MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Quality Payment Program Final Rule Call
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 listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements and Introduction

Nicole Cooney: Hi, 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 this MLN Connects Quality Payment Program Final Rule Call. MLN Connects Calls are part of the Medicare Learning Network®.

The Quality Payment Program allows clinicians to choose the best way to deliver quality care and participate in the program based on their practice size, specialty, location, or patient population. During today's call, we'll discuss the provisions in the recently-released final rule.

Before we begin, I'd like to tell everyone that – or remind everyone that today's call is via teleconference only. It's not a webinar. You should have received a link to the slide presentation for today's call in your registration emails. You can follow along with our speakers using this presentation. If you've not already done so, please view and download the presentation from the following URL – www.cms.gov/npc. Again, that's www.cms.gov/npc. Once you're on this page, find the date of today's call to access 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 I'd like to thank everyone who took the opportunity to submit questions when they registered for today's call. We took these questions into consideration as we developed today's presentation.

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

Presentation

Andrew Slavitt: Thanks, Nicole. And good afternoon to everybody.

Message from the CMS Acting Administrator

Welcome to our conversation this afternoon around the Quality Payment Program, which is, as Nicole mentioned, intended to be a conversation to talk about our progress together in advancing the Medicare program. And I just want to say at the outset that I know that any changes to a program as big and as important to all of you as Medicare represent challenges. And as a result of that, we are trying extra hard to have as many lines of communication open, both directly to us, to other people in your community, and many, many forms of getting questions answered. We have built a special location called qpp.cms.gov, which today, I think, answers probably, you know, truly 80 to 90 percent of the questions that most people have. That site is going to transform into being something that physicians and other clinicians will be able to use in a really convenient way to participate in the program.

The second thing we've really tried to do is make sure that people understand that our approach to what we're doing in the Quality Payment Program is intended to move the Medicare program in the right direction for the long term. So, we're not so focused on changes that happen immediately. And, I think, what you will find is that in the first year and even in the first several years of the program, there is actually a lessening, in most cases, of burden, an increase in flexibility and opportunities based on the way programs work today so that people can gradually adapt to any changes that occur.

But, high and above all is that we believe what we have heard from all of you is something that we are committed to, which is to make sure that this program is about patient care, not about measurement systems or payment systems or those approaches. And to that end, I think you will see as you get – as we go through the details, that while there's a lot of them, many of them are increasingly being worked into the background of the program, and many of them are intended to create more choices for you.

So in this call today, you're going to hear from our team as they talk about a couple of the basic options that exist in the Quality Payment Program. And, then, one of them is the program that's known as Alternative Payment Models or Advanced Alternative

Payment Models. What those are in plain English to me are different approaches, typically approaches that have been thought of by clinicians or physicians directly in communities that have been sent to us and we have built into a model. There are a number of those today, some that focus on primary care, some that focus on specialists, some that are especially designed for smaller practices, some that are especially designed for larger practices. And the MACRA law and the Quality Payment Program is really in — designed to allow physicians who think it is right for their practice and their patients to enter those programs.

The second approach is the approach that you will also hear about, which is – which people refer to as MIPS. And I think the way to think of MIPS, at least the way I think of it, is really just participating in the core part of the Medicare program, like you always have, and where the Medicare program will make adjustments to payments based upon the quality of care delivered based upon an assessment.

And that assessment – how that assessment's done is what you'll hear a little bit about in this call. But, by and large, two things. One, there have been specialty societies and other third parties that have defined a set of metrics. And, secondly, we built in a big part of this program where people create their own metrics with something called a Practice Improvement Initiative, where you essentially define what are the things that work well for your practice.

So, without oversimplifying things, those are the elements of the program that, I think, you will be hearing about today. I want to just talk about a couple of design features and then make one more comment and, then, I'll turn the call back over.

The first is – so, the question you might ask is, "Okay, CMS – Congress passes this law. How did you decide on how to put together the rules for it," which is an excellent question. And, I think, the principal thing that I want to leave you with is we did that with a lot of listening, a lot of communication, what we call user-driven design, which is just a fancy of saying we got into the field and heard a lot of feedback from people on what they were most concerned about. And what we heard, in the main, was people were increasingly worried about the burden that they were facing, of things that are distracting them way from patient care. Now, that's not something that I can tell you we can solve in a – in a moment. But, I can tell you it's something that really we related to

and felt like we could make a dent in over the long term and even with some big steps immediately.

So, some of the things we've done. We reduced the number of things being measured from the current programs that measure quality in half. Next, what we did was we created more flexibility and more paths, including how quickly people might adapt to the program and including the kinds of measures that people might want to use. In other words, if you see a measure that's not right for your practice, you don't have to use it. You can pick the ones that apply to your practice. And third is we exempted many, many of the practices who see small volumes or small dollar amounts of Medicare patients. Those are just – those are just some of the most important things. And, then, as I talked about, we create more and more paths for Advanced Alternative Payment Models, which was what I referred to a bit earlier at the beginning of the call.

So, with that, I think we are not done yet. We are eager to see how things are working in practice, which is why we've staggered things the way we have. It is also why we continue to have conversations like this and collect comments because I can assure you that the program will continue to adapt based upon what's working and what's not.

The final thing that I want to address is a question that I received from some quarters. "Andy, tell me what's different about things since the Presidential election last week." And it's a very good question. I think it's worth addressing. And my answer based upon everything that I know and see and I've heard from conversations is, there really is no change. And, I think – why do I think that? One is because this was legislation that passed with very strong bipartisan support. And if you 've been around Washington at all, you know that's pretty hard to come by. But, to give you a sense, 92 Senators voted in favor and 8 voted no. And in the House, 392 people voted in favor versus 37 that voted no. So, there's a real strong commitment to the program.

Also, because I think the law shares the aims that you all have expressed and many folks have expressed about the system working better, which is getting away from just paying for the services that are rendered towards a system that provides a little bit freedom like Medical Home Models do, where physicians can have more freedom and get paid more for the outcomes. Now, that's obviously a journey, and details will evolve over time, but that is an important path.

And, then, the final reason I'd say so is just my own perspective on the fiscal reality. So, let's remember that MACRA didn't just appear out of nowhere. MACRA replaced another program. Unless we all—not shorten our memories too much, that replaced something called the Sustainable Growth Rate or SGR. Now if that brought back kind of post-traumatic stress syndrome, it's because it should. It was a bad place for all of us. It was bad for physicians. It was bad for patients. It was certainly bad for us at CMS who every year had to consider really horrible payment cuts to keep the program fiscally operating and get rescued every year by Congress.

