Quality Payment Program: Answering Your Frequently Asked Questions Call

Moderated by: Nicole Cooney
May 16, 2018—1:30 pm ET

Table of Contents

Announcements & Introduction 4
Presentation 4
Frequently Asked Questions 8
Merit-Based Incentive Payment System (MIPS) 8
MIPS Eligibility and Exemptions 8
What is a MIPS eligible clinician? 9
Were there any changes to the low volume threshold for Year 2 of MIPS? 9
How is a clinician's eligibility status determined? 9
If a clinician is found eligible in the second determination, but not the first, do they receive a payment adjustment? 10
If a clinician is determined to be exempt, can they still submit data and get a bonus and/or feedback report? 10
How does exempt status affect clinicians that move from one practice (TIN) to another? 10
When will additional clinician types (e.g., dieticians, social workers, physical therapists, speech pathologists) be eligible to participate in MIPS? 11
MIPS Individual and Group Reporting 11
Do I need to register my group? 12
Can a clinician change each performance period from group to individual? 12
Can CMS clarify who makes up a group? Is it all those associated with a TIN or just the MIPS eligible clinicians? 12
If a clinician is part of a TIN that is eligible as a group, but all individual clinicians are exempt individually due to not meeting the low volume threshold, does the TIN have to submit data to avoid payment adjustment in 2020? 13
MIPS Performance Categories 13
You've changed the name of Advancing Care Information to Promoting Interoperability. Is the name change the only update for 2018? Are there any other changes to the performance category that I need to be aware of? 13

What is the reporting period for Promoting Interoperability? 14
Can I still use 2014 Edition CEHRT in 2018 to report Promoting Interoperability measures? 14
What is the difference between a Public Health Registry and a Clinical Data Registry? 14
When does the Security Risk Analysis need to be done? 14
Am I required to claim the e-Prescribing and Health Information Exchange measure exclusions if there are fewer than 100 denominator-eligible events? 14
For 2018, does a MIPS eligible clinician have to report on all four categories or can they choose which category to report to achieve the minimum 15 points? 15
How are bonus points added for the Quality performance category? 15
Which measures will clinicians be assessed on under the Cost performance category? 16
Question & Answer Session 16
Presentation (continued) 20
Alternative Payment Models (APMs) and Advanced APMs 20
APM General 21
How can clinicians determine which model is best for them? 21
How can clinicians prepare for transition, especially if transitioning from MIPS to APMs? 21
Advanced APM—All-Payer Combination Option 21
How does the All-Payer Combination Option work? 22
What payer types are included? 22
What are the timelines for the All-Payer Combination Option? 22
MIPS APM General 23
What is a MIPS APM? 23
How is the low volume threshold applied to MIPS eligible clinicians in MIPS APMs? 23
What are the MIPS performance category weights unde a MIPS APM? 23
Question & Answer Session 24
Additional Information 29

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® Event. All lines will remain in a 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 & Introduction

Nicole Cooney: Good afternoon, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'll be your moderator today. I'd like to welcome you to this Medicare Learning Network call on the Quality Payment Program: Answering Your Frequently Asked Questions.

During today's call, CMS will answer frequently asked questions about the program from the 2018 Healthcare Information and Management Systems Society Annual Conference and Exhibition, also known as HIMSS18, and inquiries received by the Quality Payment Program Service Center.

Before we get started, I want to let you know that you received a link to the presentation in your confirmation email. You can also find the presentation at the following URL, go.cms.gov/npc, N as in Nancy, P as in Paul, C as in Charlie. Again, that URL is go.cms.gov/npc. I'd also like to remind everyone that today's event is being recorded and transcribed.

At this time, I'd like to introduce our presenters for today. We have Adam Richards, Elizabeth Holland, and Molly MacHarris from the Center for Clinical Standards and Quality as well as Adam Conway and Corey Henderson from the Center for Medicare and Medicaid Innovation. Adam?

Presentation

Adam Richards: All right, great. Thank you, Nicole, and hello, everyone. It's a pleasure to be able to speak with you all again. We certainly thank you for being able to join us today. I believe the last time we spoke was back in November timeframe with a few of our experts, some of whom are actually on the call today walked you through the Year 2 requirements for the Quality Payment Program.

We provided quite a bit of information on both tracks of the program, both the Merit-Based Incentive Payment System and Advanced Alternative Payment Models. And one area of feedback that you provided to us was that you'd like to have more of an opportunity to talk with our experts. So we certainly heard you loud and clear, and that's why today we're hosting an event that is slightly different from what you've experienced in the Quality Payment Program in the past.

Today we want to have a discussion with you and hear your questions and concerns and feedback. Think of this as more of an open forum where eventually in due time we'll open it up to hear from you.

Now, before jumping into the general question-and-answer session, we do have a few announcements and updates that we want to touch on. We also want to talk you through some of the frequently asked questions that we are receiving about Year 2 of the program, all of which were collected from our various in-person

events such as HIMSS, which Nicole mentioned earlier, and our previous webinars, even up to last week when we held a national webinar on the participation criteria for Year 2 of the program.

So with that said, we'll get started. I'm going to jump to slide 3 to begin walking through some of our general announcements and updates. So beginning with the MIPS preliminary feedback, as many of you are aware, the deadline to submit 2017 MIPS performance data was April 3rd of last month. Upon closing of the submission window, we began providing preliminary feedback reports on the MIPS data that clinicians submitted. I want to make sure that each of you recognize and knowledge the term preliminary. This feedback is not indicative of a MIPS final score. Instead, this is meant to give a clinician general feedback on what was submitted. And the reason I'm emphasizing the importance of this being preliminary is that we are still working through the scoring processes, which means that a clinician's score could change between now and when the actual feedback reports are released later this summer.

So for your reference, we've listed a few of the reasons why a score could change under the second bullets on the slide, and these are some of the elements that are still being worked into the score. I won't go through all of them but you can see there are still a number of factors outstanding.

Another important element that I want to point out is that, in order to access preliminary feedback or even eventually the final score and final feedback, clinicians will need to sign into their accounts on the Quality Payment Program website, qpp.cms.gov, using EIDM credentials. So, this is kind of my first of many reminders to make sure that your EIDM credentials are up to date if you are interested in signing in to take a look at that preliminary feedback and ultimately your feedback later this summer.

I believe that that's our only true announcements that pertain to Year 1. So, the rest of our discussion should be centered on aspects of Year 2, which is a good segue to slide number 4.

Really, this is focusing on the MIPS Year 2 eligibility information, which is now available. So what's new this year is that we have different options for clinicians to check whether not they need to participate in MIPS in Year 2.

So first and foremost, we have the individual National Provider Identifier Look-up Tool available, again, on qpp.cms.gov. Clinicians can simply visit the Look-up Tool page and enter in their NPI for quick determination. This tool will display every TIN or practice where you are – where the clinician is individually included in the program and needs to participate in order to avoid that negative payment adjustment.

We've also added a new feature as recently as, I believe, this time last week, and of course based on your feedback on qpp.cms.gov, that allows for groups to identify all MIPS eligible clinicians under a certain TIN. So basically, this is a group lookup, if you will. So clinicians will need to sign in to qpp.cms.gov to use this feature. After a clinician has logged in, again, using EIDM credentials—so another good reminder—here she will be able to browse the TIN affiliated with his or her group and then click the Details screen to see the eligibility status of every clinician based on their NPI.

So like I said, this is a brand new feature, one that many of you have requested. So again, we've heard you loud and clear. Of course, we're always interested to hear your feedback on the new tool. So, please if you have any opinions, just let us know.

And finally, I do want to note before moving on that both options contain – or only contain MIPS data right now, MIPS eligibility data. We anticipate updating both tools to include APM participation and Predictive Qualifying APM Participant, or QP, status information a little later this spring.

