Quality Payment Program Year 2 Proposed Rule Listening Session

Moderated by: Nicole Cooney
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Operator: At this time, I would like to welcome everyone to today's MLN event. 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 & Introduction

Nicole Cooney: Thank you. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'd like to welcome you to this Medicare Learning Network® listening session on the Quality Payment Program Year Two Proposed Rule.

The Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, ended the Sustainable Growth Rate Formula and established the Quality Payment Program, improving Medicare by helping doctors and other clinicians focus on care quality and making patients healthier.

If you participate in Medicare Part B, the Quality Payment Program provides new tools and resources to help you give your patients the best possible care. Today's listening session is an opportunity for stakeholders to learn about proposed policy for the Quality Payment Program.

If time allows, we will open the lines for feedback. Please note, feedback received during the listening session will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on August 21st.

Before we get started, I have a couple of announcements. You received a link to today's presentation in your confirmation email. The presentation is also available at the following URL, go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press, and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have enquiries, please contact CMS at press@cms.hhs.gov. And finally, this event is being recorded and transcribed.

At this time, I'd like to introduce today's presenters, Molly MacHarris and Adam Richards from the Center for Clinical Standards and Quality, Ben Chin from the Center for Medicare and Medicaid Innovations, and, to get us started, Jean Moody-Williams, Deputy Director of our Center for Clinical Standards and Quality. Jean?

Presentation

Jean Moody-Williams: Thank you so much, and hello everyone. Really, on behalf of all of the leadership here at CMS, I want to thank you for joining this call today. And I know that many of you are in the process of digesting the proposed rule and preparing your comments.

And we really are looking forward to receiving those. We're going to probably remind it several times during this call that comments are due on August 21st, 2017. And so, please keep that date in mind.

Today, we will have many of our subject matter experts available to walk through sections of the proposal to provide clarity on the various sections.

In developing the proposals, and just as we have done from the very start of the Quality Payment Program, we began by listening to comments from hundreds of clinicians and consumers and other across the country who are extremely interested in this very significant change in how we pay for health care in this country.

I thank you all for the many invitations we've received for speaking engagements or to join your webinars. And we really did learn a lot. Of course, we also – when we finalized Year 1, that was a final rule of comment. And we did receive some good feedback there as well that we were able to incorporate in our proposals.

What we heard was that people viewed the Quality Payment Program as a big change and that they asked that we not make dramatic changes in Year 2 and that we take it slow to ensure that clinicians can easily participate, and always trying to put patients first.

And so, that's really what we did. We attempted to make proposals that will result in reducing burdensome regulations. That is a priority for this administration, and I think you've probably heard that a number of time – while still providing meaningful incentives, reducing the number of clinicians that must participate in this program, and providing technical assistance to support those that are participating. We've – setting a new direction for alternative payment models and, most importantly, still supporting clinicians in providing high quality health care to their patients.

So, as I mentioned, we're anxious to hear from you as we work toward finalizing Year 2, and we'll spend most of the time today talking about that. But before we launch into Year 2, I always like to take the opportunity to say we still have a goal of successful participation in Year 1.

So you have been very instrumental in raising awareness and sponsoring educational events, and we still have to reach the finish line there. We are past the halfway point in this year. And for those that plan to submit for the 90 days' worth of data for Year 1, we will soon be approaching October.

So we know that there are still some knowledge gaps. We've done some surveys and heard from others that are collecting data and recognize that there are still some knowledge gaps. So we look forward to working with you as we work to the finish line over the next couple of months for Year 1.

Quality Payment Program Overview

But turning our attention back to Year 2 and really, just – I'm going to skip to slide 6. And we can jump right into the discussion of the Quality Payment Program.

And, of course, as I already mentioned, the purpose of the Quality Payment Program and the fact that there are still the two tracks, the Merit-Based Incentive Payment System as well as Advanced Alternative Payment Models.

And slide 7 really just serves to remind us as we begin to talk about the various proposals, it will get very technical and it's really easy to forget the overall purpose of the program as we start to look at the scoring and

the weighting and those kinds of things. But this slide always reminds us that we're collecting data and information on improvement activities, not just for the sake of collecting it but really for the purpose of providing useful feedback to clinicians and consumers for purposes of improvement.

It's a program still in evolution, and we realize we haven't quite gotten there yet. But we are working toward making sure that what we get is useful information for everyone.

And slide 8 really I think emphasizes that that is the goal as you look at the strategic objectives that are outlined there. These really were the strategic objectives developed in Year 1 of the program.

And as we sat down for Year 2 to begin to go through them, we saw that they were still very relevant and did not really require change because beneficiary outcome is, of course, number one, looking at reducing burden and, then, all of the other objectives that you see there and that are included in the proposed rule as well, which I think kind of legitimizes that fact that we are working toward these goals.

So, as we go spend the rest of this afternoon looking at the proposals, I want to thank my colleagues here at CMS that will walk you through and turn it over to Adam, who will take you through a few housekeeping tips, and then we'll go from there.

Comment Submission Information

Adam Richards: Great. Thank you so much, Jean, and good afternoon, everyone. So I'm on slide 9, and I'll just spend a minute or two talking about when and where to submit comments for the proposed rule. And please allow me to re-emphasize that we want to hear from you. As Jean mentioned, we developed the program and put forth the final rule for the 2017 transition year. And we made it a priority to speak with clinicians, technology vendors, our partners, other stakeholders all to work with us.

So again, please be aware what while we will attempt you answer your initial questions today, if you are interested in officially commenting on the proposed rule, please do so by submitting your comments and feedback through the official submission process. As outlined in the Federal Register and below, the fourth bullet point that is on screen, there are a few different options to send your comments and your feedback to us.

Just a reminder that this is – the comment period, the submission process is open for 60 days. It will close on August 21st, 2017. And we'll go over that date a few more times during our discussion today.

In the meantime, if you need any additional information on the Quality Payment Program or on the proposed rule in general, please visit qpp.cms.gov and use the Resource page under the About tab.

Okay, so at this time, it is my pleasure to turn the discussion over to Molly MacHarris to review the proposed changes to the MIPS side of the program.

Merit-based Incentive Payment System

Molly MacHarris: Thank you, Adam. I will go ahead and begin on the MIPS proposals on slide 11.

So, jumping right into our proposals, I wanted to first highlight a handful of areas that we are seeking comment on, these proposals and the areas that we are seeking comment on that span slides 11 and 12. This is just, again, a handful of items. There are a number of areas within the proposed rule where we are looking for specific feedback. But we did just want to highlight a few for your awareness. And I will go through all of these in more detail throughout the presentation.

So, as indicated at the top of slide 11, we are proposing to increase the low-volume threshold exclusion from its current state in the transition year, which is at 30,000 or 100 beneficiaries – and we're proposing to increase that low-volume threshold to 90,000 or 200 beneficiaries.

