[Mid-tempo classical music plays]

Hello, and thank you for joining today's webinar on the Medicare Quality Payment Program Year 2 proposed rules. Today Dr. Kate Goodrich, director of the Center for Clinical Standards and Quality, will be accompanied by Molly MacHarris, program lead at Merit-based Incentive Payment System; Adam Richards, health insurance specialist; Lisa Marie Gomez, health insurance specialist; Benjamin Chin, health policy analyst; and Gregory Woods, director, Division of Alternative Payment Models Infrastructure. They will provide an overview of the proposed participation requirements for the second year of the Quality Payment Program. There will be a question-and-answer session after the presentation, if time allows. However, CMS must protect the rule-making process and comply with the Administrative Procedure Act. Participants are invited to share initial comments or questions, but only comments formally submitted through the process outlined by the "Federal Register" will be taken in consideration by CMS. Review the proposed rule for information on how to submit a comment. You can listen to the presentation through your computer speakers. Later in the webinar, a phone number will be provided to ask questions, if time allows. I would now like to introduce Dr. Kate Goodrich. Dr. Goodrich, you may begin.

Thank you so much. Hello, everybody. So, on behalf of Administrator Verma, I am pleased to talk with you today about the Quality Payment Program. This program is one of the ways in which CMS is helping to promote better care and smarter spending across the entire healthcare system. The proposed rule that we will talk about today represents an important step in our progress towards making Medicare not only sustainable but better than ever, and better for everyone -- for doctors, nurses, and patients alike. We are changing the way that Medicare pays for care by helping clinicians focus on care quality and the one thing that matters the most, which is, of course, making patients healthier. We want patients to have more time with their doctor and to experience better-coordinated and safer care. The Quality Payment Program is a big change, so we are continuing to take it slow, to ensure that clinicians can easily participate, and that patients are put first. So we are proposing to reduce burdensome regulations, provide new incentives, and reduce the number of clinicians that must participate, so that they can focus on providing high-quality healthcare to their patients. We are still listening and committed to using data-driven insights, increasingly aligned and meaningful quality measures, and technology that empowers patients and clinicians to make decisions together about their care. We are working to offer Advanced Alternative Payment Models that support state flexibility, local leadership, regulatory relief, and innovative approaches to improve quality, accessibility, and affordability. And we've heard from you the concerns that too many quality programs, technology requirements, and measures get between the clinician and the patient, and that is why we are taking a really hard look at what's working, what is not working, what's duplicative, and what's missing. We will continue to listen and take actionable steps towards improving. Like clinicians, CMS is committed to improving health outcomes for all Americans that we serve. And as we work to improve Medicare, we want to make sure that you are involved every step of the way. We know that we can't create meaningful policies without the input of those most affected -- doctors, other clinicians, and patients. So I encourage you to provide comments on the proposed rule. Let us know what works, what doesn't work, what would you change. We really want to hear from you. And since the Quality Payment Program launched, we have talked to tens of thousands of people to raise awareness, to get feedback, and to help clinicians prepare to participate in

the program. We've listened and we've put forward many policies that are based on your input. And for the second year, we really want to continue to collaborate with you. Let's find new ways to simplify the program and reduce burden so that clinicians can put their patients first. We all have the shared goal of improving quality of care and health outcomes for patients. CMS will continue to listen and take steps to improve the health outcomes of all Americans we serve, while reducing clinician burden. So, thank you for listening. And I'm going to transition now back to Adam Richards.

