects MACRA Listening Session on the Quality Payment Program Proposed Rule. MLN Connects Calls are part of the Medicare Learning Network®.

This listening session is an opportunity for stakeholders to learn about the proposed policy for the Quality Payment Program. If time allows, we will open the lines for participants' feedback. Before we begin, I have a few announcements.

Registrants for today's call received an email earlier this afternoon with a link to the slide presentation. Please follow along with our presenters using this presentation. If you did not receive the email, you can access the presentation by going to this address: go.cms.gov/npc. That's all lowercase: go.cms.gov/npc. Once you're on this page, find the date of today's call for access to the call materials.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

And at this time, it's my pleasure to turn the call over to CMS Acting Administrator Andy Slavitt for opening remarks. Andy?

Lead Operator: Ladies and gentlemen, please stand by. The conference will resume momentarily.

Operator: Ladies and gentlemen, please stand by. The conference will resume momentarily.

Presentation

Andy Slavitt: Hi, everybody. It's Andy Slavitt. Sorry for the connection problem.

I'm not going to be speaking to the slide deck s—for those of you who don't have it in front of you. But I am very pleased to have an opportunity to introduce this call today.

You know, the Medicare Program, which a number of you, I know, are all a part of, is undergoing – through, I think what we can all agree, is a pretty significant change. And I'm going to talk a little bit about what that change is before we talk about some of the details.

So, we're moving away from this thing called SGR, which frankly is a thing that none of us liked. You know, we lived in fear of payment reductions and the impact on our beneficiaries and patients. And we're moving to a better place. But I think the real question is: What is that better place? And will it, in fact, be a better place? And I think those are all the questions that we hope to begin to answer as we move forward.

I think the opportunity with this new place, which is the Quality Payment Program, are a couple things. One is, it really is the goal to be able to move to a place where the health care system payments become closer to matching the reality of how people want to practice medicine, and reward for people who are delivering quality, as opposed to an outdated system. The other opportunity, which I'll also talk about, is to take these patchwork reporting systems and things that create significant burden for physician offices and simplify them and streamline them into a simpler package and framework.

And while you hear a lot of details today, I think most of them are details that are good to know but are things that we're going to do our very best to make as easy for people to participate in as possible.

So, the Quality Payment Program—a couple things you should know about it. First of all, it was bipartisan congressional legislation, which, as someone who's just spent a couple of years in Washington, I could tell you, that doesn't happen every day. Secondly, I think there was a tremendous amount of input from the physician community and patient communities into the legislation. And I think a lot of that is what, I think, will hopefully keep it on point. And the third thing I'd say—and probably most important thing I'd want you to take away from this message—is, we are still seeking a tremendous amount of input from all of you. And what we put forward is a proposed rule, and that rule gives everyone the opportunity to provide input to it.

And I will tell you that, beginning months ago, we began a process here of going out to communities across the country to talk to physicians, to meet with them in their offices, to have small focus group sessions, to have workshops, and begin the process of informing what we were doing, based upon listening to what the physician community and other clinicians have been telling us are the most important things for us to focus on.

So, I think the things that I would want to leave you with before you start to hear about the details are really: The principles that we heard in those conversations with physicians are the things that are most important for us to be focused on And they really are three principles that are behind what we have attempted to do here.

The first, is to make the work patient-centric so that we take the focus off of reporting and requirements and programs and measurements and, as much as possible, focus around supporting patient needs, allowing you to spend your time focusing on patient needs, and coordinating the care of the patients that you see and you serve every day.

The second goal that we had, and second principle, has been to be practice driven in what we put forward. And what do we mean by practice driven? That means really allowing the flexibility for physicians and physician practices to decide for themselves what measures are most appropriate for your practices—not to take a "one size fits all" from us or from Congress, to be able to select the programs that are best suited to your needs, and to have the flexibility, if you will—the on ramps and off ramps—to be able to choose how to get measured and change that over time.

And then the third principle is to take the opportunity to simplify wherever possible. And that means reducing the amount of things we measure. That means having things that people may have to report on, in more complicated ways, reported on automatically where possible, reduce duplication, all of those opportunities.

So with those three principles, I hope that all of you will engage over the next 60 days or so, and as you hear some of the details in the call today, that you will let us know whether or not, and how we can make sure, we are being true to those principles.

So, we're very excited by the opportunity. But we're also quite aware that we – you are all incredibly busy professionals and that there's been a – certainly a significant amount of fatigue over the last number of years as people have worked in various programs and seen different measurement systems. And so it is our goal to be able to implement this in a way that really improves your ability to deliver the care you want and not add to the burden.

So with that, I'm going to turn it over back to Nicole. Thank you very much, and I'll look forward to further engagement.

Nicole Cooney: Thank you, Andy. Today's presentation discusses the two facets of the Quality Payment Program: the Merit-Based Incentive Payment System and the Alternative Payment Models.

First, we'll start with the Merit-Based Incentive Payment System, presented by Molly MacHarris, MIPS Program Lead in the Center for Clinical Standards and Quality. Molly?

Molly MacHarris: Thank you, Nicole, and thank you, everyone, for being with us here today. So, I'm going to go ahead and get started with the slide deck that, again, everyone should have received an email link to earlier today. We have a number of

slides that we are going to be going over today, so I will let folks know which slide, specifically, I am on.

So to start with, let's jump to slide 3. So there're a few topics that we are going to be talking about today. The few that I'm going to be going over are: What is the Quality Payment Program? How do I submit comments on the proposed rule and information related to the Merit-Based Incentive Payment System, or MIPS, Program? And then we will hear additional conversation related to participation in Advanced Alternative Payment Models.

The Quality Payment Program and HHS Secretary's Goals

Molly MacHarris: So moving on to slide 4, one of the things we always like to do when we start conversations related to the Quality Payment Program is talk about how the Quality Payment Program relates to Secretary Burwell's delivery system reform goals that were issued last year. These goals were the first time that specific goals were set of tying quality and value to specific payments made under Medicare. And these two goals tie directly into the work that is happening under the Quality Payment Program and the work for the MIPS path and the APM path.

The first goal of tying a certain percentage of payments to participation in an APM ties directly to the APMs. And we have actually already met this goal for 2016 of having 30 percent. And we are well on target for meeting the goal for 2018 of having 50 percent of payments tied to participation in an APM.

The second goal of tying quality and value under the Medicare Fee-for-Service Program directly relates to the MIPS Program. And those goals are to have 85 percent of payments tied to quality and value by the end of this year, and then 90 percent by 2018.