We also are making proposals and seeking comments on an opt-in option that would begin in the third year, the 2019 performance period, where clinicians would have the ability to opt in to the MIPS Program if they fall below one of the potential low-volume threshold areas. We also are seeking comment on an additional way to define the low-volume threshold, which would be based off of Part B items and services.

We also have made a number of proposals related to virtual groups. There are a handful of ways to participate in the MIPS Program. The first is as an individual. The second is as a group. And then the third option, which were newly proposed for the second year, is as a virtual group.

We're seeking comment on really all areas of virtual groups, including how we should define virtual groups, how virtual groups should be composed, how virtual groups would elect to form, and the overall participation requirements.

We also have made proposals related to facility-based measurement. Facility-based measurement is the ability for clinicians that are hospital-based to participate in the MIPS Program using their Hospital Value-Based Purchasing Total Performance Score.

And we're seeking comment on whether or not we should have an opt-in process, where clinicians would need to elect the ability to be accessed for facility-based measurement or if should just have an opt-out process.

We also have made proposals for all of the four performance categories, which again are Quality, Cost, Improvement Activities, and Advancing Care Information. For the Quality performance category, we are seeking comment on increasing the data completeness threshold for the second year to 60 percent.

For the Cost performance category, we are again proposing to have cost be weighted at zero points in the second year. But we are seeking comment on whether or not we should increase the Cost performance category to 10 percent or another number in the second year.

Moving on to slide 12. For the Improvement Activities performance category, we're seeking comment on potential thresholds that should be established for clinicians that participate in MIPS as a group.

We also have made proposals related to a handful of bonuses. The first bonus points for clinicians who care for the most vulnerable and complex patients. We're seeking comment on what the appropriate methodology should be, whether we should use HCC or we should use a dual-eligible approach.

We also have made proposals to provide bonus points for clinicians that are part of a small practice. And we're seeking comment on whether or not we should also apply bonus points to clinicians that are part of rural practices.

And then, the last item that's listed on the slide here. But, again, we are seeking comments on many other items which are within the proposed rule, which is where we should set the performance threshold. The performance threshold – as you will recall from the first year, we set the performance threshold at 3 points.

And the performance threshold is the number that clinicians would need to have their final score either at or above to either receive a neutral or a positive payment adjustment. And we're proposing to increase that performance threshold from 3 to 15 points. But we're also seeking comment on whether other thresholds should be used, such as the number 6 or the number 33 or any other number.

So let's move on to slide 13 so I can dive a little bit deeper into the proposals. The first item on slide 13 deals with the low-volume threshold. So, I as I mentioned a few minutes ago, the low volume threshold in the first year was set at 30,000 in Medicare Part B charges or 100 patients.

We're proposing to increase the low-volume threshold in the second year to 90,000 in Part B–allowed charges or 200 patients. We received feedback since the final rule was issued that, while the low-volume threshold at the 30,000 or 100 level excluded a fair number of solo practitioners and small practices who may have additional challenge in participating in the program, that there are still further challenges that these practices face. And based off of that feedback, that's why we have made the proposal to increase the low-volume threshold at 90,000 or 200 patients.

So let's move on to the next slide, slide 14. So who can participate in the MIPS Program? We have not made any changes to the clinician types that are eligible. And those are listed at the bottom of the slide. So again, that includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. So all of those same clinician types are eligible to participate in the MIPS Program in the second year. So no changes there.

For the exclusions, we still have our exclusion that deals with becoming newly enrolled to Medicare. We didn't make any changes there. So that is exactly the same as it was in the first year. We also still have the exclusion that deals with being a qualified participant, a QP, that's part of an Advanced APM.

And then the third exclusion, the low-volume threshold, I went over that, which, again, we are proposing to make a change to increase the low-volume threshold to 90,000 or 200 patients.

So let's move on to the next slide to start talking through our proposals related to virtual groups. So we're proposing to define a virtual group as a combination of two or more either solo practitioners or two or more Taxpayer Identification Numbers, or TINs, which would have 10 or less MIPS-eligible clinicians. So we've received a couple of questions on what does this mean exactly.

So the way we have proposed to define a virtual group is that it could be any combination of solo practitioners or TINs that are 10 or smaller. So the virtual group could have five solo practitioners and two TINs that each have eight people in their TIN.

They could all collectively decide to form a virtual group. We're not proposing any limit on the number of clinicians that could join a virtual group. So the virtual group itself could be very small. It could end up being still just a virtual group size of two. Or the virtual group could be large. It could be well into the hundreds.

We also have made proposals that all MIPS-eligible clinicians within the TIN must participate in the virtual groups and that virtual groups must make the election to be a virtual group by no later than December 1st of 2017.

So December 1st of this year is the proposed deadline for when we would need to receive all of the virtual group elections. Virtual groups also – once that election is made, they cannot change how they participate in the MIPS Program during the performance period.

So if clinicians decide to join a virtual group and they send their election in to us here at CMS by December 1st of this year, and if the virtual group is approved, then that is how the clinicians would need to participate in the MIPS Program in 2018.

And, then, on slide 16, a few of our other proposals that we've made related to virtual groups. Generally, we are treating virtual groups as a group.

So again, remember, under the MIPS Program, clinicians can participate either as an individual, which is based off of their unique TIN, the Tax Identification Number, and their unique NPI, the National Provider Identifier; or as part of a group, which we generally define as one TIN with two or more NPIs. And, then, the third way which we are proposing this year, again, is virtual groups, which could be any combination of one or more TINs or solo practitioners.

And we applying our group policies to virtual groups with a few exceptions, such as our policies related to how we define non-patient facing MIPS-eligible clinicians, small practices, rural areas, and practices that are in Health Professional Shortage Areas or HPSA.

We also have not made any proposals related to virtual groups and how they can form based off of localities – so geographic area or specialty. That was an area that we had sought comment on previously. And what we heard through the feedback and through our listening sessions that we've had as we've been developing our policies for virtual groups is that it doesn't necessarily make sense to have any specialty or locality restrictions.

And lastly for virtual groups, we will be sharing over the next few months additional guidance on virtual groups, specifically a sample Model Agreement, which virtual groups can use as they choose to form as a virtual group.

So let's move on to the next slide. For non-patient facing MIPS-eligible clinicians – so, again, non-patient facing MIPS-eligible clinicians are typically pathologists, anesthesiologists, nuclear medicine clinicians, and certain types of radiologists.

So we have still – we're still proposing to have individuals defined as non-patient facing if they have 100 or less patient facing encounters. Groups would be considered non-patient facing if 75 percent or more of the NPIs

that are part of that group meet that individual designation. And then, we're also proposing for virtual groups to apply that same 75 percent threshold.