So, nobody wants to go back to that stage. And it's because of that that it's recognized that Medicare needs to be on strong fiscal standing. So, you know, yes, while there are lots of opportunities for upside here for physicians and improving their practice and there are also opportunities for some smaller, lower amounts of payment, it's really important to know that this is done in a way that Congress intends to be really strongly fiscally responsible. And, so, for all of those reasons, as well as, I think, dialogue that I've had with people on the Hill and otherwise, I want to make sure people take the opportunity to plow ahead and not use anything that happened in the election as a distraction.

So, anyway, with that, I'm going to hand the call back over to Nicole. I'm going to remind you of qpp.cms.gov as a place to go forward to get answers. And I look forward to continuing to see how things unfold.

Nicole?

Nicole Cooney: Thank you, Andy.

With that, we're going to jump right in to our presentation on the Merit-Based Incentive Payment System presented by medical officer Dr. Lemeneh Tefera. Dr. Tefera?

Introduction to the Merit-Based Incentive Payment System

Dr. Lemeneh Tefera: Thanks, Nicole. Good afternoon, everyone. I'll be starting on slide number 8, an Introduction to the Merit-Based Incentive Payment System, or MIPS.

Moving to slide 10, the MIPS Program replaces the existing program that you are already familiar with, the Physician Quality Reporting System, the Physician-Based Value

Modifier Program, and the Electronic Health Record, also called the Meaning Use Program. These three existing programs will be phased out at the end of 2018. And components of each of those programs will be included in the new Merit-Based Incentive Payment System that was authorized by the MACRA legislation.

Looking at slide 11. What is MIPS? So, MIPS has four performance categories – Quality, Cost, Improvement Activities, and Advancing Care Information. MIPS will be focused on Part B clinicians. And the aim of MIPS, as our Acting Administrator mentioned, is to provide much more flexibility in the choice of activities and measures that are most meaningful to clinicians' practices. The Quality performance category will be built on infrastructure from the Physician Quality Reporting System. The Cost performance category will be built on infrastructure from the Value-Based Physician Value Modifier Program. Improvement Activities is a new category that will be helping clinicians improve the practice with a focus on the experience of not only beneficiaries but also improving their experience in their practice, how much time they can spend with their patients, and finding efficiencies. Advancing Care Information will be built on the Meaningful Use/Electronic Health Record Program.

Slide 12 gives an overview of the reporting requirements. The performance year will be 2017. Data submitted will be accepted until the end of March of 2018. Subsequent to that, there'll be feedback available. And the first payment adjustment for the MIPS Program will start in 2019.

Slide 13. Who will be participating in the MIPS Program? Slide 14 describes the clinicians that are called out in the MACRA legislation that will be participating in MIPS from the beginning. These include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists. It's important to note that a physician in the statute has an expansive definition per Medicare regulations.

So, if all these types of physicians and professionals will be participating, it is also important to know who will not be participating. And looking at slide number 16, we see the exclusions that are called out in the statute, including those professionals and clinicians that are newly enrolled in Medicare, those below the low-volume threshold that Andy mentioned – so, Medicare Part B charges less than $30,000 a year or seeing fewer than 100 beneficiaries in that same year. The other group of exclusions are for

clinicians who qualify for Advanced Alternative Payment Models and meet requirements to be qualified participants in those Advanced Alternative Payment Models.

Slide 17 walks us through a scenario asking, "Will I be excluded or not?" And what I'd like to emphasize here is simply that the final rule emphasizes an "or." If you bill less than $30,000 for the performance year or you see fewer than 100 beneficiaries, you will be exempt from the MIPS Program.

Slide 18 touches on non-patient facing clinicians. And there are some details there to note. I'd like to call out that in the rule, we say that for a group, if the group is to be identified as non-patient facing, that they must have greater than 75 percent of the NPIs billing for that group within the non-patient facing category. Otherwise, non-patient facing clinicians should consider themselves as participating in MIPS unless they meet the same exemptions that I just reviewed.

Moving to slide 20. I'd like to build upon what Administrator Slavitt was calling out as our "pick your pace for participation" for the Quality Payment Program. We developed the final rule to allow as much flexibility as possible for clinicians to either ease into program, begin the program with a more robust participation, or try to have near-complete participation. And slide 20 describes three scenarios. One is called the test pace; the second, partial reporting; and the third, full reporting.

Slide 20 describes what is possible of the test pace. And the short of it is that if a clinician submits information for the Quality Measure performance category – so, even a single measure – that they will not be subject to the maximum penalty in the MIPS program. That is also true if they submit a single improvement activity or if they submit the base requirements of the Advancing Care Information performance category. Clinicians have choices identifying what works best for their practice, and they can choose to report the minimum amount of data to be held harmless for the first year. And that is under the category of "testing the waters" of the Quality Payment Program.

Slide 21 describes more participation. So, if clinicians want to participate more, they may do so. And many clinicians, because they are already participating in the current Physician Quality Reporting System and are successful and are accustomed to reporting, will likely choose this option. It has a minimum requirement of 90 consecutive days of reporting for 2017. And based on those measures reported for the Quality Measure

performance category and how they're reporting performance compared to other clinicians reporting, they'll be able to have a higher score than if they had only reported the minimum requirements that I described a moment ago.

Slide 21 – excuse me, slide 22 describes full participation. And, again, this is what many clinicians and certainly many large groups are accustomed to. And this involves reporting quality measures, participating in the Advancing Care Information category and also successfully participating in the new Improvement Activities category. We think that there'll be many clinicians and groups who choose this option because they are already currently aware of the programs and they see the opportunities to continue to successfully report and earn a higher positive adjustment thanks to their reporting and based on their performance of their measures.

Moving on to slide 25. As is already known to most participants in existing quality programs, clinicians can either participate as individuals or they can participate as a group. And that flexibility exists for the Quality Payment Program. So, the choices that clinicians make for the Quality Payment Program will likely track to their preferences in existing programs. And they will continue to have that option in future years.