So I'm going to jump to slide 5. And this is really meant to serve as a reminder to those on the line today representing groups that the registration deadline for those who are interested in using the CMS Web Interface to report data or to administer the CAHPS® for MIPS survey, the Consumer Assessment of Healthcare Providers and Systems® Survey, it's fast approaching, that deadline.

So as you can see on the slide, the registration period ends June 30th, 2018. I do want to make sure that everyone is clear that the registration only pertains to two elements that I just described: so Web Interface and the CAHPS for MIPS survey. You do not need to register for other submission methods, nor do you need to tell CMS that you plan to participate as a group. So that is an important distinction that I want to make.

Now, as you'll see on the last bullet point in really an effort to reduce burden, if a group was registered to use the CMS Web Interface in 2017, that registration will carry over into 2018. So, in other words, the group will automatically be registered. So please note, though, that the second to last sentence in that bullet, that if you want to edit or cancel your registration, you must do so during the registration period. So please note that requirement.

And also, in what seems to be a common and important theme today, I do want to remind everyone that clinicians will need to register on qpp.cms.gov using that EIDM account. So again, just one more reason to make sure everything is up to date.

Moving on to slide 6, this kind of main – stays with the group theme really. So to support those clinicians who do intend to report as a group or are thinking about reporting as a group, we have released a number of new and helpful resources in our Quality Payment Program resource library on cms.gov. I won't go through every single one of these, but I can say definitively that they are valuable, especially the 2018 MIPS group participation guide as this walks you through everything you will essentially need to know to get started with group participation in Year 2. So I highly recommend checking out those links. I believe they're all hyperlinks so you can easily get to those resources.

Moving on to slide 7, really another announcement that we'd like to make. So – and many of you may be familiar with this, but we recently released the Inpatient Prospective Payment System, or the IPPS, and the Long-Term Care Hospital Prospective Payment System proposed rule. While those – while the proposed changes in the rule are certainly important and, of course, I always want to champion taking a look at some of those changes, I'm bringing this to your attention because we are addressing the Meaningful Use element that cuts across a number of programs. Essentially, we are rethinking the concept of Meaningful Use to focus on interoperability.

So as such, with that being said, effective immediately, we are changing the name of the EHR Incentive Programs to the Promoting Interoperability Programs. That's one key change. This means also that the Advancing Care Information performance category under MIPS will now be referred to as the Promoting Interoperability performance category. So I'm just going to say that one more time. The Advancing Care Information performance category under MIPS is now going to be known as the Promoting Interoperability

performance category. You'll begin to see these changes in all of our MIPS and APM educational resources and communications moving forward. What I want you all to understand is that this is only a name change for 2018. All of the requirements under the performance category remain the same, and Elizabeth and I will talk a little bit about that a little later on in our FAQ section.

We do want to make this program more flexible and less burdensome, really emphasize measures that require the exchange of information between patients and providers, incentivize providers to make it easier for patients to get their records. And we also want to get to a state where we're using – we have clinicians using the 2015 Edition CEHRT by 2019 and that built-in API, or Application Programming Interface, functionality to improve the flow of information between providers and patients. So that's really kind of the crux behind the move to this Promoting Interoperability. So please take the opportunity to familiarize yourself with this new effort. There is, I believe, a press release available as well as helpful factsheets on cms.gov to get you started if you're interested.

On the next slide, I'll just remind you all—and I'm on slide 8—that the deadline to submit comments on the proposed rule and the RFI is June 25th, 2018. So that is fast approaching. There are instructions about how to submit comments as well as the rule itself on the *Federal Register* and through that available link.

So just a few more high-level announcements and then we'll get into the FAQ section. So, very quickly, I'm on slide 9, just the quick announcement on the 2018 MDP Annual Report, the Measure Development Plan. So for those unfamiliar with the Quality Measure Development Plan Annual Report, this describes our progress in developing clinician quality measures to support the Quality Payment Program. So the CMS Quality Measure Development Plan is essentially a framework to help us develop and improve measures, point out known measurement and performance gaps, and recommend approaches to close some of those gaps.

So the 2018 Measure Development Plan Report adds an additional layer, if you will, to the Measure Development Plan with additional information to support measure developments, and it also records our progress since the first annual report in 2017, if you had the opportunity to read through that. Both of these resources are beneficial for those who are interested and kind of developing those clinician quality measures for consideration for the Quality Payment Program. So, if you're interested, I highly suggest clicking on that link in the slide for additional information.

The slide number 10 actually kind of connects to our measure development initiatives here at CMS. And kind of in the spirit of measure development, there is a great funding opportunity for those of you who are interested in developing, improving, updating, whatever it may be, those quality measures for the Quality Payment Program. I won't go through all the information on this slide. I think it's pretty straightforward. But please do note that the due date for the funding opportunity is – or was extended to May 30th. It isn't that far away. I think we're less than 2 weeks now. So if you're interested, please submit your applications as soon as possible.

And finally, on slide 11, to kind of close out our updates section, I do just want to call your attention to an upcoming webinar—one of, I think, many that we're working on, but this is QCDR Workgroup Webinar happening on Thursday, June 14th, from 2 to 4 pm. If you are interested in learning more about the QCDRs, we certainly encourage you to register for the event.

Frequently Asked Questions

Okay, so moving on to slide 12, we're going to get into the, I guess, question-and-answer session I think that you've all been waiting for. I know we just covered a lot with the announcements, so I hope everyone was taking copious notes. But if not, don't worry. I know there's generally a recording available, and you also have the slide deck for quick reference.

So we are going to move on to the main component today. So on slide 13, we've kind of outlined what's some of the focus areas. This is not exhaustive but just some of the things that we're going to touch on up front. We have two focus areas, right; so MIPS, the Merit-Based Incentive Payment System, and Alternative Payment Models and Advanced Alternative Payment Models.

So again, we're fortunate enough to be joined by our MIPS policy experts from the Center for Clinical Standards and Quality, Molly MacHarris and Elizabeth Holland, as well as some of our other experts who are online with us as well. We'll be discussing and answering questions related to eligibility, exemptions, individual and group reporting, some of the MIPS performance categories. These seem to be the areas of focus that have come in to us and some of the questions around these core elements.

We also have Dr. Corey Henderson and Adam Conway from the Innovation Center, who have also graciously joined us today to discuss and answer questions related to APM policy, the All-Payer Combination Option, MIPS APMs. Again, these are focal areas that we've heard from you that you're interested in learning more about. So we have those questions, and we'll certainly walk through them.

The format is fairly straightforward. We are going to address the frequently asked questions that you and your peers have asked us over the last few weeks, few events. Where possible, we are going to try to use graphics to help us explain certain concepts to provide a more concrete understanding. I am more of a visual learner, so I do find that it helps try to work through some of this policy sometimes, so that's what we'll try to do today. And we're also planning on pausing in between these two tracks to take some of your initial questions, just a few high-level questions, and then we'll jump in to the next track with APMs. So don't worry if you don't get through the first time. We'll have additional opportunities for Q&As toward the end of the call.

Merit-Based Incentive Payment System (MIPS)

MIPS Eligibility and Exemptions

So with that said, let's jump in to MIPS.

I'm on slide 14. And really we – we're still seeing a lot of just high-level questions around eligibility and exemptions. So, our three main questions that have come out of some of our conferences, our webinars, our different discussions with clinicians and stakeholders: What is a MIPS eligible clinician, especially in Year 2 of the program? Were there any changes to the low volume threshold for Year 2? And how is a clinician's eligibility status determined? And for that, I'm going to turn it over to Molly because I believe she's going to walk us through a few slides.

What is a MIPS eligible clinician?

Molly MacHarris: Sure, thanks, Adam. So if folks want to go ahead and jump to slide 15, this addresses the first question. So what is a MIPS eligible clinician?

So MIPS eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Please note this definition of who is MIPS eligible has not changed from the first year of the program. The other piece I do want to note because we do also get this question is that, when we talk about physicians here at Medicare, we don't just mean M.D.'s or D.O.'s, we also mean chiropractors, optometrists, and podiatrists.