How To Submit Comments on the Proposed Rule

Molly MacHarris: And from here, I'm going to go ahead and jump to slide 8. So where do you go to submit comments? So, the proposed rule has been issued, and the comment period that we would need to receive all comments by will close on June 27th, 2016.

The information on slide 8 outlines the various mechanisms for how we here at CMS can receive comments. We do strongly encourage everyone to go to the website on the bottom of slide 8. It's go.cms.gov/QualityPaymentProgram. That website has a lot of information related to the Quality Payment Program, including a link to the proposed rule, various fact sheets, and information for upcoming webinars and educational sessions.

The Merit-Based Incentive Payment System (MIPS)

Molly MacHarris: So moving on to slide 9, I'm now going to start talking through the MIPS Program. So MIPS, again, stands for the Merit-Based Incentive Payment System,

which was authorized by MACRA and is one of the arms of the Quality Payment Program.

And what MIPS does is a number of things. First, it streamlines and sunsets three of the programs that most commonly impact providers to date. Those include the Physician Quality Reporting System, or PQRS, Program; the Physician Value-Based Payment Modifier; and the Medicare EHR Incentive Program for clinicians. Those three programs will end in 2018, and MIPS will begin adjusting payments in 2019.

MIPS payments will be adjusted based off of four performance categories which make up an overall composite performance score. And you can see on slide 9 what those four performance categories are. They include quality, resource use, clinical practice improvement activities, and advancing care information.

The first two you're probably familiar with. The third one, clinical practice improvement activities, I will talk about in more detail later on in the presentation. But, essentially, these are quality improvement efforts that we know have been happening for years and years at the local and regional level. But we know that this will be the first time that these activities would be required under a national-scale program. And then the last performance category, advancing care information, really deals with the usage of electronic health records.

As we have been doing a lot of listening and user engagement, we have found out that the current name for the EHR Program Meaningful Use isn't really one that resonates with users. So based off of the feedback we have received, we felt it was appropriate to rename this category to reflect the way it will function under the MIPS Program. So, that is "advancing care information."

So moving on to slide 10, so again, the three programs that will be ending and will be replaced by MIPS are the PQRS Program, the VM Program, and the Medicare EHR Incentive Program for clinicians. Please note that the EHR Incentive Program for hospitals will continue as will the Medicaid side of the EHR Incentive Program.

Slide 11. So, there are four main areas that I will be talking about for MIPS based off of our proposal, so just dive in on slide 12. So who can participate under MIPS?

So under MIPS, we refer to providers as eligible clinicians. And in the first year of MIPS, those that will be eligible to participate are physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists that bill under Medicare Part B. For the third and future years under MIPS, those that are eligible can be expanded to include occupational therapists, physical therapists, dietitians, clinical social workers.

Those providers that are not currently eligible for MIPS, they do have the ability to volunteer to participate. And some of the reasons why you may want to volunteer to participate is (1) you have been eligible and participating under the PQRS program for many years, and then (2) it gives you a bit of a head start prior to actually being required to participate under MIPS, so you can get a better understanding of what participation means and how that would work for you particular practice.

Slide 13. So there are a few exclusions. The first exclusion is that, if you become newly enrolled in the MIPS Program during the first performance period – we have proposed that the first performance period would be calendar year 2017. Again, for payments that will be adjusted beginning in 2019. So if you become newly enrolled in Medicare in 2017, we've proposed that you would be excluded for that year. You would be eligible to participate in future years, however.

The second exclusion is a certain low volume threshold. The proposed low volume threshold is that, if you have a clinician bill less than or equal to $10,000 and you see less than or equal to 100 patients, you would be excluded from MIPS for a given year.

And then the last exclusion, dealing with participation and Advanced Alternative Payment Models, I won't talk about too much here now because you will learn a lot more about what that exclusion looks like later on in this presentation.

The other important piece to note is that MIPS applies directly to clinicians, and it does not apply to hospitals or facilities.

Moving on to slide 14. So just at a high level, the proposed timeline we have for clinicians. So again, the proposed performance period under MIPS this calendar year 2017, we would issue a feedback report by July 1st of 2017. The proposed data collection period would be the first quarter of 2018. And an additional feedback report would be issued in July of 2018. And then MIPS payments would go into effect beginning in 2019.

Slide 15. So, you'll hear me talk more about how MIPS will apply to clinicians, and how that will be based off of your performance on four performance categories that comprise an overall composite performance score. That composite performance score is based off of a 0- to 100-point scale. And depending upon what each clinician's composite performance score is in comparison to an overall MIPS performance threshold will determine the total amount of adjustment that you could receive.

And the law MACRA did specify for us what those adjustment percentages would be. So beginning in 2019, the total amount of adjustments that we have available is 4 percent. Please note that, over time, that will increase to 9 percent. Additionally under MIPS, we must apply the program in a budget-neutral manner. So depending upon the total distribution of scores, that will impact the total amount of payments that each clinician

could receive. And I'll talk about this in more detail because I know there's a lot of new terms that are in play here.

Moving on to slide 16. So again, when you think about the two arms of the Quality Payment Program, there is the MIPS side and then the participation in Alternative Payment Models. We do intend that, over time, more and more clinicians will be part of an Alternative Payment Model. But we do recognize that, for the first year and few years under the Quality Payment Program, the majority of clinicians will be part of an APM. And those, then, that are part of an APM, it may not necessarily be an Advanced APM. But again, you will hear more about this in more detail a little bit later on.

Moving on to slide 17. So how can you participate in MIPS? There are two ways. The first is as an individual. And we've proposed to identify an individual clinician under MIPS by using your unique TIN, your Tax Identification Number, and your unique NPI, your National Provider Identifier.

The second way to participate in MIPS is as part of a group across all four performance categories. And we have proposed to define a group as two or more NPIs that are part of one TIN, one Tax Identification Number.

For those of you who have either read the law MACRA or have listened to previous presentations, there is the concept of virtual groups under MIPS. We did not make specific proposals on how virtual groups would be implemented. In the first year, there are a number of areas that we would like to receive additional comments on. So we do encourage all of you to take a look at those and provide us feedback.

Performance Categories and Scoring

Molly MacHarris: So moving on to the next set of slides. So, I'm going to go into more detail on the performance categories and scoring, so moving on to slide 19. So, there are the four performance categories. And those each have specific weights. And those comprise a composite performance score.

So if you take a look at slide 20. For the first year, quality will count for 50 points of the total composite performance score. Cost will count for 10 points. Clinical practice improvement activities will count for 15 points. And advancing care information, again, that deals with the usage of electronic health records, will count for 25 points.

Moving on to slide 21. I'm going to go a little bit deeper into each of those four categories of what our proposals are.

