Hello, and thank you for joining today's Quality Payment Program Year 2 NPRM Office Hours Session. Today, representatives from Centers for Medicare and Medicaid Services will provide a brief overview of the Quality Payment Program Year 2 NPRM, and then take questions from attendees. You can listen to the presentation through your computer speakers. Questions will be taken by chat and by phone. A phone number will be provided later in the Webinar once the Q&A portion begins. Jean Moody-Williams, Deputy Director of the Center for Clinical Standards and Quality at CMS, will provide an introduction for today's webinar and will then turn the call over to Quality Payment Program subject-matter experts from CMS. Ms. Moody-Williams, you may begin.

Thank you and good afternoon or morning to everyone, depending on where you're calling from. I am very pleased to talk with you today about the Quality Payment Program, and we have a number of our policy experts on the phone today, and our plan is to answer as many of your questions as possible about the proposed rule. That is really what today's call is about. We do have a few slides that we'll go through with you briefly, but we think we will have ample time for questions. Now, as you've been reading through the rule, I'm hopeful that you've been able to see that we recognize that the Quality Payment Program is a big change, and so we're trying to take it slow, and as we work to improve Medicare, we want to make sure that you continue to be involved every step of the way. That's the importance of this call and your comments that we anticipate receiving. We can't really create meaningful policy without the input of those affected the most -- doctors and clinicians and those working to serve Medicare beneficiaries. From the very beginning, our goal has been to listen, to find ways to support clinicians, focus on care quality, and the one thing that matters -- making patients better. Since the program launch, we've talked to over 47,000 people to raise awareness, to garner feedback, and to help clinicians prepare to participate in the program. So I encourage you to keep the trend going and provide comments on the proposed rule. Tell us what works. That's just as important to know what you support because that can help us explain why we decided to go a certain way, and please tell us what doesn't work. How would you change or enhance the policy we've proposed? Are there ways we can simplify policy and reduce burden? We want to hear all of that from you. Now, before we move to the proposed rule, I have to say a few words about the current program year, and as you know, the program in first performance period is already well under way and runs from January 1, 2017 to December 31, 2017, but our message is, it's not too late to participate. So you can avoid a negative payment adjustment or earn a positive adjustment by participating, starting even today, and we are hopeful that you can help us get that message out. We know that specifically you can choose to participate in MIPS in one of three ways, and those ways have been well outlined in many of our other presentations, and, of course, you can choose to participate in advanced alternative payment models, as well. If you decide not to participate and don't send anything in for 2017, then that would result in a negative 4% payment adjustment, and we think that that can be avoided this year for those that just do the simple things that we've listed, and we know that the program is complex -- not to minimize that. So there is help available. We have technical assistance available to help you be successful. So that's just my plug for continuing to do the work that's required for this year, but, again, this call is about the proposed rule, so we're going to ask that you keep your questions and comments related to that because we know that the comment period is rapidly coming to an end, and we

want to make sure that you have clarity as you send us your comments. So, with that, I mentioned we have a number of experts on the phone. I'm going to turn over to Adam Richards to get us started.

Great. Thank you. Thanks so much, Jean, and thank you all for joining us today. Like Jean mentioned, we are only a few short days away from the deadline to submit comments on the proposed rule for Year 2 of the Quality Payment Program, and that date is August 21st, and we'll say that a few more times throughout our discussion today. So with that said, we thought it would be valuable to host an Office Hours Session to answer any of those burning last-minute questions and provide clarity on any of our proposals really in an effort to help shape your comments. Again, as Jean mentioned, the intent here is really to provide insight into Year 2 of the program, which means this session is not necessarily meant to be a deep dive into the policies of the current performance here and really be on the looming deadline, submission deadline on August 21st. We've heard from a number of you that you wish to have more time to speak with our subject-matter experts, so we did want to take this opportunity to provide that one-on-one connection. So let's jump right in. We'll get going. I am on Slide 3 -- just a few administrative updates before we jump into the bulk of our discussion today. So, some of you may know -- and this may be new information to others -- we recently added special-status designations to the MIPS Participation Lookup Tool on qpp.cms.gov. Many may be asking, "What does that mean?" So we at CMS ran a series of calculations to determine if a clinician or practice qualifies for special rules and considerations under the Quality Payment Program. These special rules apply to the following statuses that you'll see on-screen -- non-patient-facing, Health Professional Shortage Areas, rural, hospital-based, and small practices. Of course, all of the official definitions or descriptions, however you want to call them, are available on qpp.cms.gov when you use the MIPS Participation Lookup Tool. And just as an example of a special rule for clinicians with a special status, just to kind of give you that example, the weights for the approval activities are doubled in certain circumstances, which reduces the number of activities that a clinician would need to report for the first year. So moving on to the next slide, our second announcement is on the Quality Payment Program Hardship Exception Application. I think that this was a much-anticipated release, especially for those individual MIPS-eligible clinicians and groups may qualify for a reweighting of their Advancing Care Information Performance Category score. So in order to access the Hardship Application, you simply go to qpp.cms.gov, access the MIPS tab, and select the Advancing Care Information link. About halfway down on the screen, you'll see this link that says, "Learn more about a hardship exception." So this is where the application is located. One thing I will say is that the application is very straightforward as we've tried to really streamline the process as much as possible for interested clinicians. When you get to the Hardship Exception App screen, you will have access to plenty of information from context to process, even some of the frequently asked questions and answers that we've received, and, again, this information is specific to both individual and group supporters, so I highly suggest that each of you read through this page. Do note that MIPS-eligible clinicians, as you can see on-screen, may submit a Hardship Exception Application if they have one of the following reasons. So that's insufficient Internet connectivity, extreme and uncontrollable circumstances, or a lack of control over the availability of CEHRT. Also, one other thing to note is that MIPS-eligible clinicians who are considered Special Status do not need to submit a Hardship Exception Application. We have been receiving a lot of questions what is a submission deadline for this? So just very briefly, the Hardship Application deadline