Were there any changes to the low volume threshold for Year 2 of MIPS?

Let's move on to slide 16. So this addresses the second question, which is, Any changes to the low volume threshold? So we have a number of exclusions under MIPS, but the one that we get the most questions on, which is why we spend the most time focusing on this exclusion, is the low volume threshold.

So what the low volume threshold does is we have the ability to exclude certain types of clinicians who fall below the low volume threshold from participating in the MIPS program. So if you are excluded from MIPS, that means that you are not required to participate and you would not be receiving any of the payment impacts—either the negative payment impacts or the positive payment impacts.

So the low volume threshold, it did change from the first year to the second year. In the first year, the low volume threshold was set at 30,000 in billing annually and 100 patients. We increased the low volume threshold in the second year to be at 90,000 in billing annually and 200 patients.

One piece I do want to note because we also get this question pretty commonly—if you – as everyone continues to dig into all of our material that we have on our website, you'll note that sometimes we talk about the low volume threshold with an AND and then sometimes we talk about it with an OR. So if you're looking at slide 16, you can see that for Year 2, the final low volume threshold is 90,000 in billing AND greater than 200 patients. If both of those are true, that means you are MIPS eligible. However, if – when we talk about the context of being excluded from MIPS, you'll see it framed that you're excluded from MIPS if you bill less than or equal to 90,000 annually OR less than or equal to 200 patients. It gets into the logic of how the exclusion works, but I did just want to clarify that. So I hope that helps out folks.

How is a clinician's eligibility status determined?

And then moving on to slide 17, So how is the eligibility status determined? So I want to emphasize that the actual process itself has not changed from Year 1 to Year 2 but just to break down what the process is.

So the first thing that we do is we check to see if you meet the definition of being a MIPS eligible clinician type. And those are the clinician types of physician, physician assistant, clinical nurse specialist, etc.

Then what we do is we take a look at your historical claims data to see whether or not you exceeded or fell below the low volume threshold. Our first look, or determination period, for low volume threshold run for the

second year runs from September of 2016 through the end of August 2017. And we do this so we can tell you whether or not you are excluded from MIPS. We also – as part of this analysis, we also provide information on the concept of special statuses, which we'll talk through in a little bit later.

The second eligibility check that we do is we also check your claims data from September of 2017 through the end of August 2018. And the reason that we do that is we want to see if there were any other clinicians that were not initially captured in that first look or if someone's status has changed. We have found that people's statuses can change from one determination period to another. The piece we want to emphasize, though, is that if in the first determination period you were found to be excluded from MIPS, meaning you fall below the low volume threshold, that would carry over to the second determination period.

So I hope that helps with those questions. So let me turn it back to you, Adam.

If a clinician is found eligible in the second determination, but not the first, do they receive a payment adjustment?

Adam Richards: Sure, thank you, Molly. And I think – so we're on slide 18 now, just talking about, again, some questions around eligibility and exemption. So, Molly, I think you covered this. The – our very first question, If a clinician is found eligible in the second determination but not the first, do they receive a payment adjustment?

Molly MacHarris: Right. So as I was just mentioning as what's reflected on slide 17, so you would remain exempt in the second determination period. And so the payment adjustment, that ties into whether or not you're eligible. So, remember, if you're not eligible, you cannot receive a payment adjustment whether it be a negative adjustment or the positive adjustment.

If a clinician is determined to be exempt, can they still submit data and get a bonus and/or feedback report?

Adam Richards: Excellent. So I think that also ties into our second question. So you know, whether a – if the clinician is determined to be exempt, can they still submit data and get that bonus and/or feedback report?

Molly MacHarris: Sure, so if a clinician is exempt, they can still participate in the program. So this is where you'll hear us talk about voluntary reporters. So there is the ability for clinicians that are exempt from the program, whether that be because you fall below the MIPS low volume threshold or if you're not one of the eligible clinician types, you can still participate in the program on all four of the performance categories. You can send us your data, and we will calculate a score for you and issue you feedback. We won't, however, use that data for determining any MIPS payment adjustments, because, again, if you are not eligible and if you're a voluntary reporter, we could not issue you a payment adjustment.

How does exempt status affect clinicians that move from one practice (TIN) to another?

Adam Richards: Excellent. I think the third question on slide 18 is one we get quite often. I think it's everyone's favorite question framed in a multitude of different ways. We've seen it come in a variety of forms. But how does that exempt status affect clinicians that move from one practice to another?

Molly MacHarris: Sure. So when we talk about clinicians under MIPS, we specify that a clinician is based off of their unique TIN, or unique tax identification number, and their unique NPI, their unique National Provider Identifier. So, it is possible that if as a human doctor that you could have one NPI and you could be associated with multiple TINs. So within a given performance period, you may spend the majority of your time at one clinic and then just a few days a week at another clinic.

In that scenario, you may be eligible under one of those TIN/NPI combinations, and you may be excluded under another. So when you actually go to our website and look at the information that's available in our Look-up Tool, you will see all of the connected practices, or connected TINs, that we've been able to identify for you. So in the scenario where you move from one practice to another, we would look based off of that new practice, so that new TIN/NPI combination, to determine whether or not you meet eligibility.

When will additional clinician types (e.g., dieticians, social workers, physical therapists, speech pathologists) be eligible to participate in MIPS?

Adam Richards: Excellent. Thank you. And then I think the last question to round out slide 18, we have been hearing some of this especially as we get into Year 2, 2018. When will those additional clinician types, so dietitians, social workers, etc. be eligible to participate in MIPS?

Molly MacHarris: Sure, so by law, those that are eligible for MIPS, the clinician types are, again, the physician assistant, physician – or physicians, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and clinical nurse specialists. Those are the only clinician types that can participate for the first 2 years.

****Clarification: Physician assistant is repeated twice and nurse practitioner was omitted. This sentence should read:**

Sure, so by law, those that are eligible for MIPS, the clinician types are, again, the physician – or physicians, physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists. Those are the only clinician types that can participate for the first 2 years.**

Beginning in the third year of the program, we do have the ability to expand out to other clinician types. We would do that through our formal rulemaking process. So I can't state with any certainty on when exactly we will expand out to these other eligible clinician types. I would just encourage folks to take a look at our proposed rule when it comes out in the upcoming future.

MIPS Individual and Group Reporting

Adam Richards: Thank you. So let me give you a short breather, and then we'll return to you for a few additional questions. But I think we're going to move into slide 19, really focusing on the individual and group reporting. And really to just kind of kick this section off, we do have this graphic, which I think speaks to this, you know, the differences between the individual and the group options.

So as you can see the breakdown, you know, at the individual TIN/NPI level, you can see that we do have three clinicians, Dr. A, Dr. B, and a nurse practitioner, and how the breakdown occurs at the individual level. So just for example, Dr. A billed $250,000 and saw 210 patients. So, Dr. A would be included in MIPS because, remember, to participate, you would have to exceed both of those – both those two items that exceed the low volume threshold, whereas Dr. B as well as the nurse practitioner came under the low volume threshold. So that's kind of the crux of the individual level.

Moving over to the group at the TIN level, you see a combination of Dr. A, B, and the nurse practitioner. So all together, they billed $400,000 and saw 330 patients. So, all of those clinicians would be included under that group because, again, they exceeded the low volume threshold that Molly mentioned earlier. And really, the focus on that key term AND, they exceeded both the billing and the patient aspects of the low volume threshold.

Do I need to register my group?

So moving on to slide 20, we do have a couple questions that come in, really, around group and individual reporting. The first one, Do I need to register my group? We did address earlier when we were talking about what you need as far as group registration, just focusing specifically on those who are using the CMS Web Interface or who are administering the CAHPS from its survey. That's as far as registration goes for groups.

Can a clinician change each performance period from group to individual?