So starting first with quality on slide 22. Our proposals for the quality performance category are that clinicians would select six measures. Please note that this is a decrease in the number of measures that clinicians would have to select when taking into

consideration the prior program, the PQRS program specifically. Under that program, clinicians would have to report nine measures that cover three National Quality Strategy domains. Under MIPS, we are proposing that the measures would have to be six. We don't have a specific proposal related to the measures that would need to expand National Quality Strategy domains. We do still encourage clinicians to select measures that cover multiple domains. But we didn't feel that it was a requirement we needed to have in place under MIPS.

We do, however, have a proposal that, of those six measures, one must be a crosscutting measure if you are a patient-facing professional. And additionally, of those six measures, one must be an outcome measure. If you do not have an outcome measure available, you would need to select another high-priority measure. And a high-priority measure is proposed to be defined as an outcome measure, an appropriate use measure, patient experience, patient safety, or care coordination measure.

To make those selections of those measures, you could either do so from a list of around 300 or so measures. Or one of the things that we heard consistently, as we have been listening to users over the past year or so, is that it's a little difficult to select six measures from such a wide list. So based off of the feedback we have received, we sorted these measures based off of your particular specialty. So there's another avenue that we hope will be more streamlined for you to select your measures.

Moving on to slide 23 and then slide 24, so more information related to our proposals under the resource use performance category, or the cost category. So under this category, there's no separate submission of data that is required. You would see your patients, as normal. And we – here at CMS, we will be able to calculate these measures based off of the data we received and on your claims. Some of the measures that we are newly proposing under the MIPS Program include a set of 40-plus episode-specific measures that are more specific to the specialties of clinicians that would be eligible under the MIPS Program.

Moving on to slide 25 and slide 26, the clinical practice improvement activity performance category. So under this category, we are proposing that there's no minimum number of activities that must occur. However, the more activities that you do, the higher your total potential score. To avoid getting a zero in this category, you would need to do at least one activity. And there are over 90 activities that are proposed.

Some additional items that are specific around this category are (1) that if you are part of an APM (it doesn't have to be an Advanced APM, it can just be an APM), you would automatically get half of the total points under this category. And then second, if you are part of a patient-centered medical home, you would automatically get the full percentage points under the category.

So here moving on to slide 27. I'm going to talk about the advancing care information performance category.

So slide 28. So who can participate? You can participate under this category in the same two ways you can participate for the rest of the MIPS Program, which is as an individual or as part of a group. We do note that group reporting for the EHR Program has not previously existed. This is something that we have received feedback on for a while, that would be beneficial. And under the MIPS Program, we have the ability to allow group reporting for the advancing care information performance category.

We also know that, under the EHR Program, previously that program only applied to physicians. We also know that under MIPS, MIPS applies to more clinicians than just physicians, such as physician assistants, nurse practitioners, etc. Specifically for the first year, we have proposed that those clinicians that were not previously eligible under the Medicare EHR Incentive Program, they would not be eligible under the advancing care information performance category. So those nurse practitioners, physician assistants, etc., those would continue to be excluded for the first year under MIPS.

Slide 29. So there are a couple different areas that make up the advancing care information performance category. It is made up of a base score, a performance score, and a bonus point. Those three scores then will get scaled down to 100 points to then be applied to the total of 25 potential points.

On slides 30 and 31, there's information on the six measures and objectives that we would need to receive yes/no information on to get the base score.

Slide 32 provides information on those measures and objectives that we would need to receive performance information on to make up the performance score.

And slide 33 summarizes the advancing care information category. Some of the major changes that we have made from the current Medicare EHR Incentive Program to the way it will function under MIPS is (1) we've dropped the "all or nothing" threshold requirement. We know, currently under the Medicare EHR Incentive Program, if you miss one measure, you fail that entire program. Under MIPS, we have the ability to offer additional flexibility. We also have removed some of the redundant and burdensome measures.

Slide 34. This provides an overall summary of the four performance categories, the total possible points per category, and how that relates to the composite performance score. Please note that those points in the middle column, those will fluctuate based off of your specific provider type and how you practice.

And slide 35. So again, those four performance categories that I've talked through, those will make up the composite performance score, which will then be compared to

the MIPS performance threshold, which will then determine your total adjustment percentage.

Slide 36. So, we have a lot of proposals related to how we should calculate the composite performance score. Just a few highlights we wanted to mention here today: (1) We did make proposals related to certain scenarios where there may not be measures that are available or applicable to your particular type of practice, and what we would do in those scenarios; and then also, special circumstances that small practices, solo practitioners and practices that are in rural areas, or non-patient-facing clinicians, how we would take into account those special considerations.

Slide 37 provides a summary of how we would calculate the composite performance score. A couple takeaways to note here is: (1) Across the four categories, we convert the measures and activities to specific points. The – we also feel that it's important that clinicians, under the MIPS Program, should know in advance the specific measure benchmarks that they would be compared to as well as the overall MIPS performance threshold. We do plan on issuing those prior to the beginning of the performance period. And then lastly, we feel it's important that, for the measures and objectives that you can provide some performance information on, that we provide partial points for that.

And one item I did want to note that we will make in an updated slide deck is, under the "advancing care information," the bullet there that references that the base score is of 60 points—it's 50 points, as I noted earlier. So we will make that correction and repost the slides on the website.

Data Submission

Molly MacHarris: So just a couple more slides on MIPS, so moving on to slide 39 and to slide 40. So how will your data come in to the MIPS Program? It differs by performance category, but the three main methods that are available across all categories include qualified registry, electronic health record vendors, and qualified clinical data registry. Those are available across all of the methods, except for resource use. And again, that's because, for the resource use, or cost, category, we have not made any proposals that a separate data submission would be required. Again, we would do those calculations here in house.

Performance Period and Payment Adjustment

Molly MacHarris: Moving on to slides 41 and 42, so just a few more on MIPS related to the performance period and the payment adjustment period. So just as a recap for MIPS on slide 42, the proposed performance period is 2017 for adjustments that would go into effect beginning 2019.

Slide 43. So of those four performance categories, they would make up a specific composite performance score. If your composite performance score is below the MIPS performance threshold, you would receive a negative MIPS adjustment up to a total of negative 4 percent.

Slide 44. So, if your MIPS adjustment – or if your composite performance score, rather, as compared to the performance threshold, is at or above that threshold, your MIPS adjustment would either be neutral or you could get a positive MIPS adjustment. That could go up to 12 percent. That's based off of a 3 scaling factor, which I will talk about in just one more slide.

And there also is the ability, under MIPS, for the first few years, that if you're considered to be an exceptional performer, you can get an additional performance factor. And that additional performance factor could go up to 10 percent.