Slide 27 discusses the weighting of the performance categories. As I mentioned prior, there will be four performance categories in the MIPS Program. The Quality performance category will have the highest weight at 60 percent. For the transition year, the Cost performance category will be at 0 percent. So, although clinicians will receive feedback on the measures that are in the Cost performance category which are claims-based, those – their performance in this category will not impact their MIPS composite performance score. The Improvement Activities category is weighted at 15 percent, and Advancing Care Information is weighted at 25 percent.

Slide 28 gives an overview of the Quality performance category and describes some of the highlights, including that the expectation is reporting at least six measures out of the many options for a minimum of 90 days and that one of these measures must be an outcome measure or a high-priority measure. We also like to call out that we have specialty set measures where if you complete the measure set for your specialty, even if there are less than the six, then you'll have successfully completed the Quality performance category.

As I mentioned a little while ago, slide 29 reviews the Cost performance category. There's no reporting requirement for Cost, that that category is all claims-based. And in the transition year, this category is zero-weighted. And the intended 10 percent of this category was transferred to the Quality performance category, which you noted was 60 percent for the transition year.

Slide 30 describes the new Improvement Activities performance category. This was created by the statute and was not built on an existing program. And it's focused on improving the clinical practice for clinicians and improving the clinical experience for beneficiaries. There are multiple subcategories in the Improvement Activities performance category. And there are more than 90 activities covering a range of topics, including expanded practice access, beneficiary engagement, care coordination, and patient safety and practice assessment.

It's important to note that participation in the Alternative Payment Model will result in successful completion of the Improvement Activities performance category for the transition year.

Slide 31 describes special considerations for scoring in the Improvement Activities. This includes special consideration for practices with fewer clinicians who will have a lower threshold to be successful in Improvement Activities. Also, special consideration for rural clinicians and non-patient facing clinicians. Clinicians in the Alternative Payment Model will have a minimum 50 percent score, but could be higher, and those in a certified medical home will get a full score. And there are more details of this on our QPP homepage.

Slide 32 describes the Advancing Care Information performance category. This is built on the infrastructure of the Electronic Health Record Incentive Program, which is often referred to as Meaningful Use. And the way to look at this performance category is really providing as much flexibility for clinicians who had EHR certified for the 2015 edition or the 2014 edition. Regardless of which edition clinicians have, there's an opportunity to successfully report. The two measure sets for reporting are described on slide 32 as Advancing Care Information objectives and measures. And the alternative is Advancing Care Information transition objectives and measures.

And what slide 33 describes is whether you have 2014 or 2015 edition EHR certification, you can successfully report. If you have a mixture for your practice, you can combine your reporting to also be successful.

Slide 34 reviews the weighting for the Advancing Care Information performance category, which will be 25 percent. If they are clinicians who are hospital-based, that weighting will be zeroed. If they are clinicians with various hardships related to EHR—Electronic Health Record implementation—those clinicians will be able to submit for a hardship waiver so they can also receive a zero weighting.

Let's see. If we can go to – just skipping some slides here.

Slide 45 discusses the transition year, which will start in January of 2017. And this transition year is the year that encompasses really the important components of the pick your pace options that I described earlier. What I'd like to point out from this overview of the scoring for the transition year is that the only way a clinician will receive the maximum negative payment adjustment, which is minus 4 percent for payment year 2019 and performance year 2017, is by choosing to do nothing. So, as long as clinicians choose to participate and test the waters, as described, by even submitting a single quality measure, a single improvement activity, or the base requirements for Advancing Care Information, they will avoid that maximum negative payment adjustment.

Those clinicians who choose to submit more robust information because they already have experience with existing programs and see that our reporting requirements for MIPS will be built on this and that they can be successful in MIPS building on their current experience will have the opportunity to have a slightly positive adjustment. And those clinicians who have extensive experience in quality reporting and larger groups who have large infrastructure for quality reporting will look for an opportunity to do a full year's worth of reporting and report for all the performance categories and try to perform well to achieve a moderate or higher payment adjustment in 2019. But, the take home is, if you participate even a little bit, you'll avoid the maximum payment adjustment. And there'll be an opportunity to learn about this program and build a foundation for improvement in the second year.

Slide 46 describes the payment adjustment for exceptional performers, that the statute allows for $500 million over 6 years for clinicians who achieve a performance threshold

of exceptional performance. And the aim here is to drive quality improvement above just the more traditional performance threshold and have clinicians and groups who've already been successful at achieving that threshold have a reason to work harder and strive towards opportunities for higher payment.

Slide 47 reviews a lot of what I talked about. It's the summary slide. Again, we're streamlining the existing Quality Reporting programs into one program that is more flexible and more responsive to clinician preferences. The MIPS Program focuses on Part B clinicians and is performance-based. The four performance categories are Quality, Cost, Improvement Activities, and Advancing Care Information. And based on the reporting and performance in these performance categories, there will be a final score calculated. And that final score will help determine the adjustments that will be paid to the clinicians.

Slide 48 is our transition slide to discuss Advanced Alternative Payment Models. And I will turn it back to Nicole.

Keypad Polling

Nicole Cooney: Thank you. At this time, we'll pause for a few minutes to complete keypad polling. Holley, we're ready to start 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 one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Again, please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

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

Nicole Cooney: Thanks, Holley.

Next, Alison Falb, Health Insurance Specialist, will cover the Advanced Alternative Payment Models.

Alison?

Presentation Continued

Alison Falb: Thank you. I'm going to be starting on slide 50.

Introduction to Advanced Alternative Payment Models

What is an Alternative Payment Model? Alternative Payment Models, or APMs, are new approaches—payment models to paying for medical care through Medicare that incentivize quality and value. APMs are developed in partnership with the clinician community and offer added incentives to clinicians to provide high quality and cost-efficient care. The CMS Innovation Center developed new payment and service delivery models in accordance with the requirements of the Social Security Act. Additionally, Congress has defined both through the Affordable Care Act and previous legislation a number of specific demonstrations to be conducted by CMS.

The specific definition of APM under the Quality Payment Program includes, first, CMS Innovation Center models other than the Health Care Innovation Award; the Medicare Shared Savings Program, or MSSP; a demonstration under the Health Care Quality Demonstration Program; or demonstration required by Federal law.