for the 2017 Performance Period will be finalized with the 2018 Quality Payment Program Year 2 Final Rule. So in the 2017 Quality Payment Program Final Rule, we had finalized a deadline of March 31, 2018 to align with the submission deadline for MIPS. However, in our proposed rule, we are proposing to change that deadline for the 2017 Performance Period to December 31, 2017, or another date specified by CMS.

And we will be approving the applications as they come in. So if you submit today, you probably get approved within 24 hours.

Perfect. Perfect. Thank you. And, of course, if you need help, please reach out to our Quality Payment Program Service Center. We'll have that information a little later, as well as one of our many no-cost technical assistance organizations, all of which can support you through this process. Okay, moving on to the next slide. Now we're going to get into the bulk of our discussions. So the Proposed Rule for Year 2. The next two slides are really just very high-level information on some of the proposals that are taking place -- certainly under the Merit-based Payment System. We'll talk a little bit more about advanced APMs and the proposals for that track in a little bit. So, again, I'm just going to gloss through some of these. All of these materials were attached to the event registration, so we hope that you were able to find these and go through them. So, as you can see, our proposals, we are pressing to raise the low-volume threshold to $90,000 in Medicare Part B-allowed charges and 200 Medicare Part B-enrolled beneficiaries. We are seeking comments on the proposed opt-in option, which would allow clinicians to opt in if they exceed one or two of the low-volume threshold components. Also seeking comment on a potential third component that clinicians could use to opt in. Our proposal for Virtual Groups, we're seeking comments in a number of areas, so, very specifically, definition, composition, election process, agreements, reporting requirements. My colleague Lisa Marie Gomez will talk a little bit about this later about Virtual Groups. So we'll get into that discussion, as well. Facility-based measurements. We are proposing to implement an optional voluntary facility-based scoring mechanism based on a hospital value-based purchasing program that would be available to facility-based clinicians who have at least 75% of their covered professional services supplied in the in-patient hospital or emergency-department setting. We are seeking comment on participation through the opt-in or opt-out. We also have some proposals for both the quality and cost-performance categories. I won't read through those. They're pretty straightforward. If we move on to the next slide, we have some proposals for improvement activities -- again, another one of our activities under the Merit-based Incentive Payment System. For group participation right now, only one MIPS-eligible clinician in the TIN has to perform the improvement activity for the TIN to get credit, so we are seeking comment on alternatives for a future threshold. The calculation for complex patient bonus -- we are seeking comment on whether we should include dual eligibility as a method of adjusting scores as an alternative to, or as an addition to the hierarchical condition category risk score. Small practice bonus. We are proposing to add five points to the final score for MIPS-eligible clinicians in small practices who submit data on at least one performance category in an applicable performance period. We are seeking comment on whether this bonus should be extended to clinicians in rural practices, as well. And then, finally, we do have a proposal out for the performance threshold. We are seeking comments on whether that threshold should be set at something different than 15 points. So as you can see on-screen, possibly at 6 or up to 33 points we are seeking comments. Moving on to the next slide. Just very, very quick want to touch base on just a few