So I'm going to jump in to the second question. And that is, Can a clinician change within the performance period from group to individual reporting?

Molly MacHarris: Sure, and this is Molly again. So the answer to that is, Yes, clinicians can change how they participate in the program annually. So, yes, for one year, you could participate as individuals, and then the next year you could participate as a group. We just encourage clinicians to have those conversations within their organization to determine which approach would work best for your particular practice.

Can CMS clarify who makes up a group? Is it all those associated with a TIN or just the MIPS eligible clinicians?

Adam Richards: And we get this question a lot. Can we clarify, really, what or who makes up a group? Is it all those associated with the TIN? Or is it just the MIPS eligible clinicians?

Molly MacHarris: Sure, and so this one, it can get a little complicated, so let me try to explain this one. So when we talk about who can participate in a group for performance and reporting, it's a little bit different when we talk about when we actually go to apply the payment adjustment. So when we go to apply the payment adjustment, we would not apply a payment adjustment to anyone that's part of a group that's not considered to be MIPS eligible. But for who can participate in the group for performance and reporting purposes, it can differ to a certain extent by performance category. But generally, clinicians that are part of the group, it can be a mix of MIPS eligible clinicians and eligible clinicians.

So, for example, when we talk about the low volume threshold as Adam went over on slide 19, the low volume threshold then being applied at the group level, it would be everyone within that group would be eligible. Then when we look at some of our other exclusions, for example, the newly enrolled to Medicare exclusion, those clinicians can still participate in the group for reporting and performance purposes. But then when we go to apply the actual payment adjustment, we would not apply the payment adjustment to those clinicians that would become newly enrolled during the performance period. So I hope this helps with this one a little bit.

If a clinician is part of a TIN that is eligible as a group, but all individual clinicians are exempt individually due to not meeting the low volume threshold, does the TIN have to submit data to avoid payment adjustment in 2020?

Adam Richards: Thank you, Molly. And just to round out slide 20, if a clinician is part of a TIN that is eligible as a group but all the individual clinicians are exempt individually because they did not meet the low volume threshold, does the TIN have to submit data to avoid the payment adjustment in 2020? And I think what this one's really getting at is, Is group reporting mandatory or is it an optional – an option for clinicians?

Molly MacHarris: Sure, so a group reporting is not mandatory—it is optional. So I think this is tying into, again, a bit of the example that's on slide 19. But the scenario would be that everyone could be excluded at the individual level. So, no, an organization would not have to participate in MIPS as a group.

Some of the reasons on why organizations may choose to do so is that they anticipate that they would perform well under MIPS and they would want to receive the benefit of those payment incentives. But if everyone is excluded at the individual level, there is no requirement that people participate as a group. But the option is available to them.

MIPS Performance Categories

Adam Richards: Fantastic. So we're going to move on to slide 21. And of course, if you do have questions we are going to open up the line shortly, so just jot those down. But we're going to jump into, I think, what is everyone's favorite performance category, Promoting Interoperability. So we are joined by Elizabeth Holland today, so really, again, just focusing on some of the high-level questions that we received from you, from others.

You've changed the name of Advancing Care Information to Promoting Interoperability. Is the name change the only update for 2018? Are there any other changes to the performance category that I need to be aware of?

I know we spoke a little bit about the first question around the change and the name change from Advancing Care Information to Promoting Interoperability. This is truly just a name change for 2018. But, Elizabeth, just to confirm, there are no other changes, correct?

Elizabeth Holland: There are no other changes outside of the changes that we made in the 2018 QPP final rule. So, all of those things are still in place. But the Promoting Interoperability performance category name is the only change we've made so far. Any other changes would be effective for 2019, and we would need to propose them.

What is the reporting period for Promoting Interoperability?

Adam Richards: Okay, excellent. So into the performance category itself, what is the reporting period? Maybe I should say, What is the minimum reporting period for Promoting Interoperability?

Elizabeth Holland: It is a minimum of 90 consecutive days within the calendar year.

Can I still use 2014 Edition CEHRT in 2018 to report Promoting Interoperability measures?

Adam Richards: Excellent. We get this question: Can I still use my 2014 Edition of CEHRT in 2018 to report Promoting Interoperability measures?

Elizabeth Holland: Yes, absolutely. You have a choice to either use 2015 Edition Certified EHR Technology or 2014 Edition Certified EHR Technology or a combination of the two. However, in 2019, we did make it clear that we would be requiring 2015 Edition.

What is the difference between a Public Health Registry and a Clinical Data Registry?

Adam Richards: Excellent. Few other questions on the performance category. So can you explain to us, What is the difference between a public health registry and a clinical data registry?

Elizabeth Holland: So they're very, very similar. It's just a question of who sponsors them. Clinical data registries are administered or on behalf of non–public health agencies. And public health agent – registries are administered or on behalf of local, state, territorial, or national public health agencies. So one is public and one is other. But they both collect data for health purposes.

When does the Security Risk Analysis need to be done?

Adam Richards: Okay, next question, and we did see this – as I mentioned earlier, we did just close the submission window for the 2017 performance data – MIPS performance data. And we did see this pop up a few times. But as it relates to 2018, when does the Security Risk Analysis need to be done?

Elizabeth Holland: Okay, so the Security Risk Analysis measure is a little different from all the other measures. Generally, we say that measures need to be performed during the performance period, and that's 90 days or up to a full calendar year, whatever period of time you choose. But the Security Risk Analysis is the one measure that can take place outside of that performance period, but it must take place during the calendar year.

Am I required to claim the e-Prescribing and Health Information Exchange measure exclusions if there are fewer than 100 denominator-eligible events?

Adam Richards: Got it, thank you. And last but not least, really, around the e-Prescribing Health Information Exchange exclusions. So as a clinician, am I required to claim the e-Prescribing Health Information Exchange measure exclusions if there are fewer than 100 denominator-eligible events?

Elizabeth Holland: No, you're not required to claim the exclusions. The exclusions are just there to enable people who really don't e-prescribe or do any referring to still fulfill those measures because those are both part of the Phase 4. So, if you have actually numbers in your numerator, I would definitely recommend reporting those numbers because all they can do is improve your performance score.

Adam Richards: Excellent. Well, thank you so much. I will also plug just quickly that if you are interested in additional information on Promoting Interoperability performance category, there is a very good factsheet available under the Quality Payment Program library on cms.gov. We have a number of factsheets out there on all the performance categories and a number of different resources for various aspects of the Quality Payment Program. But if you are interested in this performance category specifically, I highly recommend taking a look at that resource.

For 2018, does a MIPS eligible clinician have to report on all four categories or can they choose which category to report to achieve the minimum 15 points?

So on slide 22, this'll be our last slide before we go into kind of an open Q&A session to hear from some of you. Just some additional performance category questions, so I'll just throw these out there. Anyone can feel free to answer.

So really just starting off, for 2018, so Year 2, does a MIPS eligible clinician have to report on all four performance categories? Or can they choose which category to report to achieve the minimum 15 points?

Molly MacHarris: Sure, Adam, this is Molly. I can take that one. So the answer is, Clinicians can choose whichever performance category or categories they would like to report on. Just so folks know, the 15 points that's being referenced here in this question, that's the performance threshold. So I think folks are aware, but just in case they're not, I'll just quickly go over it.

What we do under MIPS is we assess clinician's performance on four performance categories, and we assign everyone something called a final score, which can range from zero to 100 points. Clinicians whose final scores are above the performance threshold, and in Year 2 the performance threshold is 15 points, they would be getting a positive adjustment. If their final score is below 15 points, they would be getting a negative adjustment. And if it's directly at 15 points, they would be getting a neutral, so no impact to their claims in the 2020 year. But – so clinicians can choose to get to their 15-point final score or higher through any combination of performance categories.

How are bonus points added for the Quality performance category?

Adam Richards: Perfect. Let's just keep going, Molly. Third question – second question, how are bonus points added to the – for the Quality performance category, so the high level?