Looking at slide 52. I will note that there's a subset of Alternative Payment Models, called Advanced APMs, that we will be focusing on as a track for participation under the Quality Payment Program during this presentation. What are the benefits of participating in an Advanced APM? First, you get APM-specific rewards. The way that Alternative Payment Models are constructed, there may be reward for participation that are a part of that model's design. In addition, clinicians may have the opportunity

through this participation to receive a 5-percent lump sum incentive payment and to be exempted from MIPS reporting and a MIPS adjustment.

Going to slide 53. I will get into additional detail about those incentives. For payment years 2019 through 2024, clinicians who meet the requirements to be what's called a Qualifying APM Participant, or QP, are excluded from MIPS adjustments and receive a 5-percent lump sum incentive payment for their Part B professional services furnished during the calendar year immediately prior to the payment year for payment years 2019 through 2024.

That was a little quick. I will be re-visiting that a little more clearly in a later slide. Please bear in mind that there's not an explicit incentive in 2025. The qualifying APM participants would be excluded from MIPS reporting requirements and payment adjustments and would, as always, have the potential for rewards under the Advanced APM in which they participate.

For payment years 2026 and later, an eligible clinician who's a qualifying APM participant is excluded from MIPS reporting requirements and payment adjustments each year and, in addition, will receive a higher Physician Fee Schedule update than those clinicians who are not qualifying APM participants. The Physician Fee Schedule update following beginning in 2026 will be .75-percent annual updates for QPs and .25 -percent annual updates for those eligible clinicians who are not QPs. I will talk more about what it means to be a qualifying APM participant shortly.

Looking at slide 54. This is a nice slide that sort of reflects what we've discussed so far. On the left hand, you'll see that if you're not in an Alternative Payment Model at all, you will have MIPS adjustments associated with your performance under MIPS. If you're in an Alternative Payment Model but not in an Advanced APM, you'll still be participating in MIPS. However, you get additional APM-specific incentives based on the design of that model. There's also a special APM scoring standard for certain APMs that helps clinicians seamlessly transition between MIPS and APMs to make sure that they're not duplicating any of their reporting. Finally, on the right side, when we're talking about Advanced APMs, that's where you would be excluded from MIPS, get the APM-specific rewards and the 5-percent lump sum bonus if you're a qualifying APM participant.

Criteria for Advanced Alternative Payment Models

Slide 55. Now, I'm going to talk about the criteria set forth in the MACRA statute for what makes an APM an Advanced APM. These are the criteria where we look at the design or the structure of the model of itself and then would determine that to be an Advanced APM.

On slide 56. To be an Advanced APM, the following three requirements must be met. Number 1, the APM requires participants to use certified EHR technology. Number 2, the APM provides payment for covered professional services based on quality measures comparable to those used in the MIPS Quality performance category and either is a Medical Home Model expanded under CMS Innovation Center authority or requires participant to bear more than nominal amount of financial risk. Be aware that the final rule updated the risk requirement for an Advanced APM so that it can be defined in terms of either total Medicare expenditures or participating organizations' Medicare revenue, which may be significantly lower for small practices.

Slide 57. The first criterion is that the APM entity requires at least 50 percent of its eligible clinicians to use certified EHR technology. Remember, we want to make sure physicians can move in and out of APMs seamlessly without having to run into issues about having different types of technology requirements. So when I am talking about certified EHR technology here, it means the same as the Advancing Care Information context. So the certified EHR technology is the same.

For the Shared Savings Program only, the standard is that the APM may apply a penalty or reward to APM entities based on the degree of certified EHR technology use among eligible clinicians. This fits within its existing structure so that certified EHR technology use actually factors into the amount of shared savings or losses that ACOs can receive under SSP. That element of SSP would meet this requirement. So, SSP requires that clinicians report at the group TIN level according to MIPS rules for this criterion.

Slide 58. The second criterion is MIPS-comparable quality measures. An Advanced APM must base payment on quality measures that are comparable to those under MIPS Quality performance measures. There must be at least one outcome measure under the Advanced APM unless there is not an appropriate outcome measure at the time the Advanced APM is developed under MIPS. So you're probably wondering what does comparable means? Comparable means any actual MIPS measures or other measures

that are evidence-based, reliable, and valid. Examples would include quality measures that are endorsed by a consensus-based entity, quality measures submitted in response to the MIPS call for quality measures, or any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.

Slide 59. The third criterion requires APM entities. An APM entity is the participant in the APM. So, for example, an ACO would be the APM entity. The third criterion requires that they bear more than nominal financial risk. On the left in the box is what kind of arrangements would be considered risk. These arrangements include withholding payment, reduction in payment rates, or direct payments from the APM entity. If we meet that financial risk standard, then we will get total risk. The total risk must be equal to at least 8 percent of average estimated revenues or 3 percent of the expense – of expected expenditures. And I will note that we will be making clear which of our Alternative Payment Models meet these thresholds and can walk through those calculations to specific models in reference to their design.

There are also a few points related specifically to medical homes. The first is that this whole criterion is – the entire third criterion is completely met if the Alternative Payment Model is a Medical Home Model expanded under CMS Innovation Center authority. Currently, we do not have any model that meets that part of the criterion. Second, we recognize that pre-expansion Medical Home Models and participants are unique. So there are slightly different standard for those particular Medical Home Models, which we will cover in the next slide.

So, on slide 60. I'll go back over this concept – the more than nominal financial risk with respect to Medical Home Models, specifically. You'll notice that the first three arrangements on the left side of this slide are the exact same as the general financial risk standard. But then we added a fourth one specifically for the Medical Home Model. What this states is that there are some expected or regular payment under the APM that could be reduced or eliminated based on performance.

The Medical Home Model nominal risks standard is based on Parts A and B revenue of the APM entity. These are APM entity-specific determinations. This acknowledges that smaller practices are participating in Medical Home Models and scales it to look at particular revenue of the participants in the model.

Slide 61 outlines for the 2017 performance year which models have been determined to be Advanced APMs. That's the Comprehensive End-Stage Renal Disease Care Model Two-Sided Risk Arrangement, CPC+, SSP Tracks 2 and 3, the Next-Generation ACO Model, and the Oncology Care Model Two-Sided Risk Arrangement. We will continue to update this list as new models are announced in the future.

On slide 62. The initial list that we just looked at is expected to grow over the coming years. And CMS anticipates that these following models would qualify as Advanced APMs in future performance years: CJR, a New Voluntary Bundled Payment Model, Advancing Care Coordination through Episode Payment Model, the Vermont Medicare ACO Initiative, and ACO Track 1+.