Great. Thank you so much, Dr. Goodrich. And again, welcome everyone to our review of the Quality Payment Program proposed rule for Year 2, which is the 2018 program year. Our policy experts from both the Merit-based Incentive Payment System and Advanced Alternative Payment Model sides of the program are here with us today to provide you with a comprehensive overview of the changes we are proposing for Year 2 and really to help you understand the direction of the program as it continues to evolve. Of course, I would be remiss if I did not remind all of our participants today that this is a proposed rule, with the opportunity to provide comment. However, we still are in the midst of the first performance year, the 2017 transition year, and there's still plenty of time to actively participate this year, for those clinicians who are included in the program. So I'm going to skip over to Slide 3. And I do want to cover one housekeeping item before we get started. We intend to host a live question-and-answer session if time allows at the end. I want to emphasize that while we will attempt to offer some guidance and clarify the questions you may have, please understand that comments must be submitted through the formal comment process, as outlined in the "Federal Register," to be taken into consideration. And we'll talk a little bit more about this in a bit. Next slide, please. So, the basic structure of our conversation today. Our topics today are fairly straightforward. Dr. Goodrich just provided a nice introduction that helped refresh us on the Quality Payment Program. We'll move to the proposed changes for Year 2, where Molly MacHarris will walk us through the proposed changes for MIPS, and Greg Woods will lead our discussion on the proposed changes for Alternative Payment Models and Advanced Alternative Payment Models in that side of the program. We'll follow up this overview with a quick reminder of the resources that are available on the Quality Payment Program and then move into the question-and-answer session as time allows. Next slide, please. So, as Dr. Goodrich mentioned, we have been out in the field, listening. And as we move into future program years, we have heard some concerns from you that, at times, there is too much in the way between the doctor and the patient. One more slide, please. There we go. Perfect. We've heard that there's sometimes too much in the way between the doctor and the patient. And as you can see on the slide, things such as quality programs, technology requirements, even down to certain measures. So, for Year 2, we took a look at the program and really focused on ways to reduce that burden and to add additional flexibilities into the program. We really want to make sure that doctors and clinicians have the time to spend with their patients and care for their needs. And moving on to the next slide, we have maintained an enhanced foundational element, or what we like to call the bedrock of the Quality Payment Program. Our intentions are certainly to bolster high-quality patient-centered care. And as you will notice in our proposals, and as we move into the second year of the program, we will do this by, again, reducing burden and introducing new program flexibilities. Again, as Dr. Goodrich mentioned, with any good program, we'll keep what has been working, but we will also continue to elicit feedback from clinicians and stakeholders, our partners, and others, really as a means of program improvement. And that's where the continuous improvement comes in. And I

think it's very important that everyone knows that we are still listening and looking for the ways to streamline the program and reduce burden. So, if we move on to the next slide, please. Here we have our strategic objectives, our goals of the Quality Payment Program. And you may have seen these from our transition-year materials. But, in short, our focus is to improve beneficiary outcomes; reduce burden on clinicians; increase the adoption of Advanced APMs; maximize participation, which we hope will happen through additional flexibilities and burden reduction; improve data and information sharing; ensure operational excellence; and we've added one -- deliver information-technology systems... [Inaudible] ...practitioners, specialists, technology vendors and partners to work with the team as we continually improve. Again, please be aware that while we will attempt to answer your initial questions, if you are interested in officially commenting on the proposed rule -- which I think those guidelines are coming up in a second here, on this next slide -- if you are interested in officially commenting on the proposed rule, we ask that you please do so by submitting your comments and feedback through the official submission process, as outlined in the official register and on the slide that I believe is coming up. Yeah, we should be on Slide 9. Well, as it comes up, it will have a list of the official process. So, just so everyone abides by that process. Just a quick reminder that the comment period for the proposed rule is open for 60 days. And that comment period will officially close on August 21, 2017, so please circle that date on your calendar. That is August 21, 2017, to have all comments on the proposed rule in by that date. Of course, if you need any additional information, as I just mentioned, please visit qpp.cms.gov and use the resource page under the "About" tab. At this time, it is my pleasure to turn the discussion over to Molly MacHarris to review the proposed changes to the MIPS side of the program. Molly?

Thanks, Adam. And thank you, everyone, for being here with us today. So, I'm going to go ahead and start with an overview of the proposals related to MIPS, on Slide 11. So, as you can tell on Slide 11, we have a number of proposals, which I will go over in more detail in the following slides. But we wanted to initially flag some areas where we not only have proposals but where we are seeking comment on items. The difference between a proposal and an area that we're seeking comment on is, items that we're seeking comment on were we haven't made a specific formal proposal at this time, where we would finalize something in the final rule later this fall. Rather, it's an additional listening opportunity, an additional opportunity for all of you to give us feedback on future policies we may take in a future year. So, I'll just go over a handful of these -- what we have contained on this slide and the following slide. This does not include every item that we are seeking comment on, but these are some of the key areas that we wanted to flag for your attention. So, the first item -- and again, I'll talk through this in more detail later on -- is we're proposing to increase the low-volume threshold from its current rate of $30,000 or 100 patients to $90,000 or 200 patients. We are additionally seeking comment on an option that would apply for future years, where we would establish an additional area for low-volume thresholds specifically related to items and services and the ability for a clinician to opt in to the program if they fall under one of the low-volume thresholds. The second area that we have made a number of proposals on is related to virtual groups. We are also generally seeking comment on ways that we should define virtual groups, how virtual groups should be composed, the election process, the agreements, and the submission requirements that apply to virtual groups. We also are making proposals related to facility measurement. We are seeking comment on a number of areas related to facility measurement, including the ability for clinicians to