Molly MacHarris: Sure. So within the Quality performance category, we have two sets of bonus points that are available. The first deals with reporting on additional high priority measures. We do have a requirement under the Quality performance category that clinicians must select at least one high priority measure if an outcome measure's not available to them. So if they report on more than that one required high priority measure, they

can get bonus points there. High priority is defined as outcome measures, patient experience measures, patient safety, appropriate use, and care coordination.

We also have a set of bonus points that deals with end-to-end reporting using your Certified EHR Technology. If clinicians do that, they also would receive bonus points. And those are added – both of these sets of bonus points are added on a measure-by-measure basis for each scenario that you would be eligible to receive the bonus points. So if for a given measure it was an additional high priority measure as well as being reported in an end-to-end manner, you would get those extra bonus points. They are subject to a cap, which is approximately 10 percent of the Quality performance category denominator.

Which measures will clinicians be assessed on under the Cost performance category?

Adam Richards: And last but not least, shifting over to the Cost performance category. The measures that will – that clinicians will be assessed on under the Cost performance category, can you just give us a rundown?

Molly MacHarris: Sure. Yes, sure. Great question. And we've been getting this a lot because, if folks will remember, for the first year we didn't assess performance on the Cost performance category but we are for the second year. It will count for 10 points towards your final score.

So we're assessing cost based off of two measures: the Medicare Spending per Beneficiary Measure and the Total per Capita Cost Measure. We will automatically calculate these measures for all clinicians that we are able to calculate them for. In this scenario where we can only calculate one of those measures, we would go ahead and calculate that for you, and that is what your Cost performance category would be based off of. If we cannot calculate either of those measures for you, out of those 10 points that would normally be available for Cost would be available for Quality. So then Quality would increase from being worth 50 points towards your final score towards 60 points. Thanks.

Question & Answer Session

Adam Richards: Excellent. Thank you, Molly. So, Nicole, I think this is a good time to open up the lines just to take a few questions. And so if you could just go through how folks can dial in for us?

Nicole Cooney: Sure. And actually, before we open the lines, I can anticipate one question. And as Adam mentioned, we will post an audio recording. We'll also have a written transcript too. I know there's been a lot of great information shared. So, I'm sure folks may be wondering about that. When that is available, a notice goes out on our MLN Connects® newsletter, and it's also posted on the same page where you found the slide presentation. So those will be available.

So as a reminder, we do have a lot of folks on the line with us today. So if everyone could limit their questions to just one. Let's try to focus on MIPS-related questions in this segment. And, Holley, we're ready to open the lines.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note your line will remain

open during the time you're asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star 1 to get back into the queue, and we'll address additional questions as time permits.

Please hold while we compile the Q&A roster.

Our first question will come from the line of Jason Shropshire.
Jason Shropshire: Hi. Can you hear me?

Adam Richards: Yes, we can.

Jason Shropshire: So I have two quick questions. The first is I just want to make sure, So if I reported as a group in 2017 but I decide not to report in 2018, how does CMS know that I do not want to report, that I instead want to report as an individual instead of a group, and that I won't receive a penalty because of all the individuals underneath that TIN are not eligible?

Molly MacHarris: Yes, sure. This is Molly. So for 2017, did you participate as a group using the Web Interface?

Jason Shropshire: No.

Molly MacHarris: Okay, so then we do not – so as Adam mentioned in the slide today, that's the Web Interface and then CAHPS for MIPS. Those are the only group options where registration is required. We do automatically reenroll groups who previously participated in the Web Interface for the subsequent year. Since that is not your scenario, we will just look to receive data from your organization at the submission period either as an individual or as part of a group. So that there – so how you participated last year as a group and the fact that you want to change it for this year, there's nothing further that you need to tell us. The only situation where you would need to tell us that is, again, if you did participate as a Web Interface user and we autoenrolled you.

Jason Shropshire: Okay, great. And so my next question is: so I have a situation where, let's say a provider changes tax ID July 1st. So it's not clean; it's not January 1st for the – so it's halfway or somewhere in the middle of the reporting period. If that provider did not report MIPS under their old tax ID in 2018, but they do report MIPS as part of the new tax ID, our tax ID, in 2018, will they receive a penalty in 2020? And let's assume that both – in both situations they would – needed to report MIPS.

Molly MacHarris: Okay, so just to say it back, the scenario is a provider switches TINs in July 1st of the performance period. Under their old TIN and their new TIN, they're both eligible.

Jason Shropshire: Right.

Molly MacHarris: So if under – so in that scenario, if we receive data from the new TIN, we will use that to calculate that clinician's final score and apply the payment adjustment based off of that. The instances where – so I think the piece that you're touching on is we do have policies in place where clinicians – if they switch practices from one year to the next, we have policies where the clinician's payment adjustment percentage will follow the NPI.

Jason Shropshire: Correct.

Molly MacHarris: We do also have policies in place with that particular policy that takes into account that we would look for the higher of the two final scores. So again, in this scenario that you have, both TIN NPIs would be eligible. Let's say for one, we don't get any data, so they would get a zero final score. And then in the other TIN, we do get some data—let's say their final score is 20. We would in that instance apply the higher of the two final scores for that particular clinician.
Jason Shropshire: And that would be across all TINs?

Molly MacHarris: We would make that available for that particular NPI and for any TINs that that clinician would move towards – move to in the 2020 payment year.

Jason Shropshire: Okay, thank you.

Molly MacHarris: Thank you.

Operator: Our next question will come from the line of Dee Steinberg.

Dee Steinberg: Hi. Can you hear me?

Adam Richards: Yes.

Molly MacHarris: Yes.

Dee Steinberg: Okay, first, a comment. Pulling down the slide set, after about slide 12 there's nothing, they're all blank. So, I don't know if they were meant to have words on them or not. But in any case they didn't.

The other is I know that what we're looking for when we're assessing cost to a particular physician is according to the E&M codes. However, I'm wondering, is there any plan to make this different for, like, specialists or, you know – because if you're an oncologist, you're seeing your patient before you're going to do treatment for them, but you're really not their primary care. But then because you have the preponderance of the E&M codes because the patient's coming twice a month, you get tagged for all of their expenses. Is there any plan to revise this? I mean it seems to me that in the interest of accuracy, you would just give everybody, you know, every physician only the charges that they, you know – that they themselves have incurred from their patients.

Molly MacHarris: Yes, sure. This is Molly. That's a great question. So you're right that the two measures we have available on cost right now, MSPB and the Total per Capita Measure, they are generally more applicable to primary care clinicians. So we have been working on developing episode-based measures, and those measures deal with particular clinical conditions that can be more appropriate to specialists. So we are, again, in the process of developing those. For the second year, those will not be included as part of your Cost performance category score, but we do intend to provide feedback on those episode-based measures as part of your performance feedback that you will get as part of the second year in the summer of next year. So we do hope that that information on those episode measures will be helpful. Thank you.

Dee Steinberg: Okay, all right. Thank you.

Operator: Our next question will come from the line of Kim Sweet.

Kim Sweet: Yes, hello, everyone, and thank you for taking my call. The question was kind of asked by the previous caller, but I just want to reiterate because I believe this sounds like a change from the final rule that was – that I actually did go through and read, but it has to do with the payment adjustment and following the TIN and NPI number. I was wondering, Do you have documentation out there somewhere that specifically states how that works? Because before, it was – it followed the TIN and NPI, and it was not following the NPI number. So it sounds like there's been a change somewhere. So, I would just like to find documentation so that I can print this off and have a hard copy of it. Do you have it out there available?

Molly MacHarris: Yes, sure. This is Molly. So just to clarify, this isn't a change in policy. This is the policy we've had in place since the first year of the program. This information is contained within the 2017 final rule. I believe we briefly reiterated this policy in last year's final rule. And so the reference documents to both of those rules, that is available off of our resource library page. So, that information is available there.