Slide 45. So again, how does that scaling factor work? So, you'll recall that, under MIPS, MIPS must be implemented in a budget-neutral manner. And because of that, there is the possibility that if there are a large number of clinicians that are receiving a negative MIPS adjustment, to maintain that budget neutrality, the positive adjustment would need to go above that 4-percent threshold. So, we have the ability for a 3.0 scaling factor. So for a given year, the total adjustment could go beyond the specific percentage. So for the first year, it could go beyond 4 percent to up to 12 percent, as the example on slide 46 indicates.

And then lastly, for MIPS on slide 47, for those clinicians that would be eligible to receive an exceptional performance threshold, they could receive that for the first 6 years under MIPS, from 2019 through 2024. And there is a specific set of money, or a bucket of money, that is set aside, outside of the budget neutrality. And again, that adjustment percentage could potentially go up to 10 percent.

So that's everything I have to talk about for MIPS. I'm going to turn the call back over to Nicole. Thank you.

Keypad Polling

Nicole Cooney: Thanks, Molly. At this time, we'll pause for a few minutes to complete keypad polling. Ronni, we're ready to start the polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad, and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Nicole Cooney.

Presentation Continued

Nicole Cooney: Thank you. Next up, we have JP Sharp, Alternative Payment Model Lead in the CMS Innovation Center, to discuss Advanced Alternative Payment Models. JP?

Incentives for Advanced APM Participation

Dr. JP Sharp: Thanks, Nicole. So on slide 48, we'll start with the incentives for Advanced APM participation. There are a lot of new definitions and new concepts here, so we'll try to walk through the different layers of this from APMs to Advanced APMs to how to become a qualifying APM participant who then receives the incentives under this part of the program.

So if we go to slide 49, we'll start with the basic definition of what an APM is. And this is part of the MACRA law, and it defines this broad pool that we start off with. So not a whole lot happens with what this APM definition is, but it's our foundation for the subsequent ones.

So it includes, first, any of the models created under the CMS Innovation Center, the Shared Savings Program, and then any other statutory or Federal demonstration programs. So again, that's the broad range of APMs.

So then, we'll go on to slide 50. And this is where we look at Advanced APMs. And these are the type of APMs through which participants can receive the incentives under this part of the program. And we'll get into what each of these criteria mean later on, but this is the overview of it.

So starting with the APMs, an Advanced APM must check these three marks here. So first, the APM requires its participants to use certified EHR technology, (2) the APM bases payment on quality measures that are comparable to those under the MIPS quality performance category, and then (3) this is an either/or, so there are two ways to meet this third checkmark. So, either the APM requires its participating entities to bear more than nominal financial risk, or (2) the APM is a Medical Home Model that's been expanded under the Innovation Center authority, and we'll get to what all of these things mean in a little bit. So hold on to that.

So, we'll go to slide 51, and we'll see another definition here for Medical Home Models. And this applies in a few different places, so it's important to understand what these

Medical Home Models mean. So first of all, it pops up when we get to, later, the financial risk criterion, so that third checkmark, it applies there. And then second, if you recall when Molly talked about the clinical practice improvement activities category, under MIPS, participation in Medical Home Models can contribute to getting the maximum score under that performance category if you're subject to MIPS.

So on the right side of this slide, you'll see the proposed definition for Medical Home Model. So, it's an APM that has particular characteristics. And we propose that those are (1) there's a primary care focus, (2) there's empanelment of patients to clinicians, so you have that patient–clinician connection, and then (3) the APM can actually just have four of the subsequent seven aspects here. So through the design of the model, it meets four of those seven categories. So hold that in mind, and we'll get to where those Medical Home Models play in a little bit later.

So on slide 52, this is an important note—that the law and our proposed rule does not change how any particular APM operates. So, APMs all have their own reward structure, their own quality reporting. And so, I recommend that you look at those APMs and how they work. And those will drive, primarily, whether or not they are a right fit for you. What this program does is, it layers on an additional incentive for those most Advanced APMs. So taking on particular risks – and you'll get this additional incentive for that participation.

So on slide 53, we'll start getting into these criteria that make an APM into an Advanced APM. And we'll – at the end of these – going through these criteria, I'll actually show you the list, and we'll do this every year. I will show you the list of which APMs will be Advanced APMs for a particular year.

So, we'll show you our math, what we're doing here, first. But we'll always give you the answer so that you can know which APMs are the ones through which you can receive these additional incentives, in case you don't want to go sifting through all of the information for the various APM offerings, so…

So for the first criterion – is about certified EHR technology use. And I'll move through these a little bit quickly, but they're here for your reference. So the primary rule here is that the APM must require at least 50 percent of the eligible clinicians in each APM entity to use certified EHR technology to document and communicate clinical care. So in the structure of the APM, it requires looking at each participating entity, whether that's an ACO or a group practice or a practice site that's dependent upon the APM itself. So within each participating entity, 50 percent of the clinicians participating in that APM must use certified EHR technology in this fashion.

So, slide 54 gets to the second criterion, and that is requiring use of MIPS comparable quality measures. So there're no minimum number of measures that an APM must have here. There's no domain requirements. There is, however, a requirement that at least

one of these measures by which the APM links payment to the quality must be an outcome measure. It doesn't have to have that requirement if there is no relevant outcome measure available under MIPS at the time that that APM is developed.

And then on the bottom part of the slide, you see what we determine comparable to mean. And really, that's evidence-based, reliable, and valid. And those can come in various forms. So, this is a non-exhaustive list, but those can be actual MIPS measures or measures that are endorsed by a consensus-based entity, and so forth.

So then, we'll get to slide 55, and this is the trickiest of the three Advanced APM criteria. This is that the APM requires its participating entities to bear more than nominal financial risk. So, we've split that into two pieces, there's a financial risk standard that determines whether or not the entities bear financial risk. And then the second is how much risk they must bear under that APM to be considered more than nominal. You'll see that the Medical Home Model pops up here, so at the bottom, this criterion is completely met if the APM is a Medical Home Model that's been actually expanded under Innovation Center authority. And so, there are no such models at this point in time, but in the future, if the Medical Home Model meets these CMMI criteria for expansion, which are that it's proven to reduce cost and improve quality, or reduce cost and keep quality neutral, or keep cost neutral and improve quality, so any three of those options could mean expansion for a Medical Home Model, or any other APM for that matter.

So for those Medical Home Models that have not yet been expanded, we are proposing unique tailored criteria for this financial risk standard and a nominal amount standard that apply just to Medical Home Models. And we'll see those a little later.