aspects of the proposal for Year 2. There is no change in the types of clinicians eligible to participate in 2018. So that's physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Other types may be added for the 2019 MIPS Performance Period and beyond, and those clinicians who are not currently eligible to participate in MIPS the first two years do have the ability to volunteer to report, and that would really help you to kind of get the experience needed for future program years and beyond to really hit the ground running if and when you do become eligible for the program. And the next slide, this is just talking, really, about the performance period for MIPS moving into Year 2, 2018. So we realize that this is a big change, the Quality Payment Program, so we will continue to take it slow. So for the 2017 transition year, the performance year we're currently in, MIPS-eligible clinicians have the opportunity to pick their pace of participation in the performance period by either submitting a minimum amount of data, the 90 days, or the partial amount of data, or a full year worth of data -- a full year's worth of data. Since the Quality Payment Program will be implemented fully in its third year, we are proposing flexibilities for Year 2 that will gradually prepare clinicians for full implementation. So that means we are proposing to kind of modestly increase the performance-period requirements to include a full year of data for the Quality and Cost Performance Categories, although we may not necessarily use the Cost Performance scores for your final score, depending on the comments that we receive and how we finalize the rule, and we are also proposing to increase the performance period to 90 days of data for both the Improvement Activities Performance Category and the Advancing Care Information Performance Categories. So, with that, we'll move on to the next slide. I just want to remind everyone again that we still are in rulemaking, so the official comment period does close August 21st. That's just a few short days from now. The instructions for submitting comments can be found in the proposal rule itself. We also have a concise fact sheet on qpp.cms.gov. We also have the information for submitting comments in the fact sheet, as well. You can find all of this information, again, on qpp.cms.gov under the Resources section. So, the next two slides are really the most frequently asked questions that we received thus far. We've done a few of these Webinars on the Proposed Rule for Year 2, and these are at a high level, some of the questions that we've received. So we're hoping we can answer some of the high-level questions right off the bat, and then we'll get into some of your questions in just a few minutes. So, we're going to walk through these, just provide some concise answers. Our subject-matter experts are on the line, ready. So I'm going to begin with the very first one, and that is, "What, if any, are the proposed changes that will affect 2017?"

Okay, so this is Elizabeth Holland, and I'm going to answer this question for the Advancing Care Information Performance Category. The changes we have proposed are adding exclusions for the E-Prescribing Health Information Exchange, send a summary of care and request accept summary of care measures. Another one we proposed was to reweight the Advancing Care Information Performance Category to zero for ambulatory-, surgical-center-based MIPS-eligible physicians, also adding a decertification exception for those clinicians whose Certified EHR Technology was decertified in 2017, and changing the deadline for the Significant Hardship Application to December 31st of the performance period for 2017 and moving forward, and Adam mentioned that, but I also added make sure you apply now. Don't wait. Because we are approving them as we receive them. Next?

Perfect. I'm going to move on to the next question. So, "What are the proposed participation requirements for 2018?"

Sure. Thanks, Adam. This is Molly MacHarris. So, just one of the highlights from areas that are not changing for 2018. The first is our definition of a MIPS-eligible clinician. We're still keeping that the same as it was for the first year. That includes your MDs, your physicians, your nurse practitioners, your physician assistants, your certified registered nurse anesthetist and certified nurse specialist. So the eligible clinician type, that is remaining the same for the second year. Additionally, in this second year, we still have our options for participation, including the individual options for participating, which is based off of your unique TIN, your unique Tax Identification Number, and your unique National Provider Identifier, and also participating as a group, which is where two or more MIPS have reassigned their billing rights over to a group. Some of the areas where we have made proposed changes for the second year include the addition of the virtual-group participation option, as Adam touched on earlier, and I know my colleague Lisa Marie Gomez will go over in a little bit more detail. We also made a proposal to increase the exemption for the low-volume threshold. What it was for the first year was clinicians that had billings that were less than or equal to $30,000 annually and less than or equal to 100 patients were excluded. We propose to increase that to $90,000 in billings and 200 patients so that additional small practices and clinicians that practice in rural areas or health-professional-shortage areas HPSAs could be exempt from the MIPS. I also did just briefly want to touch on some of the additional flexibilities that we've made proposals on for small practices, because you know that is a particular area of concern for many stakeholders. We have proposed to create a new hardship exception under the Advancing Care Information Performance Category for Small Practices. We've also proposed to add five bonus points to a clinician's final score if they are considered to be part of a small practice, and we also have proposed to continue to offer three points for measures if they do not meet data-completeness criteria or if they do not meet case minimums under the Quality Performance Category. Thanks.