Qualifying APM Participant

Slide 63. What is a qualifying APM participant?

Looking on slide 64. How does an eligible clinician become a qualifying APM participant, or QP? To do so, the clinician — it's not sufficient to be in an Advanced APM. You also have to have a certain percentage of your patients or payments through that Advanced APM. And beginning in 2021, this threshold percentage may be reached through the combination of Medicare and other non-Medicare payer arrangements such as private payers and Medicaid. These payment models must meet certain requirements that are similar to requirements to be an Advanced APM under Medicare. This is formally known as the combination of All Payer and Medicare threshold option to qualify as a QP.

Slide 65. Walking through how we go from an eligible clinician to a QP is what I'll do in the next couple of slides. The period of assessment to determine which eligible clinicians are QPs is the same as the MIPS performance period. It's a full calendar year 2 years prior to the payment year. For example, 2017 is the performance period for 2019 payment.

Step one is determining QPs at the Advanced APM entity level. What that means is we will take all eligible clinicians participating in an Advanced APM entity, such as an ACO or a PGP, and assess them together. All of their performance during that year will be aggregated, and the full group will either become or not become QPs as a unit. There are two exceptions to this rule. First, individuals who participate in multiple Advanced APMs – if none of those Advanced APM entities that they're participating in meet the

QP threshold as a group, we will look at eligible clinicians on an individual level. The second exception is eligible clinicians on an Affiliated Practitioner List – so, different than the participation list – when that list is used for the QP determination because there are no eligible clinicians on a participation list. For example, this second exception would apply to a model like CJR where participants are hospitals that don't have eligible clinicians on the list but they would have a list of affiliated practitioners who collaborate with the hospitals for participation under the model.

Looking at slide 66. The second step. So, in step 1, we determined who's the group, how we're looking at them together. Step 2 is calculating a threshold score for each Advanced APM entity. We will use two methods for calculating that threshold score—the payment amount and the patient count. Those are both based on attribution under the design of the particular APM. The general idea is that the numerator is looking at beneficiaries who are attributed to that APM entity through whatever terms that APM uses to do attribution. The denominator will be attribution eligible—so all beneficiaries who could potentially be in that numerator.

Slide 67. This slide shows the two different methods that we'll use. We'll calculate a threshold score under both of these for each APM entity and take the one that results in a more favorable QP status. On the left, we have the payment amount – payment amount method, which is all of the dollars for Part B professional services in the numerator that are attributed to beneficiaries and the same types of services to attribution-eligible beneficiaries in the denominator. On the right, you have the patient count method, which is similar, but we're actually counting the number of unique people. This is calculated by taking the number of attributed beneficiaries divided by the number of attribution-eligible beneficiaries.

Slide 68. The third step is taking the threshold score and comparing those to the thresholds themselves. If the threshold score for the APM entity is above the relevant threshold that is displayed in this table, then the APM entity—so, all of the eligible clinicians within that entity—would meet QP status. You will notice that the thresholds are different based on year and also that the thresholds are higher for the percentage of payments versus the percentage of patients.

Slide 69. As I've described, all eligible clinicians in the Advanced APM entity would become QPs for the payment year if they meet that threshold. That means for those on

the right, if threshold scores are above the QP threshold, all eligible clinicians associated with that APM entity become QPs for that payment year. Whereas on the left, if their threshold scores are below that threshold, then none become QPs for that payment year. And what that would mean is that if none of them become QPs, with one exception that I'll go over in a later slide, they would need to report to MIPS and receive a MIPS adjustment.

Slide 70. The qualifying APM participant performance period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for the payment year. So this is the period of time that we're looking at where we're going to run calculations under the payment amount of patient count methods to determine if those clinicians are QPs. The QP performance period for each payment year will be January 1st through August 31st of the year that is 2 years prior to the payment year. So, for example, the first QP performance period will be from January 1st, 2017, through August 31st, 2017, for the 2019 payment year.

I'm going to skip to slide 72, which demonstrates visually when calculations will be made. Reaching the QP threshold at any one of the three snapshots will result in QP status for the eligible clinicians in the Advanced APM entity. Eligible clinicians will be notified of their QP status after each QP determination is complete, which is illustrated as Point D in this slide.

Slide 73. If clinicians do not meet the QP threshold but meet a lower threshold within this table, they may become what's called a partial QP. Partial QPs do not receive the 5-percent APM incentive payment, but they are able to choose whether to participate in MIPS. If they opt in to MIPS, they receive a MIPS final score and a MIPS payment adjustment. If they meet – if they opt out of MIPS, they are exempt from MIPS reporting requirements and payment adjustments. And any eligible clinicians participating in Advanced APMs that don't meet the QP threshold or the partial QP threshold will need to report to MIPS.

Next, beginning on slide 75, I will talk about the APM Scoring Standard. Certain Alternative Payment Models include MIPS-eligible clinicians as participants. And they hold their participants accountable for the cost and quality of care provided to a Medicare beneficiary. This type of APM is called a MIPS APM. And participants in MIPS APMs receive special MIPS scoring under what's called the APM Scoring Standard. Our

goal is to reduce eligible clinician reporting burden by streamlining MIPS reporting and scoring using APM-related performance to the extent that we can.

On slide 76. What are the requirement for an APM to be considered a MIPS APM? The APM has to meet these three criteria. First, APM entities participate in the APM under an agreement with CMS. Second, the APM entities include one or more MIPS-eligible clinicians on a participation list. And, finally, the APM bases payment incentives on performance on cost utilization and quality.

Slide 77. To be considered part of the APM entity for the APM Scoring Standard, an eligible clinician must be on an APM participation list on at least one of the following three snapshots dates of the performance period. If they aren't on an APM participation list during one of these three snapshot dates, they must report to MIPS under the standard MIPS method – so, not under the APM Scoring Standard.

Looking at slide 78. For the 2017 performance year, these are the models that are considered MIPS APMs – CEC; CPC+; MSSP Tracks 1, 2, and 3; Next-Generation ACO Model; and Oncology Care Model (All Arrangements). This list is posted on qpp.cms.gov. We'll be updating it on an ad hoc basis.

Small/Rural Practices and Health Professional Shortage Areas

So, slide 80 – turning on to 81. What is being done for small and rural practices and heath professional shortage areas? If you look at this slide, we have a couple of responses to concerns that we've heard based on the requirements on how small or rural practices will be able to succeed in the Quality Payment Program. This is something that we've paid a lot of attention to and have a lot of focus on.