Kim Sweet: So off the resource page, you refer – you're talking about you have to read the final rule in order to pinpoint where that information is. There's no document that specifically talks about payment adjustments and how they're assessed. Is that what you're saying? You have to go through the final rule to get that information?

Molly MacHarris: I don't believe at this point that we have this contained in further subregulatory educational documents. It's, you know – so thank you for the feedback that what I'm hearing you say is that you would like this is as part of a separate educational document. So we definitely will …

Kim Sweet: (inaudible)

Molly MacHarris: … take that into consideration as we start working on our new educational materials. Definitely hear you on the concern on trying to dig through the rule. I have to read it numerous times a day, and, you know, finding the right page in there can often be a little bit difficult. So definitely hear you on that. We'll take that into consideration as we work on developing additional materials related to the payment adjustment.

Kim Sweet: Like you do with your factsheets because your factsheets are very helpful.

Adam Richards: Thank you. Yes …

Kim Sweet: All right, thank you.

Nicole Cooney: Thank you.

Operator: And our next question will come from the line of Juanita Henne.

Juanita Henne: Hi. My question is regarding the classification of non–patient facing. I'm a little confused on that. And when I read some information from CMS, it states that if you bill Medicare less than or equal to the threshold, it says that you're classified as a non–patient-facing clinician. However, I do have on the Look-up

Tool a couple of providers that are included in MIPS, and they still are classified as non–patient-facing clinicians. So if I could get a little clarification on that, that'd be great. Thank you.

Molly MacHarris: Sure. This is Molly again. So I think that the piece where you're getting a little confused is the difference between being considered MIPS eligible and then what we talk about under MIPS of having a special status. So we didn't really get into this as part of the presentation here today. But what we have under MIPS is we have basic eligibility. So again, as we talked about whether or not you are a physician, physician assistant, whether or not you fall above or below the low volume threshold, and so if you meet those items, you're considered eligible for the program MIPS.

We also then have items called special statuses that we give to certain types of clinicians. And those clinicians are MIPS eligible, but what they may have to do is a little bit less under a performance category or they may not have a performance category applicable to them at all. So some of those special statuses include non–patient facing, being part of a small practice or rural practice, or being in a HPSA area, being a hospital-based clinician, being part of an ASC. So for the non–patient-facing designation, you would receive that as an individual if you have less than or equal to 100 patient-facing encounters and as a group if 75 percent or more of your individuals have that designation.

So that's what you're seeing within the Look-up Tool. I hope that helps. Thank you.

Juanita Henne: Thank you.

Nicole Cooney: Holley, that's our last question for this segment. We are going to move on to the next segment of the presentation. And if we didn't get to your question, we will take more questions here in just a few minutes.

Presentation (continued)

Alternative Payment Models (APMs) and Advanced APMs

Adam Richards: Yes, thanks, Nicole. So let's jump into Alternative Payment Model policy and Advanced Alternative Payment Models. We'll spend a little bit of time on this because we know that this is an area of interest. And then, like Nicole said, we will get back to your questions. So don't worry; stay with us.

On slide 23, I just want to call your attention, you know, as we have these – as we go out and talk to clinicians and stakeholders and we have these events, we do hear some confusion around some of the terms within the APM track events, APM track. So really on slide 23, we provided you with kind of a high-level refresher on some of the terms that are used. So we won't go through every single one of these. But I do want to just call your attention, you know, please review those. I think they're very, very helpful, in really starting to kind of speak within the Alternative Payment Model and Advanced Alternative Payment Model policy.

APM General

So I am going to jump on to slide 24. And I'm going to kind of combine these two questions because I think there're some similarities here—and certainly pose these to Dr. Corey Henderson, Adam Conway. I know they're both on the line with us.

How can clinicians determine which model is best for them?

How can clinicians prepare for transition, especially if transitioning from MIPS to APMs?

But for clinicians who are starting to think about APMs and joining APMs, you know, which – how – what are the resources that can help them determine which model is best for them? How can they really start to go about preparing making that transition, especially if they're transitioning from MIPS over to APMs?

Dr. Corey Henderson: So I'll start by responding to that question, and I know Adam Conway will back me up here. I think that, from a technical assistance perspective, the free resources we provide to the clinicians is most valuable. They will help you prepare for learning how to report measures. If you're in a practice that does not currently have the measure support, if you're in a practice that's new, as Molly spoke about, the newer clinician that's been here less than a year or newly enrolled in Medicare, understanding some of the key policies is the support that's offered. And most importantly, for participation in Advanced APM, I think it's very specific to your CEHRT preparation, in that understanding the Promoting Interoperability, or what we would call, formerly, ACI. How do you actually measure and collect using the EHR system? What does that mean? And then also understanding what are the measures that are comparable to MIPS and really just preparing for the risk-based performance as we talk about value over volume. I don't think that there is one model that's specific for preparation that's easier to benefit from or to report to that's all specific to the clinician and the entity that they want to join or develop. And, Adam, if you want to add any color to that.

Adam Conway: Sure. Thanks, Corey. This is Adam Conway. I think that one important consideration is simply the availability of models for your clinicians to join. As you all probably are aware, there are, you know, not – a limited set of opportunities to join models coming out of the Innovation Center, and CMS more broadly. And so, if one of those opportunities comes up, that would certainly be the moment to consider these questions most seriously and obviously the parameters that qualify an Alternative Payment Model to be advanced in the first place, which is, as Corey mentioned, the EHR use, but also whether the participants are capable of taking on more than a nominal amount of financial risk and their ability to report on quality measures is important.

Advanced APM—All-Payer Combination Option

Adam Richards: Thanks, Adam, and thank you, Corey. I do want to jump in to slide 25 while we have Adam, really to talk about the All-Payer Combination Option. So we do know that this is kind of an additional opportunity for clinicians. And I think, really, right now clinicians are just trying to kind of wrap their head around what this all means. So, we get these high-level questions, you know: How does the All-Payer Combination Option work? What are the payer types that are included? And, you know, what are the general timelines?

So we do have some slides following these questions that will help walk through. But I'm going to turn it over to Adam just to talk a little bit at a high level about the All-Payer Combination Option.

How does the All-Payer Combination Option work?

Adam Conway: Sure. Thanks, Adam. It's a little confusing to have two Adams on the call; apologies for that. So the All-Payer Combination Option is available to those clinicians who are already participating in an Advanced APM through Medicare. So the list of those models is available on our website; that includes the Shared Savings Program, the Next Generation ACO, the Comprehensive Primary Care Plus Initiative, and a couple of others.

And the reason for this opportunity is that the clinician's participation in those initiatives will – if they reach a certain threshold of payments or patients being seen through the model, they are then eligible for the 5-percent APM incentive payment, which is obviously a major incentive to join one of these models now that QPP is in full swing. And those thresholds are sort of the key reason that the All-Payer Combination Option is available. It begins in 2019, and that is the same time that the necessary threshold to reach that status—what we call the QP status, or the qualifying APM participation status—the thresholds jump somewhat significantly. And so while clinicians may have been able to achieve those thresholds through the participation in their entities solely through Medicare billing alone, in 2019, those thresholds again may jump, and the clinicians may not be able to achieve them through Medicare alone.

And so what we've done is added the opportunity to consider other payers that may be also offering payment arrangements that look very similar to what we have in our Advanced Alternative Payment Models under Medicare. And those again involve Meaningful EHR Use, also taking on some degree of risk, and obviously the payments based on quality measures.

What payer types are included?

Slides – slide 28 lists out the different types of payers that are involved. There's Title XIX, or Medicaid; Medicare Health Plans, which are primarily Medicare Advantage in this scenario; multipayers. So CMS has a number of models that are available that include not only Medicare but also other payers. And those include, at this point, the CPC+ Initiative and then also the Oncology Care Model.

Adam Richards: Okay, well, thank you, Adam. And I agree that it is a little confusing having two Adams…like I'm talking to myself sometimes.