Non-patient facing MIPS-eligible clinicians generally have to do a little bit less than other clinician types, specifically in the Improvement Activities performance category. To get to the maximum points, they would only have to do one high-weighted activity or two medium activities.

And under the Advancing Care Information performance category, which deals with the usage of certified EHR technology, generally these clinicians are not required to do Advancing Care Information and, instead, those points are redistributed to the Quality Performance category. And I'll talk through this in more detail in a few slides.

So let's move on to slide 18, the performance period. So, as I've mentioned earlier, in the transition year, 2017, the performance period was 90 calendar days or upwards to a full calendar year, depending upon submission mechanism and depending upon how much the clinicians or groups of clinicians were able to participate in the program.

For the second year, for the 2018 year, we're proposing a full calendar year for the Quality and Cost performance categories and a 90-day performance period for the Improvement Activities and Advancing Care Information performance categories.

Moving on to slide 19, the performance threshold. So, I mentioned this earlier. Folks will recall that the transition year performance threshold was set at 3 points. And, again, remember, the performance threshold – that's that number that clinicians would need to have their final scores either hit or exceed to either get a neutral or a positive payment adjustment.

We're proposing to increase the performance threshold from 3 points to 15 points in the second year. We are also proposing to keep the exceptional performance threshold at 70 points. There is still the exceptional performance bonus that's available for those clinicians whose final scores meet that threshold.

And then, the payment adjustment – so, the total amount of money that is available – has increased for the second year. This is required by the law. In the first year, the total amount of payment that was available was 4 percent. In the second year, it's increased to 5 percent.

And I just want to spend a minute going over a few examples of how clinicians could hit that 15-point threshold. We have received a handful of questions on this.

So in the first year for a clinician to hit 3 points, they could participate as minimally as possible, including just one quality measure or one improvement activity or the base score of the Advancing Care Information performance category.

To hit 15 points in the second year, some examples of how clinicians could meet that are to do everything that's required under the Improvement Activities performance category. So, generally, clinicians have to do either two high-weighted activities or four medium-weighted improvement activities.

An additional example of how clinicians could hit that 15-point performance threshold is to meet all of the requirements of the base score of the Advancing Care Information performance category and, additionally, submit one quality measure that would meet the data completeness threshold.

And we have, again, proposed to keep the data completeness threshold at 50 percent. An additional way that clinicians could hit 15 points is to, again, meet the base score of the Advancing Care Information performance category and then submit one medium-weighted improvement activity.

And an additional example – this is not all of the ways that you could get to 15 points but just a few – is to submit all six quality measures that meet the data completeness criteria. And, again, data completeness is set at 50 percent.

So, moving on to slide 20. So this table just briefly summarizes what I've gone over in the last slide. So you can see on the left-hand side of the chart there is the transition year policy.

So what is occurring right now in 2017 to get to the neutral point, clinicians would need to have their final score at 3 points. Anything below that would mean that clinician would be getting a negative payment adjustment.

And as Jean mentioned on the onset of this call, we really want to minimize those clinicians who are getting that negative payment adjustment. We really want as many folks as possible to participate in the program as they can.

And, then, if you look at the right-hand side of the chart, you'll see that the performance – or the performance threshold is set at 15 points, which, again, is that neutral point. Anything below that means that clinicians would be getting a negative payment adjustment. Anything above that means that clinicians would be getting a positive adjustment. And if their final score is at or above 70, they would be eligible for the exceptional performance bonus.

So let's move on to slide 21 and 2, so a summary of our submission mechanisms. So we've made no changes – we've made no proposed changes to any of the submission mechanisms that are available. So everything that's reflected on slide 21, the submission mechanisms that are available for the four performance categories for individuals and for groups – this is exactly the same as it is in this first year. So, again, no changes to the submission mechanisms that are available.

As indicated on slide 22, however, we are proposing an additional flexibility related to how the submission mechanisms work. So the way submissions mechanisms work today is that clinicians can use a different submission mechanism across different performance categories.

So, for example, for claims or for Quality, rather, clinicians cold use claims-based reporting. For the Improvement Activities performance category, clinicians could attest to those. And, then, for the Advancing Care Information performance category, someone could use their EHR. But there's currently not the flexibility in the transition year for clinicians to use multiple submission mechanisms within a performance category. So that's the change that we're proposing.

So, for example, within the Quality performance category, a clinician could do two or three measures via claims, and then they could use a registry or a QCDR to submit additional measures.

Let's move on to slide 23 to talk through our proposals related to facility-based measurement. So, as I mentioned earlier, facility-based measurement is an option that's available to those clinicians that are hospital based. For those clinicians that are hospital-based who have 75 percent or more of their services that are in the inpatient setting or the emergency room setting have the ability to elect to participate under the facility-based measurement approach.

And how that works or how we're proposing that it would work in the second year is that those facility-based clinicians would be able to use their Hospital Value-Based Purchasing score, their HVBP score, and the Total Performance score that's associated with the HVBP Program for their hospital. And that Total Performance score would be applied to both the Quality and the Cost performance categories.

Let's move on to slide 24. So I'll start talking through our proposals related to the performance categories.

So on slide 24, the Quality performance category. So, again, we still have our same participation requirements, which is that clinicians would need to submit six measures, one of which would have to be an outcome measure. If no outcome measures are available, clinicians would need to select a high-priority measure.

We also are proposing to keep the data completeness threshold at 50 percent. And the data completeness threshold – that refers to how many of your total eligible patients you would need to report the measure on. We are proposing, however, to increase the data completeness threshold to 60 percent in the third year.

Within the second year, we have made a few proposed changes to scoring, specifically for measures that fail data completeness. So if they fall below that 50-percent threshold, instead of clinicians receiving 3 points for that measure, they would receive 1 point.

The exception to that is if clinicians are part of a small practice, they would still be eligible to receive the 3 points. We haven't made any changes to the points that would be available for measures that don't have a benchmark or measures that don't have case minimums.

Moving on to slide 25. We have made some additional proposals to quality measures that are considered to be topped out. In last year's rule, we simply finalized our definition of topped-out measures, and we also indicated which measures were topped out within the quality measure benchmarks, which are posted on our website at qpp.cms.gov right now.

With the topped-out measures, in our proposals for the second year we've proposed to apply a scoring cap of six points to a small subset of topped-out measures. I believe it's just about five or six measures that we're proposing to apply scoring cap to in the second year.

We also have proposed a timeline for removal of topped-out measures. The timeline for removal for topped-out measures is generally a 3-year cycle. So, first, we would identify the measure as topped out in our benchmark. We would not have a scoring cap applied in the first year. And then in the second and third year that the measure is still identified as topped out, we would apply that scoring cap.

So instead of clinicians being able to get 10 points for a measure, they would only be able to receive 6 points. And, then, after the third year that the measure has the scoring cap, the measure we would propose to be removed from the program.