So, where can you go to learn more? Slide 83. We have the Transforming Clinical Practice Initiative, QCPI, as a resource; the Quality Innovation Network Quality Improvement Organizations. And if you are in an APM, the Innovation Center's Learning Systems can help you find specialized information about what you need to do.

And slide 84. To remind you that this was a final rule with comments. So, if you do have comments that you want to submit, we have the information here. And broadly, I would encourage you to look at qpp.cms.gov not only to submit comments but for additional

information and resources. At this point, I will turn it over to Nicole Cooney, and we will do some Q&A.

Question-and-Answer Session

Nicole Cooney: Thanks, Alison.

Our experts are now ready to take your questions. Before we begin, I'd like to remind you that this call is being recorded and transcribed. We have a lot of folks on the line with us today. In an effort to get to as many questions as possible, we ask that you limit your questions to just one. And we can address additional questions as time permits.

All right. Holley, we're ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And our first question will come from the line of DeeAnne McCallin.

DeeAnne McCallin: Hi.

Nicole Cooney: Hi.

DeeAnne McCallin: I'm, calling to see about the status of the direct technical assistance and if it's potentially slowed down because of the 2017 Pick Your Pace or is it anticipated to be rolled out shortly?

Nicole Cooney: Give us one second.

Dr. Kate Goodrich: Hi. This is Kate Goodrich for CMS. Thanks for the question. Just to be sure I understand, you're asking if there's going to be any slowdown in the availability and implementation of the technical assistance such as the TCPI and the technical assistance for small practices because of the Pick Your Pace Program. Is that correct?

DeeAnne McCallin: Yes. So, folks are looking for direct technical assistance and the awards have not been made, and it's difficult to respond whether it's available, if it's coming soon.

Kate Goodrich: Sure. So, much of the technical assistance is already available. So, there's technical assistance available from the Quality Improvement Networks that is primarily focused on larger practices, practices of 15 or more. There's the Transforming Clinical Practice Initiative, which has a goal of reaching 140,000 clinicians. That is primarily focused on practices that are ready to begin the transformation to Alternative Payment Models. I think what you're referring to probably is the technical assistance that will be available for small and rural practices and practices in health professional shortage areas. That is on track to be available starting probably early 2017. There's nothing about the Pick Your Pace Program that would slow that down. So, we're definitely on track for that. So, there will be more information coming to the qpp.cms.gov website in the very near future about that.

Nicole Cooney: Thank you so much for your question. Next question.

Operator: And your next question will come from the line of Judith Shubow.

Nicole Cooney: Hi, Judith. What's your question?

Operator: That question has been withdrawn. Your next question comes from the line of Kim Sweet.

Kim Sweet: Hello. Can you hear me?

Nicole Cooney: Yes.

Kim Sweet: Yes. Hi. Slide 45 has a wonderful chart—I really like this chart—for the transition year for the possibility of getting your positive adjustments of over 70 points and so on. My question is, where – do we have a breakdown of where those points are coming from? I know that the Quality Program is worth 60 points. I was wondering, is there a breakdown yet of each category, what those possible points will be? And if so, where can I find that?

Dr. Lemeneh Tefera: Thanks for your question. This is Lemeneh Tefera. So, just to clarify the difference between the points and the percentages for the performance categories. In previous slides, you'll see that the Quality performance category is weighted at 60 percent. The Cost performance category is weighted at 0 percent. The Improvement Activities performance category is weighted at 15 percent – 1-5. And the Advancing Care Information performance category is weighted at 25 percent.

Kim Sweet: Correct.

Dr. Lemeneh Tefera: So, that is how the categories are weighted. The difference here, transitioning to points, is talking about how the combination of performance in those particular categories will provide the clinician an opportunity to receive a positive or negative payment adjustment. Starting at the top, you know, clinicians who achieve the highest scores above the 70 are those that will be eligible for the exceptional performance. The large band in between is where we think the majority of clinicians will fall, between 4 and 69 points. And the lowest two bands are really for clinicians who opt out and don't participate or who minimally participate. And, you know, where clinicians land in those different bands will determine – will be determined by whether they decide, based on their particular practice, if they are going to just test the waters in the transition year or provide more robust reporting with at least 90 consecutive days or try for a full reporting year for all the different performance categories. Thank you for the question.

Kim Sweet: But, that didn't answer my question. That was – I completely understand that. I just don't know what makes up those.

Dr. Lemeneh Tefera: What makes up those particular points is the particular metrics that are chosen. So, depending on how many measures, for example, are chosen in the Quality performance category, that will determine, you know, how many points they will get in the Quality performance category. And that will extrapolate to the total number of points for what you're seeing in this transition year table.

Nicole Cooney: Thank you so much. Next question, please, Holley.

Operator: Our next question will come from the line of Jason Shropshire.

Jason Shropshire: Hi. Can you hear me?

Nicole Cooney: Yes.

Jason Shropshire: So, I have – I'm having difficulty finding the answer to this question. I've emailed a couple of contacts – QPP and various other entities and haven't received a response. So, my question is specific to Advanced APMs, specifically Next-Gen. When will we know the exact measures that make up the 2017 quality component for Next-Gen? I know in 2016 it was comprised of GPRO Web Interface and claims measures and CAHPS® measures. Is that going to be exactly the same for 2017? And, if so, when and where will that list be published?

Patrice Holtz: Hi. Yes. This is Patrice Holtz. So, for the Next-Generation ACOs, under the MIPS APM Scoring Standard, the measures that they will be scored in for MIPS will be the Web Interface measures only. So, any measure that's submitted via the Web Interface will count towards the MIPS APM quality score.

Jason Shropshire: But, what about the non-MIPS, just the actual ACO score? What counts for that?

Patrice Holtz: Oh, I'm sorry. We don't have our Next-Generation ACO staff with us today. So, that would be a question that should go directly to the program.

Jason Shropshire: Okay. So, I've sent the question and have not gotten a response in 2 weeks. Should I just send it again?

Patrice Holtz: Yes, please do. We'll notify them as well.

Jason Shropshire: Okay. Thank you.

Operator: And our next question will come from the line of Lisa Gall.