And again, these are a little complex, so I'll get through these relatively quickly. But hopefully, they lay them out clearly so that you can come back to them and look later. So, this is the generally applicable one, so it applies to all APMs, not just Medical Home Models, at first.

So this is what financial risk is, under our proposal. So if actual expenditures exceed expected expenditures, you can think of that as some benchmark under the APM. Then one of those three things on the right happens under the APM.

And then we'll go to slide 57, and that shows you how much that risk must be. And that's broken into three parts. There's total risk, which is the maximum amount that an entity could be responsible for under the APM. And that must be at least 4 percent of that benchmark amount. There's marginal risk, which is: What percent of each dollar over that benchmark would that entity be responsible for? And then a minimum loss ratio is really an exception to that marginal risk rate. So there's a particular buffer zone for a certain amount of expenditures over that benchmark for which no risk is incurred.

So, you'll see on the right is a graphical representation of this. If you look at a particular APM's risk arrangement and plot that out, if the line's above this one at all points, then it would meet this nominal amount standard. And again, we'll tell you which APMs meet this in an annual determination.

So on slide 58, we go back through this – I'm sorry, this is an example here. So this is good for reference if you just want to see a hypothetical APM that would meet both that financial risk and nominal amount standard.

So on slide 59, we get to the Medical Home Model version of this. And so it looks very similar. Things to note that are little different is that it doesn't necessarily have to have risk associated with expenditures. It can be other performance metrics. And second, on the bottom, there's a fourth option there for "reduces an otherwise guaranteed payment or payments." So certain payments through that Medical Home Model could be reduced in the future, and that would be considered risk for losses.

And then, the nominal amount standard for Medical Home Model also looks a little different. You'll notice this is only based on total risk. It's not looking at any marginal risk aspect to it. Second, those total risk amounts are based on the revenue of the participating entity instead of some objective benchmark. And so that scales with the size of the entity so that a smaller entity with less revenue would have a lower amount of total risk that it would have to incur under the APM.

And then second, on the left, the lower left-hand side, you'll see we've proposed, for starting in the second year, a size limit, but this would only apply – the special Medical Home Model standard would only apply to entities that are part of organizations that have fewer than 50 eligible clinicians in them.

So if we go to slide 61, as promised, this is the list of Advanced APMs for 2017. And keep in mind this is using the proposed criteria and looking at currently available—so APM information that we have released or currently operating APMs and those current specifications. So matching those up together, these are the APMs that would be Advanced APMs in 2017. Of course, Oncology Care Model—we caveat that with, the two-sided risk model that would meet the financial risk criterion starts in 2018.

Then we'll move into the second step of this, which is, so you participate in an Advanced APM, but then you have to participate to a certain degree to be determined to be a qualifying APM participant, or QP. So there's this extra threshold that the law puts out there. And this is – these are proposed steps for going from participation to QP, where you get the incentives.

So, on slide 62, you see what those incentives are, and we'll come back to that before the end. But QPs are excluded from MIPS and then they receive a 5-percent lump sum

bonus payment in the payment year. And then in 2026 and later for the long term, is actually a higher fee schedule update for these individuals.

So on 63, we'll look at this summary page for how to become a QP. And then there're a bunch of slides that walk through that that we'll skip over later. But again, they're for your reference.

So, 63 shows the steps to go from participation in an Advanced APM to QP status. So first, we'll look at the APM entity. So we'll take all of the participating clinicians and consider them together as a collective group. And so they'll either become QPs or not become QPs together.

Second, we'll calculate a threshold score, and this is based on both – on one hand, payment amount through that Advanced APM, and (2) a patient count through that Advanced APM. So two different methods, and we'll calculate both of them for each entity, and then we'll take the one that gets them the better QP result. So if the payment amount option results in QP status and the patient count method does not, we'll just take that payment account – payment amount to one.

So then third, we'll – to do that, we compare that threshold score to these QP thresholds that we proposed and that the law put forward. So that's that step where we calculate those scores, we compare them to another – to this table, and then if they're above that number, then you become a QP.

And on that fourth, again, all of those eligible clinicians in an APM entity become QPs together.

And then at the bottom of this page, you'll see that to line up with MIPS, the performance period is very similar—it's the calendar year that's 2 years prior to the payment year. So 2017 will be that first performance period. You see the subsequent slides go through each of those steps in a little more detail, but we're going to skip over those because we're running close to the end of time here.

So, on 69 is just a quick page and there'll be a lot more information about this in the future. But starting in the third year—so, payment year 2021, performance year 2019—there will be this all-payer combination option, which means that, through your Advanced APM participation (you still have to participate in one through Medicare), you don't quite get to the thresholds, but you get to a lower threshold. You can get to that overall QP status. You can meet the big threshold through payments or patients with other payers—so, commercial arrangements, Medicaid arrangements. So, we'll calculate all of your payments. So, we can look at all those arrangements together; get you through a higher threshold that way.

Then next, we'll go – once we've determined that you are a QP through what we went through earlier, on page 70 here, we'll look at how we calculate that APM incentive payment. And as we saw earlier, we're stating that QPs are excluded from MIPS. And they receive that 5-percent lump sum bonus payment for years 2019 to 2024.

So at the bottom we'll see how much – or what that payment comprises. So, that first checkmark states that it's based on the estimated aggregate payments for professional services furnished the year prior to the payment year. So what does that mean? So for payment year 2019, we look back to the prior year, to 2018, and we count up all your services, the payments for professional services under Part B of Medicare. So we get that aggregate payment amount, and we take 5 percent of that, and then send you that amount in 2019—in that payment year.

So, on slide 71, you'll see that kind of laid out, what happens in each year. So, 2017 is that performance period, so that's where we look at your Advanced APM participation, and we determine whether or not you are a QP based on that. Then 2018, for those QPs, we'll look at all those services under Part B. And we'll add those payments up, take 5 percent of that, and send you that in a lump sum payment in 2019. So that repeats every year—so, 2018 performance period, 2019 base period, 2020 payment year.

So then 72 and then 73, we'll get into how all of these pieces fit together and the time scale overall. So on 73, you see the payments that we talked about for MIPS and Advanced APMs kind of line up in this calendar.

And in 74, we see the physician fee schedule updates that are structured under the MACRA law.

And then on 75, you see it all together there, so, lines it all up with the fee schedule and the Advanced APM incentives. And so on the fee schedule part, I'd like to point out, so the law sets forth these 0.5-percent updates for the next couple of years, then there's no change while MIPS and the APM incentive payment ramp up. And then in 2026 and later, those fee schedule updates diverge. So the 0.75-percent update applies to QPs. And then for people who are not QPs will receive that 0.25-percent update. And so that compounds upon itself, so every year that gap widens by 0.5 percent between QPs and non-QPs. So over time, that becomes the true incentive for Advanced APM participation.