Perfect. Thank you, Molly. And one last question for Molly. "Does the NPRM propose new measures or requirements for Quality in 2018?"

Sure. So, for the Quality Performance Category overall, we have proposed to add in a few more measures. Remember, we finalized in last year's rule around 270-some-odd quality measures. So we have proposed to add in a few additional measures. We do still have the same performance criteria in the second year as we did in the first year, which is that clinicians would need to select six measures. Of those six measures, one would need to be an outcome measure. If an outcome measure is not available, clinicians would need to select from another high-priority measure, which could be an outcome measure, a care-coordination measure, patient safety, efficiency, or appropriate use, and there are a few other types, as well, and if clinicians can choose those six measures either from that comprehensive set of 270-plus measures or by selecting specialty sets, and we have proposed to continue to keep the specialty sets, and we have made a few proposed changes to those. The Quality Performance Category also we have proposed to keep at 60% toward the clinician's final score. So, again, that's the same way it worked in the first year. The same for the data-completeness criteria. We propose to keep that at 50% for the second year, the same as it works in the first year. For how we score quality, we did propose to make a few changes. The first is that for measures that fail data completeness and measures that fall below

that 50% rate, unless you are part of a small practice, you would only get one point. If you are part of a small practice, you would get three points for that measure. We did continue -- We propose to continue to keep our other elements of quality scoring, including that if there's not a benchmark available for a measure, clinicians could receive three points. If measures do not meet the case minimum, they would receive three points, as well. And then the last piece, I'll note for the Quality Performance Category that we made proposals on, if we did propose additional details on our topped-out measures, and the way that those topped-out measures should be scored in the proposed rule, we added a life cycle to topped-out measures, and as part of that life cycle, once a measure had been identified as topped out for two years, we would apply a scoring cap to that measure of six points. Thank you.

Perfect. Thank you, Molly. So the next question we have -- I'm going to turn it back over to Elizabeth Holland. So, "What is the proposed hardship exception for Advancing Care Information in 2018?"

Okay. So the only new hardship exception that we've proposed for 2018 is the hardship for those clinicians in small practices, but that also means if we do finalize the decertification hardship that I mentioned for 2017, it would also be applicable in 2018, and we did establish hardships for the program last year, and those include the insufficient Internet connectivity hardship, the extreme and uncontrollable circumstances hardship, and lack of control over the availability of Certified EHR Technology. The other change that we're hoping to finalize for 2017 and moving forward is the change for the application deadline, again, from March 31st to December 31st.

Okay. Perfect. Thank you so much. Moving on to the next slide. We'll go through these rather quickly. I'm going to turn this over to Lisa Marie Gomez to describe a little bit the proposal for Virtual Groups.

Thanks, Adam. So participating in a Virtual Group is another way clinicians can elect to participate in MIPS. Virtual Groups would include fellow practitioners and groups of 10 or fewer eligible clinicians who come together virtually with at least one other such practitioner or group to participate in MIPS for a performance year of at least a year. Clinicians -- Generally, clinicians in a Virtual Group will report as a Virtual Group across all four performance categories, and they need to meet the same measure and performance category requirements as non-Virtual MIPS groups. And then the next question -- Adam, do you want me to go on to the next question?

Yep. Absolutely. Thank you.

Okay, so the next question is, "Can a provider join a Virtual Group if they don't meet the threshold for participation?" So if you're a solo practitioner, and if you do not exceed the low-volume thresholds, you will not be eligible to join a Virtual Group. Similar to when you think about groups, if you're a group, and your group has 10 or fewer eligible clinicians, if your group collectively does not exceed the low-volume threshold, your group would not be eligible to participate in a Virtual Group. You would still be able to participate -- I mean, if you wanted to voluntarily participate, you could, but as, like, a regular group or a rural practitioner, but in terms of joining or forming a Virtual Group, you would not be eligible.

Perfect. Thank you so much, Lisa Marie. And now we're going to turn it over and really talk a little bit more about the proposals for the Advanced APM side of the Quality Payment Program. So we have three questions here, and I'm going to turn it to my colleagues over at CMMI to explain the proposals in 2018 for Alternative Payment Models and Advanced Alternative Payment Models. So I believe we have Benjamin Chin on the line.