Moving on to slide 26, the Cost performance category. So, as I mentioned earlier, we are continuing to propose to have Cost weighted at zero points in the second year. So what that means is that, again, similar to how it's occurring in the first year, we would calculate the cost measures that we can for MIPS-eligible clinicians and share feedback on that.

Even with our proposal, however, to have cost weighted at zero points, we are proposing to modify the cost measures that we would assess for clinicians.

We are proposing to maintain the Medicare Spending for Beneficiary measure and the Total Per Capita Cost measure. But we are proposing to remove the current set of 10 episode-based measures. We are in the process of developing new episode-based measures with additional transparency and with additional clinician feedback on ensuring that these episode-based measures that are newly being developed really are meaningful to clinicians and to clinician specialties.

We also do intend to provide feedback to clinicians that we can calculate these new episode-based measures on later this fall and the spring of next year.

Moving on to slide 27, the Improvement Activities performance category. So minimal changes here. The Improvement Activities performance category will still count for 15 points, and the Improvement Activities will still be weighted as either high or medium, with high-weighted activities counting for 20 points and medium weighted activities counting for 10 points.

We have proposed to add around 15 or 16 new improvement activities to the Improvement Activities Inventory to further expand those that clinicians can choose from. We also are proposing with the new improvement activities to identify those that would be eligible for bonus points under the Advancing Care Information performance category.

And we also have made a proposal under the Improvement Activities performance category that for those clinicians that are part of a patient-centered medical home and if they're participating as a group, 50 percent of the group would have to be considered part of a patient-centered medical home to be able to receive the maximum points under the Improvement Activities performance category.

So let's move on to slide 28. Additionally, for improvement activities, we will still continue to allow just a simple attestation as a submission mechanism that's available.

Moving on to slide 29 and to slide 30 for the Advancing Care Information performance category. We've proposed to allow clinicians to use either the 2014 or 2015 edition of certified EHR technology. But we are proposing to provide bonus points for those clinicians who are only using the 2015 edition in 2018.

We also have proposed to expand the options beyond the One Immunization Registry Reporting measure for 10 percent toward the performance score of the Advancing Care Information performance category and allow

reporting on a combination of other public health registry measures that may be more readily available for 5 percent each towards the performance score, up to 10 percent.

We also have proposed a decertification hardship for eligible clinicians whose EHR was decertified. We've also proposed to change the deadline for the significant hardship application for 2017 and future years to end on December 31st of the performance period.

And we've also proposed a new category of exceptions for MIPS-eligible clinicians that are either in a small practice or in a HPSA area. If those clinicians are in a small practice or HPSA area, they would have the ability to reweight the Advancing Care Information performance category to zero and redistribute those points to the Quality performance category.

*****Clarification: HPSA should be removed. The above sentences should read:**

> **And we've also proposed a new category of exceptions for MIPS-eligible clinicians that are in a small practice. If those clinicians are in a small practice, they would have the ability to reweight the Advancing Care Information performance category to zero and redistribute those points to the Quality performance category.**

And as mentioned on the – on slide 30, the 21st Century Cures Act made some changes to how the Advancing Care Information performance category works, specifically that there are additional exceptions available such as for those clinicians that are ambulatory surgical center–based. They can have the Advancing Care Information performance category weighted to zero and redistributed to Quality.

Moving on to slide 31, some of the proposed changes related to scoring. Beginning in the second year, by law, we are required to start assessing improvement. So what improvement means is generally looking at how a clinician performed in the – in a prior year to how they're performing in the current year. We are required to assess improvement for the Quality and Cost performance categories. And we're doing it a little bit differently for each.

So for the Quality performance category, we are proposing to have improvement measured at the performance category level. And improvement scoring would be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed as well.

For the Cost performance category, we are proposing to have this apply at the measure level. And improvement scoring for cost would be based on statistically significant changes at that measure level.

And so, remember for Cost, we are still proposing to have it at zero points. So, while we would still perform calculations related to improvement – and we would provide that information to folks through feedback – it would not affect their final score.

Just a few more slides on MIPS. So moving on to slide 32, the complex patient bonus. So, we understand that there a number of clinicians across the country who care for the most vulnerable and complex patients. And we are proposing to add an adjustment of 1 to 3 bonus points for those clinicians who treat those patients based

off of the HCC risk score. As I mentioned earlier, we also are seeking comment on an additional or a different methodological approach using dual eligible beneficiaries.

On slide 33, we also are proposing to have a small practice bonus available. So for those clinicians that are part of the small practice – and, again, we are – or we've defined a small practice as 15 or fewer clinicians, those small practices would receive an automatic 5 points toward their final score as long as they participate in MIPS in one performance category.

They would have to do one thing in a performance category, and then, they would get an automatic 5-point score toward their final score.

And then moving on to slide 34. So just to summarize the MIPS scoring slides that I've gone over. So, again, remember for the four performance categories, Quality we're proposing would count for 60 points, Cost would count for zero points, Improvement Activities account for 15 points, and Advancing Care Information would count for 25 points.

We're proposing to add bonus points for small practices and bonus points for clinicians who treat complex patients. We also are proposing a new extenuating circumstance hardship for clinicians across the MIPS Program. We understand that sometimes clinicians face extenuating circumstances such as natural disasters, which would limit their ability to participate in the program.

And so, at this point, I will go ahead and turn the rest of the presentation over to my colleague, Ben Chin. Ben?

Alternative Payment Models (APMs)

Ben Chin: Thanks, Molly. So, I'm going to talk about the proposed policy changes for Alternative Payment Models or, rather the Advanced APM track of the Quality Payment Program.

So moving on to slide 36. As a refresher, the MACRA statute defines APMs fairly broadly to include CMS Innovation Center models, the Medicare Shared Savings Program, demonstrations under the Health Care Quality Demonstration Program, and other demonstrations required by Federal law. However, to be an Advanced APM, a model must meet three requirements, which we finalized in last year's rulemaking.

The first is that it must require participants to use certified EHR technology. Second, it must provide payment for covered professional services based on quality measures comparable to those used in MIPS's Quality performance category.

And third, it is either a medical home model expanded under CMS Innovation Center authority – and I'll note to date here that no such model has been expanded under Innovation Center authority – or, alternatively, it requires participants to bear more than nominal amount of financial risk.

And in order to qualify for 5 percent APM incentive payment, model participants must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance year.

Moving on to slide 37 to talk about the generally applicable nominal amount standard. In last year's final rule, we finalized two ways that APMs could meet the generally applicable nominal standard criterion.

Total potential risk under the APM must be equal to at least either 3 percent of the expected expenditures an APM Entity is responsible for under the APM for all performance years or 8 percent of the average estimated Parts A and B revenue of the participating APM Entities, which was only finalized for the 2017 and 2018 performance periods.