Lisa Gall: Hi. Thank you for taking my call. I have a question regarding slide 34. And if, for Advancing Care Information, if objectives are not applicable to a clinician, it says that CMS will reweight the category to zero and assign the 25 percent to the other performance categories. Can you tell me where those and how that's weighted out and

where it's weighted out to? And assuming to Quality and to Advancing – I mean Improvement Activities – but, how does that get separated out? What – where does the 25 percent go? Just to Quality?

Elizabeth Holland: So, the score – the 25-percent Advancing Care Information would be zero and, then, all that 25 would move to the Quality category.

Lisa Gall: So, it does move to Quality. Thank you.

Elizabeth Holland: Correct.

Operator: And our next question will come from the line of Dr. Deborah Tracy.

Deborah Tracy: Yes. Good afternoon. Thank you. I have a question regarding the Quality category on slide 20. You say to avoid the downward adjustment, you need one Quality measure. Is that one Quality measure on one patient or one quality measure on the performance period? And later – that's not on a slide – you said that you would allow measure set reporting. So, I would imagine you're referring to the group measures that we used to report. And last year, we can only report those through a registry and it was 20 patients. So, would that be the same as well? Thank you.

Dr. Lemeneh Tefera: Thanks for your question. This is Lemeneh Tefera again. So, on slide 20, what that's trying to describe is that, if you do report a single measure even for a single patient and you successfully report that, it's possible to meet the minimum requirement and avoid the maximum negative adjustment. Obviously, based on your question, it sounds like you've had previous experience reporting. So, the other two options are probably, you know, more attractive to be more successful in the transition year and the QPP Program overall.

Your second question regarding the combined reporting, in the final rule, there are specialty set – measure sets that are described. And if clinicians or groups report those specialty measure sets, then they can achieve the highest score for the Quality performance category. And those are different from the specialty sets that you described. So, the final rules describes quality measures – specialty sets that will satisfy maximum performance in the Quality performance category.

Thank you again for your question.

Operator: And our next question will come from the line of Bonita Shok.

Nicole Cooney: Hello. Do you have a question?

Bonita Shok: Hello. Thank you. Yes, I do. I'm looking at slide 77, the key dates for the APM Scoring Standard. We're a part of a MIPS APM, an MSSP Track 1, and we are required to send in our provider list every year in December, and then we are required to send in updates when a new provider joins us. And we need to do that within 30 days of his or her onboarding. But, I understand from this that if we have a provider join us, say, September 1st, that provider will not be considered part of our ACO and has to separately report MIPS to avoid the adjustment?

Patrice Holtz: That is correct. So, for the 2017 performance year reporting in 2018, the participants has to be a participant of the ACO at least during one of those three snapshot dates. So, for example, if you're in the ACO on March 31st but you choose to leave the ACO later in the year, you're still counted as being under the APM Scoring Standard. But, if you don't join the ACO until later in the year, you would not be counted under the MIPS APM Scoring Standard, and you would be responsible for reporting on your own either as an individual or through another group under MIPS requirements.

Bonita Shok: Thank you.

Operator: And our next question will come from the line of Julia Kyles.

Julia Kyles: Hi. Thanks for taking my question. When and where will CMS post the Quality measure specification for 2017?

Dr. Lemeneh Tefera: Hi. This is Lemeneh Tefera again. So, you 've likely seen our website already that's given – giving an introduction to how the shopping cart works for ...

Julia Kyles: Correct.

Dr. Lemeneh Tefera: ... viewing various measures. So, we're working on developing an online portal that will take folks directly from that site to the specifications for the

individual measures. That's in process. And when that is available and ready, we will announce it.

Julia Kyles: Okay. Quick follow up. Will you also still be releasing that document that shows everything that changed for the different measures?

Dr. Lemeneh Tefera: I'm not sure which document you're referring to. But, the measure specification detail that will be released will be comprehensive. And if you've received them in the past, I'd suspect they will be in the same format as you're accustomed to.

Julia Kyles: Brilliant. Thank you.

Operator: And our next question will come from the line of Marie Harris.

Nicole Cooney: Hello. Did you have a question?

Marie Harris: Can you hear me?

Nicole Cooney: Yes.

Marie Harris: Hello? Okay, great. I'm wondering – we have a few of our providers that are not on the EHR and are still using paper. Are they able to participate in MIPS? And if so, in which of the four capacities?

Dr. Lemeneh Tefera: Hi. This is Lemeneh Tefera again. So, again, there are multiple opportunities to participate in the Quality Payment Program. There are four performance categories, of which you've mentioned one. And in the transition year, to be successful and avoid the negative penalty, reporting in the Quality performance category or the Improvement Activities performance category would help the clinicians you describe be successful for the transition year.

In regards to their reporting practice, it sounds like these clinicians may have difficulty with certified EHR technology and would benefit from the technical assistance that we've previously discussed and would be able to better prepare themselves for Year 2 and onward.

So, yes, they can be successful in the transition year. But, they will need to look for opportunities to improve their electronic heath records for Year 2 and onward.

Marie Harris: So, would they report – would we report via claims like we would with PQRS?

Dr. Lemeneh Tefera: Yes. So, for quality measures, yes. You can also report by claims if that particular quality measure has that option available.

Marie Harris: Okay. All right. Thank you.

Operator: And our next question comes from the line of Dr. Sean Kuamtan.

Okay. Our next question will come from the line of Lou Ann Gaggi.

Lou Ann Gaggi: Hi. Thank you. This is a question that I have not had addressed. It's how does this affect locum tenens in your practice?

Dr. Lemeneh Tefera: So, this is Lemeneh Tefera again. I think, the way to view who is impacted by the Quality Payment Program is that all clinicians who participate in Part B Medicare need to participate in the MIPS Program unless they have an exemption. And those exemptions are seeing very few Medicare beneficiaries, less than 100; charging very little on Medicare, which is less than $30,000; or being a qualified participant in an Advanced Alternative Payment Model. If the clinician does not have one of those exemptions, regardless of their specialty or how often their practice, locums or otherwise, the expectation is that they will need to participate in the MIPS Program.

Lou Ann Gaggi: Even if reassigning the benefits to the physician that they're working under?

Dr. Lemeneh Tefera: Yes.

Lou Ann Gaggi: Okay. Thank you.

Operator: Okay. And our next question will come from the line of Vicky Sorecki.

Vicky Sorecki: Hi. Hello?