And so in the next few slides, we'll go over a little bit of the comparative aspects because we know that – you know, each individual and each entity will have their own particular calculus about whether they are ready for participation in Advanced APMs, whether an APM – any other APM is right, or if MIPS is the right place. So we want to make sure that (1) it's flexible and as easy as possible to move between these programs, but also that, you know, we know at certain points in time each of these parts of the program may be better for you than others.

So, this is – kind of lines up what some of these incentives look like under each of them. So on 77, you'll see that if you're not in an APM, you'll be subject to MIPS.

Slide 78. If you're in an APM—there in the middle—but not an Advanced APM, you're subject to MIPS still. But then you also have whatever the APM itself offers. So there can be its own risks and rewards associated with that APM. In addition, as we discussed earlier under that clinical practice improvement activities category, there's a starting minimum of half that amount for that performance category. So you get a little favorable scoring there in that category under MIPS.

And then on 79, you see, for advanced APM participation, if you become a QP, you are excluded from MIPS. So you don't have that MIPS plus-or-minus adjustment. And you get those APM-specific rewards. And in reality, usually these Advanced APMs have larger risks, larger rewards than those other APMs. So that box could be a little bigger if you think about it. And then you get that 5-percent automatic lump sum bonus added on there as well.

So, we'll do some takeaway points, and then there're a few other aspects about the Quality Payment Program and some other pieces of MACRA that are useful to pay attention to that we'll go through. So overall, as we said, the Quality Payment Program changes the way Medicare pays clinicians. It offers various financial incentives, whether it's through MIPS or Advanced APMs, for providing high-value care.

And this is focused on Medicare Part B clinicians. So those are the people who will be participating in MIPS. Those are the dollars and the patients we'll be focusing on for calculating the QP, the Advanced APM incentives. However, those Advanced APMs can expand to that all-payer combination option later. And again, we'll have more information about that all-payer combination option as we get it out and in future years.

And then, finally, these payment adjustments and the bonuses begin in year 2019. Then we'll go on to some extra materials here after that.

So on slide 81, we're looking at additional things.

So, we'll move to 82. And this is just noting that there is an allocation under the MACRA law for technical assistance to small practices and those in rural areas and health professional shortage areas. There's also the development of a Physician-Focused Payment Model Technical Advisory Committee.

So we'll move to slide 83 that highlights that. And this is a new channel through which we can get stakeholder proposals for creating new Physician-Focused Payment Models, which then can become APMs—and, potentially, Advanced APMs if they meet the criteria that we went through earlier.

So this PFPM Technical Advisory Committee, or PTAC as we call them, is 11 GAO-appointed members, and they have been appointed, and they've had a couple public meetings so far. And so, they can receive stakeholder proposals. And they will assess these proposals according to criteria that we're proposing. And then they'll provide recommendations to the Secretary for actual implementation of some of these ideas.

So, we'll go to slide 84. And you'll see kind of the broad overview of what these criteria are that the PTAC will assess proposals by. And those are payment incentives for higher-value care, care delivery improvements, and information availability and enhancements.

And as you see there at the bottom again, any Physician-Focused Payment Model that's selected for testing by CMS and meets the criteria for the Advanced APMs would be an Advanced APM. So we like to see this as an opportunity to get a lot of new ideas from all of you, other stakeholders for new APMs—potentially, new Advanced APMs—that one may fill gaps in our portfolio. There may not be certain opportunities right now for everybody to participate in APMs.

And so this is an opportunity to give us some ideas for that, and also ways to structure things differently, find new ways of collaborating, and focus on specialty models in particular. And so, I suggest that you look into the PTAC, and give some thought about that, and use that process to help CMS develop new APMs in the future.

And it looks like we have a little bit of time to go into the appendix where there are a couple of useful pieces as well. And then we can, hopefully, get to some questions there for the last few minutes or so.

On slide 86 there, this is about partial QPs. And this may not apply too much in the early years when the thresholds are relatively low, but if you look back to those QP thresholds that we talked about earlier, the increase over time, so it becomes increasingly difficult to become a QP through Advanced APM participant – through APM participation. So, there's a range. If you don't quite get to that QP threshold, there's a partial QP threshold. And so, partial QPs have an option. They can either participate in MIPS and be subject to MIPS adjustments, just as all other MIPS eligible clinicians are, or they can elect to opt out of MIPS and essentially be neutral. There would be no incentive payment, but there would also be no MIPS adjustment. So that would be an option for people to elect in case they end up in that partial QP territory.

Next, on slide 87, this is part of how we want to make sure that there's a seamless transition between MIPS and APM participation because we know only QPs are excluded from MIPS under the law. So there are a lot of other APM participants who may be subject to MIPS. So, we want to make sure that the MIPS reporting and the

incentives under MIPS work well with the work that you do under an APM. And so, there's particular APM quality reporting, resource use assessment – practice activity, there.

So this is really trying to reduce the burden for people that are going to be associated with both an APM and MIPS. And so, we have streamlined reporting, particularly in the quality and resource use performance categories.

And again, just like we do the QP performance – or the QP assessment, all eligible clinicians in an APM entity will be assessed together for this. So they would be getting one MIPS score that would be associated with the same MIPS adjustment for all those clinicians participating in that entity.

And so, the next few – or the next slide just goes into a little bit more detail about which APMs that would apply to. But I recommend you, if you're interested in that, look into our fact sheets and proposed rule on the particular aspects of the APM scoring standard.

And with that, I think I'll end it here. There are a few more slides there where you can get into the details of that APM scoring standard, but I'll hand it back to Nicole to see if we have questions.

Feedback Session

Nicole Cooney: Great. Thank you, JP. At this time, it does look like we have a few minutes to open the lines for your feedback. It's important to note we will not consider feedback during this call as formal comments on the rule. Please refer to slide 8 of today's presentation for information on submitting these comments by the close of the 60-day comment period on June 27th.

Ronni, we're ready to start the feedback session.

Operator: To provide your feedback, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before making your comment to ensure clarity. Please note your line will remain open during the time you're providing your comment, so anything you say or any background noise will be heard in the conference. Please hold while we compile the roster.

Your first comment comes from the line of Marni Abramowitz.

Marni Abramowitz: Yes, OK. I just had a question about who MIPS does not apply to. There was a slide in the beginning that said, didn't apply to hospitals or facilities. So by facilities, does that include nursing facilities?

Molly MacHarris: Sure, this is Molly. Thank you for the question. So if you look at slide 13, that's where we mentioned that MIPS does not apply to hospitals or facilities, and so – no, it would not apply to nursing facilities for charges that are made outside of the physician fee schedule.