In this year's proposed rule, we are proposing to extend that 8-percent revenue-based standard for an additional 2 years through performance period 2020. We are also requesting comment about whether we should maintain that 8-percent standard or whether it would be appropriate to adjust it upward or downward in future years.

Moving on to slide 38. In addition to the general nominal risk standard I just discussed, last year we also finalized the special financial risk criterion for medical home models. Medical home models start with a payer arrangement where the participants are focused on primary care. It empanels patients to primary care clinicians, and there is patient-clinician link. There are also seven model design options that the model can incorporate, of which at least four must be met. We are proposing two changes related to the medical home model financial risk criterion, which I will discuss in the next couple of slides.

Moving on to slide 39. It was finalized last year that starting in performance year 2018 and thereafter, the medical home model standard would apply only to APM Entities with fewer than 50 clinicians in their parent organization.

This year, we're proposing to maintain that standard with a limited exception.

Specifically, we are proposing to exempt Round 1 with the current round of participants in the Comprehensive Primary Care Plus Model from the requirement that the medical model standard applies only to APM Entities with fewer than 50 clinicians in their parent organization. All future participants in the CPC Plus model will be subject to the 50-clinician cap as finalized last year.

Moving on to slide 40. We are also proposing one additional change to the medical home nominal amount standard. In last year's rule, we finalized the total potential risk for an APM Entity must be equal to at least 3 percent in 2018 and gradually ramp up to 5 percent in 2020 and thereafter.

We are proposing to change the nominal amount standard for medical home models so that the minimum required amount of total risk increases more gradually, starting at 2 percent in 2018 and ramping up to 5 percent in 2021 and thereafter.

We believe this approach may allow for greater flexibility and encourage more participation in medical home models and be more sustainable for the type of APM Entities that would potentially participate in Medicaid's medical home models. We seek comment on this proposal.

So moving on to the – to slide 41 and the All-Payer Combination Option. This option, along with the Medicare Option, is one of two pathways through which eligible clinicians can become QPs or partial QPs. Beginning in

performance year 2019, QP determinations under the All-Payer Combination Option are based on an eligible clinician's participation in a combination of both Advanced APMs and Other Payer Advanced APMs.

It is important to note here that QP determinations are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option. Only clinicians who fail to become QPs under the Medicare Option will have the opportunity to participate in the All-Payer Combination Option.

Moving on to slide 42 to discuss the Other Payer Advanced APM criteria. Last year, we finalized that the criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar but not identical to the criteria used within Medicare.

The first criteria requires that at least 50 percent of eligible clinicians are required to use certified EHR technology to document and communicate clinical care information. The second requirement is they base payments on quality measures that are comparable to those used in the MIPS Quality performance category. And third, they're either a medical – Medicaid medical home model that meets criteria that meets criteria that is comparable to a medical home model or they require participants to bear more than a nominal amount of financial risk.

Moving on to slide 43. In last year's rule, we finalized that the nominal amount of risk must be equal to marginal risk of at least 30 percent, a minimum loss rate of no more than 4 percent, and total risk of at least 3 percent of expected expenditures the APM Entity is responsible for under the APM.

In this year's proposed rule, we are maintaining the marginal risk and minimum loss rate requirements but are also adding in a revenue-based nominal amount standard that would only apply to models in which risk for APM Entities is expressly defined in terms of revenue. It would be an additional option. It would not replace or supersede the expenditure-based standard we previously finalized last year.

Moving on to slide 44 to discuss QP determinations under the All-Payer Combination Option. Last year, we finalized that QP determinations under the All-Payer Combination Option would be made at either the APM Entity level or the individual eligible clinician level, depending on the circumstances. We are proposing this year that QP determinations would be made at the individual eligible clinician level only.

This aims to account for the fact that participation in APMs will vary across payer and the eligible clinicians participating in an APM in Medicare may not be identical to the eligible clinicians who participate in an APM in a commercial payer or Medicaid.

Moving on to slide 45. Last year we finalized that eligible clinicians, or APM Entities on their behalf, would report information about the payment arrangements they participate in after the 2019 QP performance period. This year we are proposing to establish a process for payers to submit information to CMS regarding non Medicare payment arrangements prior to a given QP performance period so CMS can determine whether the payment arrangement meets the criteria to be an Other Payer Advanced APM.

The payer-initiated process would be voluntary. Payers would be able to request a review of multiple other payer payment arrangements through the payer-initiated process, though CMS would make separate

determinations as to each other payer arrangements. Payers would also be able to submit other payer arrangements with different tracks within that arrangement as one request with information as to each track.

And like the payer-initiated process, APM Entities and eligible clinicians would also have an opportunity to request determinations of other payer arrangements they participate in. But that process would take place after each QP performance period.

Moving on to slide 46. To add a little more detail to that proposal, prior to each all-payer QP performance period, CMS would make Other Payer Advanced APM determinations based off information voluntarily submitted by payers.

This payer-initiated process would be available for Medicaid, Medicare Advantage, and CMMI multi-payer models for performance year 2019. We do intend to add remaining payer types in future years. APM Entities and eligible clinicians would also have the opportunity to submit information regarding the payment arrangements in which they were participating in the event that the payer had not already done so.

Guidance and submission forms for both payers and clinicians will be made available for each payer type early in the calendar year prior to each All-Payer QP Performance Period. The specific deadlines and processes for submitting payment arrangements will vary by payer type in order to align with pre-existing process and meet statutory requirements.

APM Scoring Standard

Moving on to slide 47. Now I'll discuss some changes to the APM scoring standard.

As a reminder – on slide 48, as a reminder, the APM scoring standard finalized last year offers a special minimally burdensome way of participating in MIPS for eligible clinicians in APMs who do not meet the requirements to become QPs, and are therefore subject to MIPS, or eligible clinicians who meet the requirements to become a partial QP and, therefore, are able to choose whether to participate in MIPS or not.

The APM scoring standard applies to APMs that meet the following three criteria, the first being they have APM Entities participate in the APM under an agreement with CMS. They have APM Entities include one or more MIPS-eligible clinicians on a participation list. And they base payment incentives on performance, on cost utilization, and quality measures.

Moving on to slide 49. Last year we finalized different scoring weights for the Quality performance category for ACO models and other MIPS APMs. For performance year 2018, we are proposing to align weighting across all MIPS APMs and assess all MIPS APMs on quality.

And moving on to slide 50. We're also proposing additional details on how the Quality performance category will be scored under the APM scoring standard for non-ACO models who had quality weighted to zero in performance year 2017.

In 2018, participants in these models will be scored under MIPS using the quality measures that they are already required to report on as a condition of their participation in their APM. So participants in those models would not be required to separately report any quality information as part of MIPS.