either opt in to the facility measurement process or a process, if technically feasible, where we would just ask clinicians to opt out if they don't want to be assessed for facility-based measurement. We also have made a number of proposals for all four of the performance categories for quality, cost, improvement activities, and advancing care information. For quality, we have, again, proposed to maintain that at a 60% weight, and we're seeking comment on potentially raising the data completeness threshold in future years. For the cost performance category, we are, again, proposing that at 0% for the second year, but we are seeking comment on whether we should increase that. And then, on the following slide, Slide 12, for improvement activities, we are, again, proposing to maintain improvement activities at a 15% weight, but we are seeking comment on ways that we should define group reporting under improvement activities for future years. We also are proposing to introduce some additional scoring enhancements -- specifically, a calculation adjustment for those clinicians who treat the most vulnerable and sick patients. So, for those clinicians who treat those patients, what methodology should we use? Should we use the HCC methodology or a method that looks at patients as dual-eligible status? We also are proposing to add a small-practice bonus for those clinicians who are part of a small practice, but we're additionally seeking comment on whether or not we should expand that bonus to rural practices in a future year. And then the last item that we have listed on Slide 12 here is where to set the performance threshold at. We're proposing to set it at 15 points, which is an increase from where it sat at in the first year, of 3 points. But we're also seeking comment on whether or not that is the right number. Should we have a lower number, such as 6 or a higher number such as 33? And again, I'll talk through all of these proposals in more detail in the following slide. So, let's move on to Slide 13 to start into those proposals. So, the first item is the low-volume threshold. So, as I mentioned just a few minutes ago, as folks are aware, in the first year, the low-volume threshold is defined as clinicians would be excluded if they bill less than or equal to $30,000 in Part "B"-allowed charges, or provide care for less than or equal to 100 Medicare Part "B" beneficiaries. We've received additional feedback from clinicians and stakeholders across the country that, while that threshold does exclude some solo practitioners and some small practices, there are still challenges that those practices face. So we have proposed to increase the low-volume threshold to $90,000 in Part "B"-allowed charges, or providing care for 200 Part "B" beneficiaries. Again, the low-volume threshold would apply at either the individual level or the group level, similar to how it does in the transition year. Let's move on to the next slide. So, what are the changes that we made, related to who can participate? Overall, generally minimal changes here. We still are defining the eligible clinicians as those clinicians that are physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, and where as it exists today in Year 1. We also have our same exclusion that we have available in the first year, so we have our exclusion that deals with clinicians that become qualified participants under an Advanced APM or partially qualified participants. That exclusion still exists. We also have made no changes to our exclusion related to eligible clinicians who become newly enrolled in Medicare. So, again, if you are a clinician who becomes, for the first time, newly enrolled in Medicare during the performance period, you would be excluded for that year. And then the low-volume threshold exclusion, I just went over what the proposed changes are. Again, we're proposing to increase that low-volume threshold from $30,000 or 100 patients to $90,000 or 200 patients. Moving on to Slide 15. So, another area where we have made proposals for the MIPS program is related to virtual groups. So, generally, under MIPS,