Marni Abramowitz: OK, because our providers – we're not a nursing facility, but our providers only treat patients in nursing facilities. But we bill Medicare Part B, so our providers would still be subject to MIPS, then?

Molly MacHarris: So – yes, so for the services that are provided to the patients that are under Part B, yes, those services would be eligible for MIPS. It's any of the facility services—those would not apply under MIPS.

Marni Abramowitz: OK. Thank you.

Nicole Cooney: Thank you.

Operator: Your next comment comes from the line of Allison Brennan.

Allison Brennan: Hi, I have a question about the MIPS bonuses. Would those be included if they were paid to, for example, a Track 1 ACO? That payment amount of the MIPS bonus be included in the ACO's benchmark in future years?

Nicole Cooney: Hi. This is Nicole Cooney. I'm sorry. Due to the nature of the question, we're not able to answer that at this time. We'd encourage you to submit a formal comment by slide 8. Thank you.

Allison Brennan: Thank you.

Operator: And your next comment comes from the line of Marsha Lawrence.

Marsha Lawrence: Hi. I'm calling about physical and occupational therapy. And I understand that we will not be included initially. The question is: What are we supposed to do in the meantime? Do we continue to submit PQRS? Do we continue to submit Functional Limitation Reporting as we have been doing? Or do we just submit Functional Limitation Reporting and wait until the Secretary decides to include us in the MIPS Program?

Molly MacHarris: Sure. This is Molly. That's another great question. So as I mentioned earlier in the presentation on slide 12, so physical and occupational therapists—they are not eligible for MIPS for the first few years. There is the ability, though, for you all to volunteer to participate in MIPS because we know that physical and occupational therapists have been participating in PQRS since that program began back in 2007.

And there's a number of measures that have been developed specifically for your specialty type.

So, basically, you don't have to do anything for MIPS. However, if you have been participating in the PQRS Program and if you want to understand how MIPS – how the performance requirements would apply to you prior to actually being scored under the MIPS Program, you do have the ability to still submit data for quality measures. We would – you could select clinical practice improvement activities that would apply to you, and we would issue to you a feedback report. And there is…

Marsha Lawrence: OK.

Molly MacHarris: …more specific information on those proposals within the rule.

Marsha Lawrence: OK. So we are not required to submit PQRS. And Functional Limitation Reporting is something completely different, and as far as you know, we would just continue to do that as we have been doing it.

Molly MacHarris: So, I can't speak to the Functional Limitation reporting. I apologize, I'm not a subject matter expert on that. So, I would say, yes, you would still have to continue that, but I would say that you should probably check with those experts.

And I do just want to clarify one thing: so, PQRS—that program will end after this year. So, 2016 is the last reporting period for PQRS. 2017 will be the last that – that first quarter 2017—that will be the last time that data would come in for PQRS. And 2018 will be the last year that your claims would be adjusted under PQRS. So, you should still do PQRS for this year so you don't get a 2-percent reduction in 2018. But for MIPS, which begins in 2017, you don't have to participate right away, but you have the option to do so.

Marsha Lawrence: Got it. Thank you so much.

Nicole Cooney: Thank you.

Operator: Your next comment comes from the line of Bob Halinski.

Bob Halinski: Yes I had a question about the interaction with the Medicare Advantage plans, you know, if this program is for the traditional fee-for-service, you know, particularly on, like, the Advanced APM when you have the 5-percent bonus. So if you're a physician or physician group that's contracted a Medicare Advantage plan, will that plan be able to pay that bonus to you? Or will that come from CMS? Or can you just describe a little bit, both for MIPS or APM, you know, how that – there might be an interaction there?

Dr. JP Sharp: Sure. This is JP, and thanks. I think that's an important point about how MA plans fit in here. So on the Advanced APM side for the first 2 years, the law's pretty explicit that it only focuses on Part B of Medicare. And so those payments under Medicare Advantage would not be considered for QP status, and the incentive payments would not be based on those payments either.

So starting in the third year, and we'll have more information about this, but Medicare Advantage arrangements can be considered Other Payer Advanced APMs, based on if they meet similar criteria to those that we put forth for the Advanced APMs. So those arrangements can be considered for individuals to become QPs. However, that APM incentive payment amount will always be based on Part B professional services. So the services furnished under Medicare Advantage could contribute to becoming a QP, but the amount of that incentive is limited under the law to Part B payments.

Nicole Cooney: Thank you so much. Next caller, please, Ronni.

Operator: Your next comment comes from the line of Brenda Simms.

Brenda Simms: Yes, since this is Medicare Fee-for-Service, does that exclude providers who work at FQHCs and rural health centers?

Molly MacHarris: So on the MIPS and – so this is Molly, and I'll answer on the MIPS and then I'll turn it over to JP to answer on the Alternative Payment Model side. So for MIPS, so remember this is under services for the Physician Fee Schedule for Part B. So we understand that the majority of services that occur through the RHC or FQHC don't necessarily always fall under the Physician Fee Schedule. So in those instances, no, clinicians that work at an RHC or FQHC would not be eligible or able to participate in MIPS. But in the instances where a given clinician works at multiple offices, so let's say they work at an RHC but then they also work at another clinic, they would be eligible for MIPS for the service they do at the other clinic.

And then the last thing I'll note on the MIPS end, and then I'll let JP answer on the APM side, is that – so for the RHCs, FQHCs those – I'm sorry, I think I actually covered it all for MIPS. So I will turn it to JP. Sorry about that.

Dr. JP Sharp: OK. This is JP. So for APMs, so each individual APM has its own participation aspects to it. So, you know, many APMs, like ACO initiatives, can include FQHCs, RHCs, CAHs as well. However, for purposes of the incentive, again, FQHCs, RHCs can be part of that entity that we would look at. But when we're counting up whether or not someone gets to that QP status, we're only looking at Part B payments, and that's the same. So it's very similar to that Medicare Advantage question earlier where the incentive payment itself is also only based on Part B payments. However, that doesn't stop any overall participation by any of those entities in APMs themselves.

Nicole Cooney: Thank you. Next question.

Operator: Your next question comes from the line of Tammy LaBar-Hoffman.

Tammy LaBar-Hoffman: Hello?

Nicole Cooney: Hello.

Tammy LaBar-Hoffman: Hi. The reason I'm calling is I work for licensed clinical social workers. We are unable to currently meet the PQRS. I know, for the first 3 years, we're not on the NPI, but how do we work towards getting to the point where we can meet the standards so we can stop the reduction?