Nicole Cooney: Hi. Did you have a question?

Vicky Sorecki: Yes. So, I had sat in on another QPP webinar a few weeks ago. And they said that to qualify for the full-year of participation, it would anytime from 90 days up to a full year. So, if we reported 91 days, you would qualify for having submitted for the full year? Is that correct?

Dr. Lemeneh Tefera: Hi. This is Lemeneh Tefera. I think what was trying to be expressed is that clinicians who seek to fully participate and fully report quality measures in that particular case have the opportunity to do that throughout the year. So, there is a 90-consecutive-day minimum threshold. But, the more reporting that is done, the more successful clinicians can be. The extent of their reporting will vary by some measures that require longer periods than others. But, I think, as a high-level guide, clinicians who participate and report throughout as much of the year as possible, much more than 91 days but less than the maximum possible number of days, will be more successful than those who just do 90 days.

Vicky Sorecki: All right. So, it's a 90-consecutive-day minimum. And, then, if we can report additional throughout the year, then, all the better. Is that right?

Dr. Lemeneh Tefera: That is correct. That is correct.

Vicky Sorecki: Okay. Thank you. All right. Thank you.

Operator: And our next question will come from the line of Sailesh Dixit.

Nicole Cooney: Hello. Did you have a question?

Sailesh Dixit: Yes. Are you able to hear me?

Nicole Cooney: Yes.

Sailesh Dixit: I had a quick question. I was reading one of the sections on the final rule for ACI. It mentioned that if an individual provider is excluded from a certain

ACI measure, right, then that provider should be excluded from group reporting. Meaning, basically, if the provider is a part of a group, then just for that one particular ACI measure, that provider should be excluded and submitted the data for the rest of the other group. So, what is the expectations for the vendors from CMS's perspective? When or how, you know, you are expecting us to support those kinds of scenarios?

Elizabeth Holland: If a particular provider can't report on a measure, their information would still be transmitted along with the group's information. They're not excluded...

Sailesh Dixit: Correct.

Elizabeth Holland: ... excluded. They just wouldn't be performing on that measure. And that would be fine.

Salesh Dixit: That would be fine, right?

Elizabeth Holland: Yes.

Salesh Dixit: So, it's not as if like we report only three providers for one certain measure and then the rest of the group for the other measures that they are reporting. Correct?

Elizabeth Holland: Yes.

Salesh Dixit: Okay. Thank you.

Operator: And our next question will come from the line of Scott Welsch.

Scott Welsch: Hi. I had a question regarding specialty-specific measure sets. In reviewing the document, I realized that some of the specialty-specific measures sets are way over six quality measures. So, is there any incentive to actually reporting anything over six when you're doing those specialty sets?

Dr. Lemeneh Tefera: Hi. This is Lemeneh Tefera. So, the advantage or the extra points are for reporting measures that are appropriate use and outcome-focused. If the specialty set has more than the six available, then you can choose your preference for the six minimum. If your specialty set happens to have less than six—for example,

four—if you report all of those four, then you'd have successfully completed the requirement to maximally score for the Quality performance category. What we're hoping to do when there was an opportunity to provide more options for clinicians is include as many as possible so that clinicians would be the ones who can choose their preference of what to report.

Scott Welsch: Okay. Got it. Thank you.

Remarks by Dr. Kate Goodrich

Nicole Cooney: At this time, I'd like to introduce Dr. Kate Goodrich, Director of our Center for Clinical Standards and Quality, for a few final thoughts. Kate?

Dr. Kate Goodrich: Yes, thank you.

Hi, everybody. It has been great to listen to the presentation and to hear all of your questions. I have no doubt that there are many more questions on your mind. And, unfortunately, we don't have time for all of them. But, we know that there's many more out there. We are very, very aware that there's a lot of information to digest, that the Quality Payment Program is complex—we know that—and really appreciate your attention to this today, to the presentation and for all the questions that we've gotten.

We are working as hard as possible to make this information about the Quality Payment Program as accessible and understandable as possible. I know that others on the call—and I presume Andy when he opened the call—talked about our website, which undoubtedly many, if not most of you, have gone to – qpp.cms.gov. That has quite a bit of information on it. But, as we are hearing in your questions today and have been hearing since we launched the website and the final regulation, there's still more that people want to know.

And, so, we do have the ability to continue to rapidly update our website as well as all of our materials as we hear from you. And we want to hear what you need that isn't on the website or that hasn't been available, what needs to be clearer and, importantly, what kinds of tools that you all would need that would be most helpful to help you succeed in the Quality Payment Program.

I'm sure Andy talked about the fact that this program, and in particular, the first year, transition year of the program, was designed with a great deal of input from clinicians and other stakeholders, including practice managers, patients, consumers, and so forth. It's going to be a much longer journey to get to a program that is the most useful to clinicians to help them take the best care of their patients that they possibly can and that truly improves the outcomes for patients. We think that this is – this first year is the first good step in that direction to help people understand what it is that they need to do to be successful. But, we fully intend for the program to evolve over time as we learn what works well and what needs to be improved.

And, so, to that end, we hope that you all have – are continuing to digest the final rule. It is a final rule with comments. We would like for you to send in your comments to us by December 19th. And we will be using those comments in addition to our ongoing outreach to inform the second year of the program as well as the long-term future of the program. And we will continue to use our user-centered design practices and approach to not only the design of the program but also for our website and all of our operations and the information that we communicate to all of you.

And then, finally, just to reiterate, help is available. We have talked to some about the technical assistance that is out there already and that is coming. Much more information will be coming about that. But, we are deeply committed to providing that technical assistance and working with medical societies and specialty societies and other stakeholders such as vendors to help clinicians to be as successful as possible in this program. So, please return to our website frequently for updates on the program, to get your questions answered, but also related to the technical assistance.

So, thank you very much for attending today, and have a good day.

Additional Information

Nicole Cooney: Unfortunately, that's all the time that we have 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.

All registrants for today's call will receive an email with the URL to evaluate your experience with today's call. Evaluations are anonymous, confidential and voluntary. We hope you'll take a few minutes to evaluate your experience.

Again, my name's Nicole Cooney, and I would like to thank our presenters and also thank you for participating in today's MLN Connects Quality Payment Program Final Rule Call. Have a great day.

Operator: This concludes today's conference call. Presenters, please hold.

-END-


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