We are proposing one other significant change under the APM scoring standard, which is adding a fourth snapshot date of December 31st for full TIN APMs for determining which eligible clinicians are participating in a MIPS APM. This would allow participants who join certain APMs between September 1st and December 31st of the performance year to benefit from the APM scoring standard.

And this concludes the discussion of the proposed policy changes for the Advanced APM track of the Quality Payment Program. And now I'll turn it back over to Adam to talk about resources and technical assistance.

Resources

Adam Richards: Great, and thanks to Molly and Ben for providing that overview of proposed changes for Year 2 today. I'm going to move quickly through this section. As I know, we do want to get – have some time for questions at the end.

So as a reminder, there are resources available to those clinicians who are either currently participating or are preparing to participate for the transition year or just are looking for questions or answers to their questions for the proposed rule for Year 2. So we do have a number of resources available.

Of course, there's the Quality Payment Program website, which is always a great starting point, at qpp.cms.gov. We do have additional resources for the Quality Payment Program, as you can see in the bottom right-hand quadrant of the screen.

You can certainly always reach out to us at qpp@cms.hhs.gov for any questions that you may have. For those of you who are in APMs or need information on APMs, we do have the APM learning systems that are available. And you can get additional information on the learning systems through the various APM model – or various APM support inbox.

Of course, we also have on-the-ground supports, again, to those clinicians who are either participating or are preparing to participate. So for clinicians in smaller practices, typically those with 15 or fewer, we do have the Small, Underserved, and Rural Support Program available.

For larger practices – so, greater than 15 clinicians – we have the Quality Innovation Networks and Quality Improvement Organizations, both of those, again, available at no cost and are currently on the ground working with clinicians.

We also have the Transforming Clinical Practice initiative. Our Practice Transformation Networks under the initiative are working with clinicians right now.

I will remind everyone that there is an enrollment process to receive help from the PTNs. Therefore, there is a time and data commitment. This is usually for practices that are looking for more large scale practice transformation and that are ultimately moving toward an APM or an Advanced APM.

Two other things that I'd like to call out. One, at the bottom of the screen you'll see we do have a Technical Assistance Resource Guide. That's under the Resources section of qpp.cms.gov. It is a comprehensive listing of all the support that is available as well as the contact information for all of our technical assistance organizations. And we also recently launched a webpage on qpp.cms.gov that is dedicated to small and rural practices.

Again, there's a lot of good information on the available options for the 2017 transition year as well as direct contact information to the technical assistance organizations that are available to help clinicians.
So we'll move on to the next slide, slide 53. This is reminder that comments for the proposed rule are due on August 21st, 2017. Again, please follow the instructions for submitting comments. They do need to go through the official process to be considered.

And as you can see on the screen under bullet two, there are a number of options for submitting your comments. Of course, if you have any – if you need any additional information on the transition year or certainly on the proposed rule, always, please visit qpp.cms.gov. And I believe at this time we are going to open it up for questions and answers.

Question & Answer Session

Nicole Cooney: Thanks, Adam. As you'll see on slide 54 and as we said before, we do want to hear from you on today's call.

But, just a reminder that comments provided on today's call will not be considered formal comments on the rule. And also, another reminder, this event is being recorded and transcribed.

All right, Paula. We're ready to take our first caller.

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 asking making your comment to ensure clarity.

Please note your line will remain open during your time – the time you're providing you comment, so anything you say or any background noise will be heard in the conference. Please hold while we compile the roster. You have a question or comment from Regina McNally.

Regina McNally: Hello. I'm from the Medical Society State of New York, and I have some specific questions relative to the proposed rule on virtual groups, specifically with regard to how they're created, what agreements need to be made with CMS, how billing is expected to be done, how claims are supposed to be filed.

I'm also concerned with whether or not you're expecting virtual groups to reassign their benefits to the TIN. So then, how are payments to be distributed to the individuals within the group?

None of that seems to be explained or discussed at all in reference to the Federal Register. I have raised some of these questions to the regional office here in New York who referred me to someone else who has not yet

responded to any of my questions in that regard. And I was wondering if there was any clarity that might be able to be offered at this point.

Molly MacHarris: Sure. This is Molly. That's a great question. So, I'll give you some feedback here, but I'd also strongly recommend that you share these questions and these comments with us through the formal comment process.

So, generally, virtual groups – as I've mentioned, it includes a combination of one or more TINs, which could be defined as a solo practitioner or a TIN with 10 or less MIPS-eligible clinicians.
So the virtual group would be formed specifically for the purposes of participating in the Quality Payment Program for MIPS. So the existing billing arrangements that the solo practitioners or TINs that have 10 or less MIPS-eligible clinicians would continue. So any current reassignment of billing rights that an NPI makes to their TIN – that would still apply.

In regards to your question about agreements and how the virtual groups can form, as I've mentioned earlier and as we mentioned within the proposed rule, we do plan on publishing a sample Model Agreement, which is something that could be leveraged by the virtual groups to assist them as they form.

I hope that helps address some of your questions. And, again, I would just re-emphasize that you go ahead and share these questions and comments to us through the formal process, which we've touched on a couple of times in this call here. Thank you.

Regina McNally: Molly?

Molly MacHarris: Yes.

Regina McNally: It's still me. In referencing the virtual groups, it indicates that the election process will end up with a VG TIN and that Virtual Participant Identifier would be VG numbers 10 and then an NPI. But my question, then, is of the individual NPIs who have joined this VG, do those then have to reassign their benefits to the VG for billing?

Molly MacHarris: So, based off of the example you are providing right now, I don't see why they would. So the purpose of us providing a Virtual Group Identifier – that will be for our purposes as well as for the virtual group's purposes for us to be able to track the specific TIN and NPI combination for the virtual group.

So the additional Virtual Group Identifier won't be used for billing purposes as in when you normally send your claims in to Medicare to get reimbursed. Rather, they will used, again, for purposes just for dealing with the Quality Payment Program and for our internal tracking purposes and then for the virtual group itself to track who are the specific TIN NPIs that are part of the virtual group.

Operator: Your next …

Nicole Cooney: Thank you. Next caller, please.

Operator: Your next question or comment comes from Jaimie Chamberlin.

Jeanne Chamberlin: Hi. Yes. I wondered if there's going to be any further information published about the validation process similar to the old MAV process under PQRS.

Tim Jackson: Hi. This is Tim. So there is a validation process. But just to clarify, it is not available across all submission mechanisms. So the validation process is looking at the eligible measures that are applicable to the clinician through claims and registry reporting. Does that answer your question? Or did you have a follow up?

Operator: Your next question or comment comes from Sahah Wilsay.

Sahah Wilsay: My question has been addressed. Thank you.

(Unidentified female on speaker line): That never happens.

Nicole Cooney: Thank you. Next question

Operator: Your next question or comment comes from Bona Desai.