Hi, Adam, and thanks so much. So, yeah, so we're maintaining many of the policies finalized for the transition year, but some of the major changes and updates we are proposing for 2018 include, but are not limited to, we're expanding the revenue-base nominal amount standard, which is previously finalized to performance year 2018 for two additional years through performance year 2020. We are also changing the nominal-amount standard for medical home models so that the minimum-required amount of total risk increases more slowly. We are also proposing to exempt the Comprehensive Primary Care Plus Round 1 practices from the 50-clinician cap, and we are also giving much more detail about how the All-Payer Combination Option will be implemented, including the payer-initiated Other Payer Advanced APM Determination Process, as well as the eligible-clinician-initiated Other Payer Advanced APM Determination Process. And lastly, we propose many more details on how other clinicians participating in select APMs will be assessed under the APM scoring standard, and as a reminder, this is a special scoring center that reduces burden for certain APM participants who are subject to MIPS reporting.

Great. Thanks so much. And to kind of continue on with that -- "How can someone participate in an APM or in an Advanced APM moving forward?"

Yeah. Thanks, Adam. This is a great question. So we currently have seven Advanced APMs in operation with more opportunities available coming in 2018, and then there are many more regular Advanced APMs at the Innovation Center. But to join an APM or an Advanced APM, first visit the QPP website to learn about specific APMs and Advanced APMs and how to apply to those payment models directly, and the list of all APMs is available on the qpp.cms.gov website. Second, you would apply to the Advanced APM that fits your practice and is currently accepting applications for new participants, and just as a reminder, there are certain benefits to participating in an Advanced APM of clinicians who meet certain payment or participation thresholds in a given performance year will be excluded from MIPS adjustment and receive a 5% APM incentive payment.

Excellent. Thank you. And one last question. "Are APMs and Advanced APMs required to use Certified EHR Technology in 2018?"

Yeah, so as we established last year, to be considered an Advanced APM, a model must require participants to use Certified EHR Technology, and, specifically, the Advanced APM CEHRT criterion states that to be an Advanced APM, an APM must require at least 50% of eligible clinicians in each participating APM as a group to use CEHRT to document and communicate clinical care to their patients or other healthcare providers.

All right. Great. Thanks so much. We're going to move over to our next slide, which will be really the opening of our Q&A session. So I just wanted to walk through a few ground rules. To ask a question, please use the phone number that is listed on-screen. Again, we'll try to answer your questions and provide some clarity as much as possible. Please remember that we are still in the rule-making process, so if you do have comments, please submit

them through the official mechanisms that we discuss below. If you need additional information on this mechanism, it can be found on qpp.cms.gov, or even in the Federal Register. Again, that period closes August 21st, so please submit your comments as soon as possible. Also, for callers who are lining up right now, we ask that you limit to one question per caller to start. We have a lot of folks on the line right now. We want to try to get through as many questions as possible, so please just one question to begin. If you have additional questions, we also have our subject-matter experts working the Q&A chat right now, so they'll also, hopefully, be able to address your questions there, as well. And please, just as Jean mentioned earlier, we are taking questions on the Proposed Rule of Year 2, so with that said, I think we can open up the phone lines and take our first caller.

Again, if you would like to ask a question, please press star, then the number 1. Our first question is from Erin Solis.

Hi. Thank you for taking my call, or my question. I have a question related to your small-practice determination. So, in 2018, I understand you're proposing to use claims information to determine if a practice is small. However, the website information is including that, but the 2017 rule said you were going to use attestation. So I'm trying to figure out if you're using 2018 proposed information and applying to the 2017 performance period, or what's going on there.

Sure. This is Molly. So what we indicated in last year's final rule is that we would assess -- so just so everyone is aware, we defined a small practice as 15 or fewer clinicians, and a small practice is important because a small practice is considered to be one of our special statuses, and our special statuses of what that means is that clinicians who have a special status, they may, in some instances, have to do a little bit less under a performance category, or they may be excluded from doing a performance category and those points redistributed to another performance category. So what we said in last year's rule is that we would determine clinicians' special statuses, particularly their small-practice designation based off of available data to CMS, and if not available, we would allow attestation. We were able to calculate the small-practice determination for all clinicians. So no separate attestation is required. If what you're seeing in the Lookup feature on the qpp.cms.gov website, if for any reason that doesn't look accurate to you, I suggest that you contact our Help Desk, and the information for the Help Desk is available on the slide that's being presented right now. Thank you.

Your next question is from Mr. Shaw. Mr. Shaw, your line is open. We will proceed to the next question. Your next question is from David Friedenson.

Hi. Yes. This is David Friedenson calling from Colorado. My question is, if a clinician reports in 2017 as a part of a group, but they don't meet the $90,000- or 200-patient threshold, would they be exempt in 2018 as reporting as individuals because they no longer meet the threshold even though their group may meet the threshold as a group?