Molly MacHarris: Sure. This is Molly again, so as I – so, similar to one of the other questions from one of the other callers, so, as indicated on slide 12 of the presentation, the licensed clinical social workers—they're not eligible to participate in MIPS for the first 2 years. For the third and future years, so beginning in 2021, they could participate in the MIPS Program. We will clarify that through future rulemaking, but as I mentioned to the other caller, I do just want to clarify the licensed clinical social workers—they are still eligible, able to participate in PQRS.

Again, this is the last year of reporting under the PQRS program, calendar year 2016, for adjustments that would occur in 2018. So for you as a licensed clinical social worker – sorry, for the practice that you work for, they have the option to start engaging in MIPS early if they so choose to do so beginning in 2017. Or it's an option; you wouldn't have to do so. You could take a year or two off, and then, when you would become eligible in the future, then you would be subject to MIPS.

Nicole Cooney: Thank you.

Operator: Your next comment comes from the line of Karen Houchlei.

Karen Houchlei: Hi. This question's for Molly. Regarding the MIPS Program in Years 1 and 2, physician assistants are eligible clinicians as noted on slide 12. And my question is, on slide 28 where they're not eligible for the advancing care information performance category, do they end up taking a zero point for that, and then get 0 times 30 percent, so that becomes a goose egg for them in their total points?

Molly MacHarris: Sure. This is Molly. Great question. So, you're correct. So as you note on slide 12, so, physician assistants—they are overall eligible for MIPS. But then on slide 28, we do say that, within our proposal, the physician assistants would not be eligible for the advancing care information category.

So, there are those 25 points, and what do we do with them? So, what we have proposed is that those 25 points would be redistributed to the other categories. And that's actually a really important piece to note for MIPS. So, the composite performance score will always be based off of a 100-point threshold. So we wouldn't just take those 25 points away and kind of throw them to the side; rather, we'll take those 25 points and redistribute them to the quality resource use and clinical practice improvement activities categories. That's what we've proposed.

Karen Houchlei: Thank you.

Nicole Cooney: Thank you.

Operator: Your next comment comes from the line of Jeanne Chamberlin.

Jeanne Chamberlin: Hi. Yes, I have – this is about MIPS, so I guess it's for Molly. I have one question, one comment. My question is: How does this program MIPS apply to nonparticipating providers?

Molly MacHarris: Sure. So, it does apply to nonparticipating providers—that – the non-par status. Since you are still a Medicare-enrolled provider, you would still be eligible to participate in both the MIPS Program and the APM side of the Quality Payment Program as well.

Jeanne Chamberlin: So the payment adjustments, how are they applied then? Would they be shared with the patient's portion as well as Medicare's portion or…? Do you understand what I mean?

Nicole Cooney: Give us one second.

Jeanne Chamberlin: Sure.

Nicole Cooney: We'd like you to submit a formal comment. We're not able to answer that question at this time. And, again, the instructions to submit a formal comment are found on slide 8 of the presentation. Thank you.

Jeanne Chamberlin: OK, great. Thank you. Yes, just a really quick comment. This is all very, very complicated, as I'm sure you all are very aware of. What – just a thought for you all, what would be very helpful for people in understanding exactly how all these calculations are going to work would be, if you could maybe put together some scenarios and show us the actual calculations of the different scores for each of the categories of MIPS, and then how that's combined into the composite score, and then how that is converted into a payment adjustment.

Nicole Cooney: Thank you very much.

Jeanne Chamberlin: Because it's very hard to read it. Thank you.

Nicole Cooney: OK. Thank you for that comment. Next caller.

Operator: Yes, your next comment comes from the line of Paul Krause.

Dr. Paul Krause: Yes, hi. This is Dr. Krause representing Caravan Health in National Rural Accountable Care Consortium. And my question is about the Medical Home Models and wondering if you know if there's a cap on the number of participants that will be eligible to be in a certified or patient-centered medical home, and when we'll have more information from CMMI about the details?

Dr. JP Sharp: Hi, this is JP. So, I'll try to answer that one as best as I can. Let me know if I'm not quite getting there. So for the Medical Home Model, there is in the definition itself of what a Medical Home Model is. There is no proposed cap on the number of clinicians who are part of that medical home to be considered part of that definition. The cap that we do mention is for that Medical Home Model to have that unique financial risk criterion when we're determining whether or not it's an Advanced APM. So, we'll look at – or Advanced APM entity, rather. So, we'll do this kind of entity-by-entity look to see whether or not they can get to that advanced status. That's where we'll look at the overall number of people. But just to be labeled a Medical Home Model and the participating medical home in such model, there's no proposed cap for that. Does that get to your question?

Dr. Paul Krause: It does, yes. Thank you.

Nicole Cooney: Thank you. Ronni, I have time for one more caller.

Operator: OK. Your final comment comes from the line of Cynthia Morton.

Cynthia Morton: Hi. Thank you for the presentation today. My question is about the facilities that you mentioned – the nursing facilities you mentioned on slide 12. So if they're not eligible for MIPS, how will the Part B therapy services that they bill – receive the payment update, you know, 2019 and beyond?

Molly MacHarris: Sure. This is Molly. So let me try to address the question. If I don't completely, I would – regardless, I would suggest that you submit a formal comment, and the way to do that is indicated on slide 8.

So when we mentioned on slides 12 and 13 who's eligible and who's not eligible, and we say that MIPS doesn't apply to hospitals or facilities, we mean that the services and charges that are billed to Medicare specific to the hospital or facility—so services that are made under Part A—those are not MIPS-eligible services.

Cynthia Morton: Right. OK.

Molly MacHarris: But we do know that, you know, clinicians work at hospitals, clinicians work at facilities. And when they work there, they have services to their patients that are under the Physician Fee Schedule for Part B. And so those services are eligible for MIPS. And again, those would be eligible for the first year for physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists.

Cynthia Morton: OK. Even if those services are not billed through the clinician, they're not billed with an NPI, they actually go on an institutional claim through the nursing facility…?

Molly MacHarris: So for that piece, I would recommend that you go ahead and submit a comment so we can explore that and fully understand that in more detail. So I'd suggest that you submit a comment as detailed on slide 8. Thank you.

Additional Information

Nicole Cooney: Thank you. Unfortunately, we are out of time for today's call. We'll post an audio recording and written transcript on the MLN Connects Call website, and we'll release an announcement in the MLN Connects Provider eNews when these are available.

Again, my name is Nicole Cooney. And I'd like to thank our presenters and also thank you for participating in today's MLN Connects MACRA Listening Session on the Quality Payment Program Proposed Rule. Have a great day.

Operator: This does conclude today's call. Presenters, please hold.

-END-


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