What are the timelines for the All-Payer Combination Option?

But we appreciate that, just to kind of start to whet the – our appetite on the All-Payer Combination Option. You know, please take a look at those slides. I think they have some really great information available to you. I know there is also a recorded webinar that is available on our resource library that was done a few months ago on the All-Payer Option. So I certainly recommend taking a look at that as well if you're interested in deep diving into this specific option.

MIPS APM General

I'm going to move on to slide 32 and talk a little bit about MIPS APMs just generally. So we get a lot of questions on MIPS APMs. You know, at a high level, what is a MIPS APM? How does the low volume threshold apply to MIPS eligible clinicians who are in MIPS APMs? What are the performance category weights under MIPS APMs? And those are just some of the high-level questions. We get a lot of questions.

So I'm going to turn over to both Corey and we do have a special guest. Ben Chin is also on the line to talk a little bit about MIPS APMs at a high level.

What is a MIPS APM?

Dr. Corey Henderson: And, Ben, if you want to take it from here, what I will do is I'll prepare to give you guys a little overview of the MIPS APM performance category weight. And then I also have in the room with us Rabia Khan, who maybe would add just some specificity around the Shared Savings Program. Ben?

Ben Chin: Sure. Thanks, Corey. So MIPS APMs are a subset of general APMs, so that is, Alternative Payment Models that meet three additional criteria. The MIPS APMs have APM entities that participate in the APM under an agreement with CMS. The APM entities are included on one or more MIPS eligible clinicians on a participation list, and the APM bases payment incentives on performance either at the APM entity or eligible clinician level on cost utilization and quality. So MIPS APMs benefit from the special APMs scoring standard, which has different performance category weighting under MIPS.

How is the low volume threshold applied to MIPS eligible clinicians in MIPS APMs?

Dr. Corey Henderson: So just for the acknowledgement of time because we do want to leave time open for questions around APMs, we're just giving a cursory overview. As Adam has already said, we have other recorded webinars that are available for you with more depth and understanding.

What are the MIPS performance category weights unde a MIPS APM?

As it relates to the Year 2 category weight for quality, it is now 50 percent: it's still zero percent for cost, 20 percent for improvement activities, and 30 percent for Promoting Interoperability. And I will pass it over to Rabia to say something about the Shared Savings Program and MIPS APMs.

Rabia Khan: Thanks, Corey. So, within the Medicare Shared Savings Program, ACOs participate and – by track; so you can be a Track 1, Track 2, Track 3, or as a part of our model, a Track 1+ ACO. So the Quality Payment Program has identified the entire Shared Savings Program as an alternative payment model. However, only the Advanced – the Tracks 2, 3, and 1+ are Advanced APMs, whereas Track 1 ACOs will be scored under the MIPS APMs scoring standard. And Corey went over the category weight.

And just high level for quality, quality measures will be used – will – the quality data reported by ACOs for the CMS Web Interface and for CAHPS for ACOs for Year 2 will be used to calculate that quality category score. And as Corey noted, there is no scoring for cost. But for improvement activities, that has already been designated as full credit for those – for ACOs participating in the Shared Saving Program. So there is a

resource in the resource library that identifies for all APMs what the improvement activity assigned points are for your APM entity.

And then for Promoting Interoperability, ACOs within the Shared Savings Program must report that not only for MIPS but also for the ACO 11 quality measure that we calculate as a part of the Shared Savings Program. So that reporting Promoting Interoperability does apply to those tracks that are deemed in Advanced APM, and that is reported by the participant TIN—they are ACO participants—and not by the ACO. The ACO is required to report the quality measures as designated and required by the Shared Savings Program.

Adam Richards: Excellent. Well, thank you all so much. As you can hear, we do have quite a large team, but it is an integrated team, while working through these different answers together in these different parts of the Quality Payment Program.

Question & Answer Session

So I think now what we'll do is just kind of give you a little – the time to dial back in. And if we can just remind everyone how to dial in, and we'll get started with the question-and-answer session again.

Nicole Cooney: Right. Thanks, Adam. So we still want people to limit their questions to just one. We do have a lot of folks queuing up for questions. We'd like to get to as many of you as possible. And don't forget, as I mentioned, the event is being recorded and transcribed. And, Holley, we are ready to take our next question.

Operator: To ask a question, 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 question before asking your question to assure clarity. Once your line is open, state your name and organization. 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. If you have more than one question, press star 1 to get back into the queue. We will address additional questions as time permits.

Our next question will come from the line of Tara Bickhart.

Tara Bickhart: Hi. Thank you for taking my call. My question is related to MIPS reporting, specifically those that are reporting group data. I was wondering how a group should go about handling if there's a multispecialty group practice and maybe a handful of the clinicians, maybe a certain department—not the majority, but maybe just a handful of them—are not on EMR, but the group has chosen to report MIPS as a group under one tax ID number. How would we – how should we go about handling specifically the ACI – or I'm sorry, the PI measures for those clinicians that are not on EMR?

Rabia Khan: Because using Certified EHR Technology is a requirement for the Promoting Interoperability performance category, you would just exclude them from your calculations. We don't have any data from them, but they would still be included as part of your group.

Tara Bickhart: Okay, so we wouldn't have to manually aggregate their encounter data and add them as a manual process to the measure denominators. That would be above and beyond.

Rabia Khan: No, if they're not using Certified EHR Technology, no. But if you have, for example, in a group, two different certified EHR technologies being used, you would have to add the numerators and denominators from the two versions of EHRs. But if people are not on the EHRs, you do not add their data.

Tara Bickhart: Beautiful. Thank you very much for that clarification.

Nicole Cooney: Next question, please, Holley.

Operator: Thank you. Stand by for our next question.
David Richards: Okay, as we're waiting for folks to dial in and get in line for the next question, I do just want to call your attention to slides 37 and 38. Starting on slide 37, I just want to reiterate that we do have no-cost technical assistance available to clinicians who are included in this program. Corey alluded to this earlier as a means of really thinking about making the transition from MIPS to APMs. We do have that form of support available through the Transforming Clinical Practice Initiative. But for folks who just need basic support, you know, please feel free to reach out to any of the networks and support forms listed on this infographic.

I will also say, on slide 38, stay informed, stay up to date with us. So the easiest way to do that is to sign up for our listserv on qpp.cms.gov. We try to make it as easy as possible. You just visit the website, scroll all the way down to the bottom of the page and enter your email address, and then click Subscribe, and you will be part of the QPP listserv. You can also follow us on Twitter at @cmsgov. We do have some announcements on there as well, but the best way is to subscribe to our listserv.

So we'll take the next question.

Operator: Our next question will come from the line of Pamela Morand.

Pamela Morand: I'm employed by two physician internal medicine practice, private practice. We are non-PAR with Medicare. We do not accept assignment. My question is—and I've asked numerous people, numerous organizations—How do we fit in to the MIPS program? We're bound by a limiting charge. Are they going to give us the bonus to raise our limiting charge? Are they going to send us a separate bonus payment? That's my question.

Molly MacHarris: Yes, sure. This is Molly. So the fact that you or your practice has a non-PAR, has a nonparticipating status with Medicare, you are still eligible and able to participate in the MIPS program itself. For questions on additional details of exactly how the payment adjustment percentage will be applied due to the limiting charge that you have in place, it's a great question. We're still working on getting those additional information and factsheets out where we will be providing, you know, specific guidance on exactly how you can anticipate seeing the MIPS payment adjustment being applied to your claims beginning in 2019.

Pamela Morand: Okay.

Molly MacHarris: So great question and just stay tuned for more information on that.

Pamela Morand: Yes. No wonder nobody knows the answer. And one more quick question, we just joined the ACO to our physicians association even though we're a private practice. It's an ACO MSSP Track 1. I am so

confused, the difference between that and an APM and what measures we are supposed to report on through the ACO. And am I allowed to report individually, like I did in 2017, and through the ACO? Or do I have to do one or the other?