Sure. This is Molly again. So let me try to piece this one apart, because I know it can get a little complicated when we're talking about what we said we would be doing for the first year, and then now we have the proposed rule out right now, which has made a proposal to how we would change those requirements for the second year. So just to be clear, the threshold determination for the first year was based off of the $30,000 or 100

patients, and all that information is available now. So if you haven't already gone to the qpp.cms.gov site to look up your practice's NPI, I would encourage you to do so, and so that sets forward who each of the eligible clinicians are for the first year, and so if on the Lookup Tool, it indicates that you're eligible, I would strongly encourage you to participate in this first year because we don't want anyone to be receiving that negative 4% payment adjustment. We really want to try to minimize that as much as possible. When we talk about the second year and our proposed increase to the low-volume threshold of $90,000 or 200 patients, if we finalize that, we would finalize it -- If we finalize it as proposed -- We're still in the public-comment period, and we will need to review all the comments before we can say definitively what we will be doing, but if we finalized it as proposed, we would make the determination of whether or not each clinician or group of clinicians are eligible using $90,000 in charges and 200 patients based off of a timeframe that we would finalize in the rule. Again, if we finalize it as proposed, the timeframe would span approximately from September through August. So your eligibility and your participation in the first year doesn't necessarily mean that you would be eligible and able to participate in the second year, and then it could be vice versa. It could be that you're excluded for this first year, but then you would be eligible in the second year. So I hope that helps clarify. If it doesn't, please feel free to get yourself back into the queue or add a question to the chat. Thank you.

Your next question is from Marissa Pearce.

Hi. Good afternoon. Thanks for taking my question. My question's related to small group and the Virtual Group. So the small-group bonus that's proposed for next year, if a small group decides to participate in a Virtual Group, do they forgo that small-practice bonus?

Hi. This is Molly. So, the small-practice bonus -- Again, that would apply to practices that have 15 or fewer eligible clinicians.

Mm-hmm.

Virtual Groups can be comprised of clinicians that have one TIN that has up to 10 clinicians or a TIN that has as little as one clinician, and there's no limit on the number of clinicians that can join a Virtual Group. So, if, for example, a Virtual Group is formed with one TIN that has 10 clinicians and then four other solo practitioners, yes, they would still be considered a small practice, and they would be eligible for the small-practice bonus. If, however, a Virtual Group is comprised of five TINs with 10 clinicians, and then five solo practitioners -- I think if I have my math right, they would mean that that Virtual Group would have 55 clinicians. In that scenario, they have exceeded that 15-clinician small-practice limit, and they would not be eligible to receive the small-practice bonus. Again, this is all working under the assumption that we finalize things exactly as proposed, and I'll just reiterate that again now and probably in future answers just because I want to be clear that we are still in a proposed rule and we do really want to hear all the feedback and comments from all of you as we shape our final proposal. Thank you.

Thank you so much.

Your next question is from the line of Kim Sweet.

Yes. Hello. Thank you for taking my call and thank you for providing this forum. I'd like to go back again on the hardship for small practices in relation to the Advanced Care Information Category. I didn't see in there in the proposed rule where they really defined what the hardship pertaining to small practices were. Is this not yet completely defined or can you define it for me? I mean, just being a small practice, does that mean they get a hardship for the ACI just because they're a small practice?

Yes. We define small practice as a practice with 15 or less clinicians, and the hardship would be if you apply for this hardship, you would have and are approved your Advancing Care Information Performance Category would be reweighted to zero.

Okay. Thank you.

Your next question is from the line of Sandy Rosenblum.

Hello. So, I'm a consultant in Cleveland, Ohio, and one of the biggest issues that practices that I work with face is their ability to communicate the HIE referrals -- the electronic summary of care, and probably the biggest problem there is getting other doctors to participate with them. They get the idea of the EHR and the electronic referral, but there are a lot of road blocks in terms of actually making that electronic summary of care transfer. Some of these have to do with technical blocks because some vendors, of course, create proprietary technology for that, and you may be aware of that. In other cases, it's simply large organizations versus small practices, and small practices are at a disadvantage, of course. So my question is, do you have any concern or consideration for encouraging vendors and larger organizations to participate? And probably the best way to do that would be to publish a universal database of doctor summary of care addresses -- kind of like an e-mail database. Of course, it would take technology to filter out e-mails that were sent in error, but is there any effort in that direction or any way to address that?

Well, we do point out that the threshold is one patient, and we did propose exclusions for this measure, but we are working to try to increase the availability of partners for which you can exchange.