Bona Desai: Yes. This is on the Dr. Desai's office, and I don't know if it's – you are the right people to ask this question. We have – half of our patients are hospital patients, and we just see them only at the hospital. They don't come to our office.

So how should we do the measures like pneumonia, vaccines, and DEXA scan – all those measures we choose? They are not our patients. We just saw them at the hospital. So is there any kind of – how do Medicare adjusts those – for those patients, all those measures? I don't know you understood my question?

Dr. Daniel Green: Hi. So this is Dan Green. So a couple of things. It really depends on how you submit your quality data. For example, if you were submitting data attached to a claim – so, through the claims-based reporting, when your doc bills for the services that he or she provides, you would append a quality data code attached to the measure saying, for example, "Patient already had the pneumo vac shot" or "She received the influenza shot" or "She had – she's up to date with her mammogram," whatever measure it is that you're trying to report.

If you're submitting through a registry or QCDR, Qualified Clinical Data Registry, again, you would send that information in – "Hey, I had an encounter with Mrs. Jones. She's up-to-date with her mammogram" or "She's had her pneumo vac," or "We gave her pneumo vac," whatever the quality action on the measure that you're reporting is.

And, again, there are other methods that you can support – that you can report, depending on the size of your group, whether you're using an electronic health record, etc.

Nicole Cooney: Thank you.

Operator: Your next…

Nicole Cooney: Next caller, please.

Operator: Your next question or comment comes from Leanne Denison.

(Unidentified females on participant line): You want to go? I'll try to.

Leanne Denison: Hi. We are a multi-specialty group of surgeons that participate currently in a group module through a registry. And I'm wondering about the APM because we have physicians of multiple different specialties. In terms of nominal risk, do we have to have 8 percent of our dollars across the whole TIN be at risk? Or could we pick, for example, our cardiothoracic surgeons and attempt to create an APM kind of model for coronary artery bypass graft and that would qualify our whole group as a TIN, even though the money at risk related to CABGs would be less than 8 percent of the income expected for our total TIN?

Ben Chin: Yes. And this is Ben Chin here at CMMI. And thank you for that question. And I should probably just clarify a bit. And so, the nominal amount standards, both the 3 percent expected expenditure and the 8 percent revenue-based standard – they apply at the APM level – so at the model design level.

And for Advanced APMs, that is Medicare Advanced APMs, we designed those models so that given APM Entities or participants in those models, will have to assume risk at either of those levels. And those would be also risk floors.

So it's not necessarily something that you would have worry about at the individual or multi-specialty practice level but if you are participating in one of our already-designed models and whether or not you would have to meet those levels of risk as designed and as part of one of those alternative payment models.

Operator: Your next question or comment comes from Alan Bass.

Alan Bass: Thank you for taking my question. What is the benefit of individual practitioners becoming a virtual group?

Molly MacHarris: Sure. This is Molly. So, virtual – so what we've heard from a number of clinicians, especially from solo practitioners and small practices, is that they want to participate in the Quality Payment Program but there are still additional challenges that they may face since they're typically smaller practices, they may not have as many resources available to them and they may not have the full staff that larger practices may have.

So a benefit for a solo practitioner or a small practice, again, a practice of 10 or less clinicians, to join a virtual group is that they can pool their resources for participation in the Quality Payment Program.

There also could be benefits that there are different submission mechanisms that are available to clinicians that are participating as a group as compared to an individual.

And those clinicians who decide to join a virtual group – they may want to partake in some of the – or if they want to partake in the group submission mechanisms that are available and not the individual mechanisms. So, those are just a few of the advantages of virtual groups.

Operator: Your next question or comment comes from Rhonda Quast.

Rhonda Quast: Good afternoon. A question would be will the proposed rule have an impact to the ask for the patient relationship modifiers or will those still be required beginning January 1st of 2018?

Nicole Cooney: Give us just one second.

Rhonda Quast: Okay.

Nicole Cooney: I'm sorry, we don't have anyone in the room to address that question. But if you could send it in to the service center, which is qpp@cms.hhs.gov, we can get that addressed for you. Thank you.

Rhonda Quast: Thank you.

Operator: Your next question or comment comes from Anthony Werner.

Anthony Werner: Hi. Good afternoon and thank you for having this session. I have one comment and one question. The comment is that it would be very helpful for groups, especially small groups, to have a – have it where the things that you are proposing or the things that go into place – have at least a 24-month lead time before they would go in place.

Many times – there were several things today on – that you said we have to make decisions by December 1st of this year – things like that – and many times there isn't enough time to actually prepare to meet the requirements when you're implementing them in 6 months or less.

So if you could, it would be great to put a stipulation in there that none of the things that you put will be implemented within 24 months.

The second one is, is there an option yet for additional groups or organizations to join as serve support groups or PTNs or SANs as you look at it moving forward? I've asked this question of the help line a couple of times and have not received a response.

Jean Moody-Williams: Molly, this is Jean. I'll take that. I moved to a noisy place, so I hope you can hear me. First, on the comment or the time or lead time, we certainly understand that request.

And for some of our more mature programs, we are able to do rulemaking for several years out. This program, of course, still being quite new and some of legislative timelines that are in place, there are instances where we don't have as much lead time as we would prefer.

Then there are instances where the requests people have made – they would like to see them implemented as soon as possible rather than wait. So we try to balance all of that.

And, then, on the second related to additional PTNs and SANs, those – at the moment, we are not able to open them up to – for additional organizations. But we continue to look for opportunity as we do with all of our models in CMMI when that might be available. However, the existing PTNs are still accepting members.

And so we encourage partnerships. So it might be an opportunity for you to have a partnership with an existing PTN.

And then, lastly, I just want to say on the virtual groups, because there have been a number of questions on that, emphasizing that you must already be eligible to participate in MIPS to join a virtual group so that when you're looking to form your partnership, the individual or the group must be eligible to participate in MIPS. Thank you.

Operator: Your next question or comment comes from Robin Hook.

Robin Hook: Thank you for taking our call. I have three questions. I'll be very quick about it. First of all, we went on the qpp.gov site and we did not see where you mentioned those six topped-out measures. We'd like to find out where those are. Number two, we don't hear anything on the Medicaid program for 2018. We'd like to know more what's happening with that. How are they participating? Are they participating? And, number three, providers that met the threshold for 2017 and do not meet the threshold for 2018 – how do they participate if they don't meet that threshold?

Molly MacHarris: Sure. This is Molly. I'll take questions one and three, and I'll let my colleague Ben weigh in on your question related to Medicaid in case there's anything he can address there.

So for your first question regarding where are the six topped-out measures that are in the proposed rule, so if you go to the qpp.cms.gov website, there's a link where you can look at the proposed rule. And the six measures are contained within the proposed rule. I apologize. I don't have the table number in front of me. But the six measures that we've identified as topped out are within the proposed rule.