Dr. Corey Henderson: So thank you for that question. We love APM questions. So let me just give a general overview of what an APM is, and then I will let Rabia speak to your Shared Savings Program Track 1 participation.

An APM is the general umbrella for anything that's outside of MIPS in a sense. So, what I mean by that is, if you are a MIPS participant as a clinician and you're not assigned to a model specifically, then more than likely you're in an APM.

An APM could be either advanced—and Advanced APMs are specific models that were described by Adam Conway earlier, a Shared Savings Program, Tracks 2 and 3. And the tracks do matter because they do determine how much risk you may be taking on, and that determines the advanced level of the model.

There's also the MIPS APM which kind of falls in this bucket where you're participating in an APM, but we give the additional points in your scoring. That's the APM scoring standard.

And then the final are those that may submit data as part of a model that they have a relationship with. And we call them APM participants, but we don't track them because they're just submitting data to help us to look at quality or specific measures that we're looking at for health improvement overall as a nation. And those participants would just report to MIPS, and they do get additional scoring under the improvement activities.

But as it relates to your specific question, as it relates to your participation, I will hand that over to Rabia. But Shared Savings Program is an APM because it is an alternative payment method or alternative payment model outside of the fee-for-service that the MIPS merit-based incentive program currently operates under.

Pamela Morand: Even though they're calling it an ACO?

Dr. Corey Henderson: ACO and APM entity are kind of interchangeable names. Po-tay-to, po-tah-to.

Pamela Morand: Okay, that's what I thought. Okay.

Dr. Corey Henderson: So ACO is an Accountable Care Organization. Alternative Payment Model entity would just be the organization. So, Accountable Care Organization, Alternative Payment Model entity—it's kind of the same thing; we just use different terms for different sides of the house, but they are the same exact thing.

Pamela Morand: Thank you so much.

Dr. Corey Henderson: Oh, you're welcome so much. Rabia?

Rabia Khan: Yes, absolutely. So in regards to you participating for the 2018 performance year in a Shared Savings Program Track 1 ACO, so it is a MIPS APM. So, as Corey said, the Shared Savings Program is an

alternative payment model. And the entity that we refer to is the ACO on this program. So, you'll be scored under the MIPS APM scoring standard which is a special scoring. And I believe it's on slide …

Dr. Corey Henderson: Thirty-five.

Rabia Khan: … thirty-five. So, your quality data will be reported by the ACO. So the – your ACO you're participating in is required by the Shared Savings Program to report the CMS Web Interface and CAHPS for ACO measures by selecting a CAHPS for ACO vendor as a part of our program requirement. So, the quality data their ACO reports will be used by MIPS to calculate your quality category for the MIPS – under the MIPS scoring standard. And so the data that you would report will be through your ACO, right? So, your ACO is going to be working with all of their participants to report data through the CMS Web Interface. You can …

Pamela Morand: Okay.

Rabia Khan: … still report outside of the ACO if you so choose in the event that your ACO does fail to complete reporting. And, like Adam noted earlier, if you want to report outside of the ACO and would like to choose the CAHPS for MIPS or CMS Web Interface reporting options, you would still have to register for that. The ACO does not …

Pamela Morand: I use a registry.

Rabia Khan: Okay.

Pamela Morand: Is that okay?

Rabia Khan: You can still use the registry reporting outside of the ACO; however, if your ACO completely reports, the ACO reported data is going to be used by MIPS for the quality category.

Pamela Morand: Okay.

Rabia Khan: And you will still need to report Promoting Operability.

Pamela Morand: Right, yes.

Rabia Khan: As part – yes.

Pamela Morand: Okay.

Nicole Cooney: Thank you so much, I need one more question, Holley.

Operator: All right. Our next question will come from the line of Alan Bass.

Alan Bass: Good afternoon. Thank you for taking my question. I just want to confirm something you said earlier about MIPS. During the first payment year if a clinician was eligible to participate and they successfully participated in submitting data, that's good. If they subsequently found out during Year 2 that they are exempt,

but since they are in a workflow within their practice and continue to collect data, and don't know what the future holds, and they still don't – still collecting data in Year 2, and they submit the data, although they are exempt, I want to confirm, you said that they can submit the data. But are they eligible for a payment adjustment if they are exempt?

Molly MacHarris: Sure. This is Molly. The answer to that is, No, they would not be eligible for a payment adjustment if they are exempt.

Alan Bass: Okay.
Molly MacHarris: Thank you.

Alan Bass: Very simple question. Thank you.

Nicole Cooney: Thank you. Next question, Holley.

Operator: Our next question will come from the line of Mary Ann Parilla.

Mary Ann Parilla: Hi. I have a question going back to the clinical data registry submission. I understand that one – the clinical data registry is a non–public health registry vs. a public health registry, which is public health based. But is there a difference in the type of data that either of those registries receives? Is their focus that much different, or could a clinical data registry also be a part of the public heath arena? And could you give me an …

Elizabeth Holland: Yes, a clinical…

Mary Ann Parilla: … example of both.

Elizabeth Holland: A clinical data registry could certainly be collecting public health. Examples would be, for example, if it's an immunization registry (that's probably not the best example) but immunization registry—that's sponsored by the county. So because it's a county, it would be considered – it could be considered public health. But something that's sponsored, for example, by a specialty society, for example, eyes and the IRIS® Registry—so ophthalmologists report there, but it's sponsored by their specialty society, so that would be connected – collecting public health information but by a non–public health entity. So, it would be considered a clinical data registry. Does that help?

Mary Ann Parilla: So then if it – it does. The instance about a specialty society that sponsors a registry, then is that just going back to the old definition that we've been used to: a specialized registry? Are we just calling it …

Elizabeth Holland: Yes.

Mary Ann Parilla: … different or?

Elizabeth Holland: Correct. It would be – we're breaking up the specialized registry from the transition measures into two different categories—public health and clinical data registries—for the 2015 edition.

Mary Ann Parilla: Okay, thank you.

Nicole Cooney: Thank you. Holley, I've got time for one more – one final question.

Operator: Okay, our next question will come from the line of Randy Soles.

Randy Soles: Hey, there. Thank you. Our question is for our anesthesiologist for CRNAs on quality measures. There's really only about six that they can report. Two scenarios: one, if they did two measures for six/seven months, how many points would they get? And if they did six measures, how many points would they get?

Molly MacHarris: Sure. This is Molly. So generally for clinicians under the Quality performance category, they have to report on six measures. One of those would need to be an outcome measure or another high-priority measure. There are some scenarios where, if a clinician does not have six measures available to them, we do reduce that requirement, but that's only available through certain submission types. And again, it really occurs on a case-by-case basis for the specific clinician.

But so if I'm understanding your scenario correctly, if you're – if a clinician is required to do six measures and they only report on two, then, you know, the maximum number of points they could receive for the Quality performance category – so generally, the denominator there is 60 points because we're looking for six measures—we issue a maximum of 10 points per measure. So, the maximum number of points they could get would be 20 out of 60, which then we multiply by the performance category weight. That's, again, assuming that the measures that are selected, they would receive, you know, maximum performance on.

So it can get a little complicated when you're looking for the specific details for your specialty. What I would encourage you to do, though, is to contact our service center or our free technical resources. That information is available towards the end of the slide deck. And we have resources available there where they can actually walk you through your particular specialty, and then which measures would apply best for your specialty, and then what you could anticipate the scoring to look like. I hope that helps. Thank you.

Nicole Cooney: Thank you. Unfortunately, that's all the time that we have for today. If we did not get to your question, you can email it to the address listed on slide 37, and that's qpp@cms.hhs.gov.

Additional Information

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

Again, my name's Nicole Cooney, and I'd like to thank our presenters and also thank you for participating in today's Medicare Learning Network Event on the Quality Payment Program: Answering Your Frequently Asked Questions. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.