Yeah, and I highly recommend because this is a good conversation that this is submitted through the official comment process, so this is something that we can review as we move into the final rule for Year 2 of the program. I see a couple comments that are directly related to your comment, so I certainly encourage all of you to submit these comments so that we can take a look and review. Go to the next question, please.

Your next question is from the line of Vickie Leach.

Hi. This is Vickie. I'm in psychiatry. I did put it on the Question-and-Answer thing, as well, but my question is, I have a psychiatrist who saw in-patients and out-patients and was able to attest under meaningful use. He now has changed, and he's totally in-patient. So how can I attest when he has no out-patient information or quality measure for his out-patient as an individual? Is there a way that I can get him? Because when I did the Lookup to see if he was eligible to participate, he is eligible based on his previous meaningful use, but now he will not have any out-patient information or quality measures, and he's only seeing in-patient as psych.

Okay. So he is not considered -- We don't make the determinations based on his meaningful-use status. We base it on the claims that he submitted.

Right.

So we will do another look at that.

Yeah. This is Molly. So we'll be doing a second look for the low-volume threshold determination, which will run from the dates of service of September 1, 2016 through August 31, 2017, and so if he doesn't -- If he switched from being out-patient to now being in-patient, if he has less than $30,000 in charges and sees less than 100 patients during that timeframe I just gave -- September 1, 2016 through August 31, 2017 -- he would be considered newly excluded, and so we intend to update our Lookup Tool with clinicians that would be newly excluded closer to the end of this year.

Okay. All right. And then since he is in-patient, then he falls under the hospital for any quality measures?

And so we would also do an additional determination of the special statuses, which includes whether he's part of a small practice, rural practice, hospital-based, non-patient-facing, etcetera.

Okay.

I will say if he does see any out-patient patients...

Mm-hmm.

...the participation requirements for the very first year of MIPS are really minimal, so if he could be at that borderline of hitting that $30,000 or 100 patients, I would strongly encourage you to work with him to find a quality measure that he could report or look at the improvement activity and try to do one of those.

Okay. All righty.

Thank you.

Okay. Thank you.

Your next question is from Lee Ann Dangelo.

Hello. Good afternoon. I wonder if you can help me understand what the process is after the comment period closes on August 21st and the time frame?

Sure. This is Molly. So, August 21st, that is the last day for us to receive comments. So, again, if anyone on the phone here today, if they have not yet submitted your comments, please, please do so by that date so we can consider those.

And tell us what you like and what you don't like.

Correct. Correct. Please try to be as specific as possible. That really helps us as we finalize our proposals. We will then take a look at all of the public comments received, and we will then finalize our policy. We

intend on publishing the final rule around the end of October, the beginning of November. So the policies can be effective beginning on January 1, 2018. Thank you.

Your next question is from Elizabeth Gutierrez.

Hi. This is Elizabeth. Thank you for taking my call. Hello.

Hi. We've got you, Elizabeth. Thanks for calling.

Okay. Thank you. I have a quick question. So I am working with a group of anesthesiologists, and we do not have electronic medical records. Would that be considered to be hardship or wouldn't it not be considered?

Sure. This is Molly. So if you do not have an electronic medical record, you can still participate in the program. Remember that MIPS, the MIPS branch of the Quality Payment Program, performance is assessed on four performance categories, which include Quality, Cost, Improvement Activities, and Advancing Care Information. While we encourage all clinicians that are able to have an electronic health record to get one and to use one, but you do not have to have an EHR, an EHR to participate in the program. You could still participate in the Quality Performance Category without an EHR, and you could also complete Improvement Activities without an EHR. What that would mean, though, is that your total final score would be a little bit lower than those clinicians who do have an EHR. Thank you.

Okay. Thank you.

Again, to ask a question, please press star, then the number one. Your next question is from Tara Green.

Hi, everybody. Good afternoon. I do have a question, and this is provider-specific question. This provider was previously billing Medicare and meeting the threshold for Calendar Year 2016. I'm assuming that's where CMS received information from was from his claim, but as of January 1 of this year, he has not billed to Medicare and will no longer probably be billed by Medicare. He's billing Medicaid at this point. So can we roll him over? It does show that he's eligible for being in MIPS and probably doing APM, but I'm not quite sure where he falls in that category. Can someone assist me with that?