It looks like it's in section – and you'll probably want to write this down because it's a little lengthy. It's section – in the proposed rule, 2C7A2C. So, again, that's section 2C7A2C. There should be a table that calls out what those six measures are.

And, then, I think your third question dealt with those clinicians who, I believe, may have been eligible in the first year but, then, because we are proposing to increase the low-volume threshold in the second year, what does that mean for them?

So, again, with the low-volume threshold, we are proposing to increase that from 30,000 or 100 patients to 90,000 or 200 patients. So we do – we did note within the proposed rule that if we finalize that, there would be additional clinicians who are currently eligible to participate that would not be eligible.

So if you're not eligible to participate in this program, you do still have the ability to volunteer to report. So you could still decide to participate in this program. You could still send in information on the performance categories.

If you're not eligible, however, you would not be able to receive any of the money that's associated with the program, whether it would be a positive adjustment or a negative adjustment. And I'll let Ben see if there's anything he wants to add regarding the Medicaid question.

Ben Chin: Yes. Thanks, Molly, and thanks for the question. In regards to Medicaid, I will just say that generally speaking, when looking at the Advanced APM track, it mainly deals with Medicare Part B, except when you get to the performance year 2019 and the All-Payer Combination Option, which I discussed in presenting the slides.

An so when that option takes effect, we will look at a clinician's participation in Other Payer Advanced APMs, which includes Medicaid and Medicaid Advanced APMs. And so, I will encourage you to look at the proposed rule and all the proposals that we've made this year around the All-Payer Combination Option.

Then, also, I'll point you to a fact sheet that we have in the resource library on the Quality Payment Program website. It's titled "APMs, Medicaid Models and All-Payer Models." And that has more general information about Medicaid in the All-Payer Combination Option.

Operator: Your next question or comment comes from Jessica Peterson.

Jessica Peterson: Hi, yes, this is Jessica Peterson. I have a few questions for you. So, my first question is about the statement that you can now report via multiple mechanisms to meet the minimum number of measures for the Quality category and the other categories.

I know that you don't need to do that for claims because of the EMA clinical clusters, but I'm a little concerned or confused about how that would apply to those participating via registries who might be subspecialists and not have enough measures there or really elsewhere. So that's question one.

Question two is about the Part B. There's something in the rule about how Part B drugs are going to be evaluated. It was a little confusing. I wasn't sure if that – if the cost of Part B drugs were being added into the cost measurements or if the adjustment was being applied to those. And – yes. That's it.

Molly MacHarris: Sure. This is Molly. So to address your first question. So our proposed change for submission mechanisms where a clinician could now within a performance category use more than one submission mechanism – so as we mentioned earlier in response to a question today, the validation process to check to see specifically for the quality performance category if there are enough measures available, that applies only to the claims and registry submission mechanisms.

For the QCDR and the EHR submission mechanisms, we assume that those clinicians would have measures available to them.

So how it would work for the ability for clinicians to use multiple submission mechanisms is that if they are using both their QCDR and their EHR, for example, let's say from their QCDR there were a couple of specialty specific measures that they wanted to use but then they also wanted to use some of the measures within their EHR, they would be able to do that if we finalize this proposal where they could submit some measures using

their EHR, using the eCQMs that are built within the EHR, and then some measures using the QCDR or another submission mechanism.

And then for your second question, which was in regards to Part B – thank you. So – and it sounds like there were some questions related to how Part B drugs apply to the MIPS Program overall and then how those get built into the cost measures.

So the MIPS Program applies to Part B overall, which is a difference from how the legacy programs were treated. So the legacy programs – the Physician Quality Reporting System or PQRS Program, the Medicare EHR Incentive Program, and the Physician Value Modifier or VM Program – those apply only to the Physician Fee Schedule.

The MIPS Program applies to all of Part B, which, of course, contains the Physician Fee Schedule but additional payment methodologies.

So what we clarified within the proposed rule is which of the Part B methodologies beyond the Physician Fee Schedule that we, CMS, have the capability to take into consideration for eligibility determination and also for applying the MIPS payment adjustment.

So we have outlined the additional specific methodologies. Part B drugs are, in some instances, part of the MIPS Program for eligibility determination, specifically if they are billed as part of the Physician Fee Schedule with some particular modifiers.

I apologize I don't remember what the modifiers are off the top of my head. But then there are additional scenarios for Part B drugs based off of how they're billed. But those would not be eligible for the program. I hope that addresses your question. Thanks.

Ted Long: This is Ted. I can answer the question on the Cost measure piece of it, too.

Molly MacHarris: Yes. Thank you, Ted.

Ted Long: Yes. No problem. So Part B drugs are included in the Medicare Spending Per Beneficiary and the Total Per Capital Cost measures. The episode-based Cost measures – as you know from the proposed rule, we are currently working to build a new set of now.

So the decisions for the new episode-based Cost measures we are looking to the clinician community to make with us. And that's ongoing work that we'd be happy to share more information on either offline of after this call. But to specifically answer your question, yes, those drugs are built into the two aggregate Cost measures that we currently have in the program.

Nicole Cooney: Paula, I have time for one final caller.

Operator: Okay. Your final caller is Kara Gainor.

Kara Gainor: Hi. My question is, when calculating the threshold score for a QP using the payment amount method, generally I understand the denominator is defined as the aggregate of payments for Medicare Part B–covered professional services furnished to all attribution-eligible beneficiaries during the performance period.

But my question is in instances of episode payment models such as CJR, is the – are the denominator payments for all Part B services furnished to the attribution-eligible beneficiaries during that performance period or is it limited to those payments for Part B services that's related to the procedure or condition?

So in the case of CJR, is it only for those services related to that procedure that the attribution-eligible beneficiary had?

Ted Long: Give us one moment and we'll answer that question for you.

Kara Gainor: Okay.

Ted Long: So, thank you for that question. And to respond, generally, for the attribution-eligible construct, we did finalize the definition of what that is in last year's final rule. And there, generally speaking, there were six criterion.

The first five criterion identified what essentially a Medicaid Fee-for-Service beneficiary is. And the sixth criterion did allow us some flexibility to implement an alternative methodology for models that don't base attribution off evaluation of management claims.

And so, generally speaking, episode payment models are different. But, we can't speak to how we would implement any different methodology for CJR at this time.

Additional Information

Nicole Cooney: Unfortunately, that's all the time that we have for today. Again, my name is Nicole Cooney, and I want to thank our presenters and also thank you for participating in today's Medicare Learning Network event on the Quality Payment Program Year 2 Proposed Rule Listening Session. Have a great day, everyone.

Operator: Ladies and gentlemen, thank you for your participation in today's conference. This concludes today's call. You may now disconnect.