Sure. This is Molly. So if I'm understanding your scenario correctly, it sounds like your clinician previously billed Medicare last year, but now this year, in 2017, he's only billing Medicaid. So based off of the information off of our first eligibility-determination snapshot, it's showing that he's eligible. So this sounds similar to the scenario that a previous caller gave. I think in that instance, they were a psychiatrist who was previously seeing out-patient patients, and now they're strictly in an in-patient setting. So just wanted to remind folks that we will be doing a second eligibility-determination snapshot based off of dates of service of September 1, 2016 through August 31, 2017. We will be looking during that snapshot to see if clinicians exceeded our low-volume threshold, which is, again, $30,000 in billing and 100 patients. So if we find that this clinician of yours, who switched from doing Medicare to Medicaid, exceeded the $30,000 or 100 patients, they would be eligible for the program, and they would need to participate doing something under our Pick Your Pace

approach. Otherwise, they would be eligible to receive that negative payment investment, which we want to avoid.

Okay. Thank you.

Thank you.

I'm actually going to pull one out of the chat because we've gotten quite a few questions on this about FQHCs and what that looks like for 2018. I know we don't have a lot of changes that are going to be made to FQHCs because it's not a facility-based program, so those clinicians could still voluntarily participate if they are interested, but I'm certainly just going to throw this out to our subject-matter experts if there's anything else that we want to add as far as FQHCs go for future program year.

Sure. This is Molly. So, great question, Adam, and for the questioner for asking it. No, we did not make any additional proposals in this year's NPRM for changes on how we would assess clinicians who participate or work under an FQHC or an RHC. So no changes to how it's currently working under the program.

Okay. We'll go back to the phone line for maybe one or two more questions.

Your next question is from Crystal DeCoster.

Hi. I actually have two. I think they're pretty easy questions. One is for the QPP website. We were actually informed, because you guys are doing that second snapshot, that the information that's on there might not actually be correct. Do we have a rough idea of when that information will be available and be correct because of the second snapshot? And then I just had a question about the hospital-based clinicians, but I did put that in the Chat.

Sure. This is Molly again. That's interesting that you've heard that it's not correct. We're having confused faces here in the room.

So let me step back because we're an Advanced APM. Some of our providers were approved to be Advanced APM, and then some of them have not. So is it that we're on the Advanced APM, their stuff is not up to date, it's not correct, and we've actually gotten a few e-mails saying that it will be coming. It might be October, but you guys will get the information.

Can our colleagues over at CMMI address that one?

Hi. This is Ben Chin at CMMI, and so I'm having a little trouble understanding your question. Were you talking about the eligibility determination for MIPS eligibility and that you said that you are an Advanced APM participant?

We are. We're an Advanced APM participant with, I believe, it's 31 providers -- 37, maybe, and then we also have like 87 other providers that were not approved to be a part of CPC+. So it's looking at it from the perspective of can we report as a group for these CPC+ guys and then as a group for everybody else, and if so, the QPP website, when you put their NPI number in, clinicians that are part of the Advanced APM are listed that they need to report for MIPS when they're a part of Advanced APM, so they wouldn't have to do that. So, will that site be updated to the point where we'll be

able to say, no, you're exempt when you report because they're a part of an Advanced APM?

So, if your participants are in -- the providers are in CPC+, they'll benefit from the APM scoring standard, and those that aren't part of the CPC+ practice can report as a regular group to MIPS; and so, also, to answer the second part of your question, my understanding is that the second eligibility determination will include Advanced APM data or APM data, but I'll have Molly and others confirm that.

Sorry, Ben. Could you repeat that last part?

That the second eligibility determination will include APM participation data.

I believe it will, but I think that's something we would need our operational colleagues to confirm, and I know they weren't able to join us today, unfortunately.

So we'll double-check that one for you.

Okay.

And we are recording this call, so we will have these questions available so that we can come back in and make sure we answer. Well, ladies and gentlemen, we've reached the top of the hour, so we do have to end our session today to be respectful of everyone's time. So please, please, please just remember that comments for the Proposed Rule for Year 2 of the Quality Payment Program are due on August 21st. That is five days from now. So if you do need additional information, please visit qpp.cms.gov for the proposed rule, as well as the concise proposed rule fact sheet. If you do need any additional support in the meantime, the information for the Quality Payment Program Service Center is on the slide. We'll leave it up for another minute or two, but we also encourage you to reach out to our Technical Assistance organizations. These are very professional, very experienced organizations with a deep history of work with CMS, and they are all at no cost to you. So please reach out. We have that information also available on qpp.cms.gov. There are different branches available for different practice sizes, so please, please, please take advantage of that no-cost support. And with that, we are going to end today. Thank you, everyone, for being with us, and we look forward to talking to you soon.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.