clinicians can participate either as an individual or as part of a group practice. And we define a group as two or more NPIs who have reassigned their billing rights over to a TIN. We also have, within this proposed rule, made proposals and definitions related to what a virtual group is. And so we've proposed to define a virtual group as a combination of two or more TINs -- so, the Taxpayer Identification Number -- which could be comprised of a solo practitioner or TINs that have 10 or less eligible clinicians. Of those clinicians who decide to join a virtual group, all virtual-group participants must make that election prior to the beginning of the MIPS performance period, and they cannot change that election once the performance period begins. So, as I'll touch on in a few upcoming slides, the performance period for MIPS for the second year will be calendar year 2018. So that means that all virtual groups will need to make their elections prior to the beginning of 2018. The deadline we have proposed, related to the election, is December 1st of 2017. So clinicians would need to make their elections by that date. And if they are accepted, they would not be able to participate through another method during the performance period, with the exception of those clinicians who decide to join an Advanced Alternative Payment Model. And we'll cover more details related to the interactions between Alternative Payment Models and virtual groups later on in the presentation. Moving on to Slide 16, some of the additional proposals we've made related to virtual groups is that virtual groups will have a lot of flexibility in how they form. We have not set forward any constraints related to how virtual groups can form, related to a specific location or a specific specialty that they must exist under. We also have not placed any restrictions on group sizes. So virtual groups could end up being sizes on the small end -- groups of 25 or 30 or 50. Or a virtual group could be much larger than that. Overall, virtual groups and the policies that will apply to them will be the group policies that exist today under MIPS. There are a few exceptions to that, such as how we've defined non-patient-facing MIPS-eligible clinicians, small practices, rural areas, and HPSA areas. We have made separate proposals and designations for how those policies would apply to virtual groups. But, otherwise, generally virtual groups will be treated as groups -- meaning they would have the same submission mechanisms available to them, and the same general scoring standards would apply. We also intend to define a model agreement, which will be issued through additional communications and guidance over the next few months to provide a sample to virtual groups on what that agreement could be, as they decide to form. So, let's move on to the next slide to talk through non-patient-facing MIPS-eligible clinicians. Again, here we've kept our proposals generally the same. We've made no changes to our definition of an individual or as a group. We have, however, made a proposal for how we would define non-patient-facing MIPS-eligible clinicians for a virtual group, and that is 75% or greater of NPIs within a virtual group would need to be labeled as non-patient-facing. We still have kept our proposals related to non-patient-facing MIPS-eligible clinicians, but under the improvement-activities performance category, they have to do a little bit less. And under the advancing care information performance category, in many instances, those clinicians do not have to do advancing care information performance category, and then that category would be reweighted to quality. Generally non-patient-facing MIPS-eligible clinicians would include pathologists, anesthesiologists, nuclear-medicine clinicians, and certain types of radiologists. Let's move on to the next slide. So, the performance period. So, as I mentioned earlier, the performance period for MIPS for the second year is generally going to be calendar year 2018. So, as a reminder, how the performance period works in the first year is that, for the majority of the submission mechanisms, clinicians were only required to

participate for a 90-day performance period during calendar year '17. There is the flexibility, however, that if clinicians are able to participate longer than 90 days, we encourage them to do so. The proposed changes for the second year are that the quality and cost performance categories, the performance period should be the full calendar year of 2018. And then, for the improvement activities and advancing care information performance categories, we would still keep a 90-day performance period. Overall, however, the data submission period would still be the first quarter after the end of the performance period. So, for the 2018 year, we would expect to see all performance data submitted by no later than March 31, 2019. So, let's move on to the next slide -- Slide 19 -- to talk through the performance threshold. So, for the first year, we set a very low performance threshold, based off of stakeholder feedback that we received across the board that we needed to ensure that all clinicians are able to participate in the program. So, within the first year, our performance threshold was 3. And, again, remember, the performance threshold is the number that a clinician's final score will be compared to. And if a clinician's final score is below the performance threshold, they will receive a negative payment adjustment. If their final score is above the performance threshold, they will receive a positive payment adjustment. And if their final score is at the performance threshold, they will receive a neutral payment adjustment. So, as you can see on Slide 19, we have proposed to increase the performance threshold from 3 points to 15 points in the second year. We have continued to propose the exceptional performance threshold to maintain at 70 points. And as you'll note on Slide 19, as well, the total amount of payment that can be distributed has increased. Statutorily, the payment amount must increase for the 2020 payment-adjustment year, from 4% to 5%. I do just briefly want to go over a few ways that clinicians could achieve the 15-point performance threshold, because we really want to ensure that all clinicians are participating in the program, and we, ideally, want to minimize the number of clinicians that are receiving the negative payment adjustment. So, just a few scenarios on how clinicians could get to 15 points. The first is to report all the required improvement activities. So, improvement activities count for 15% of a clinician's final score. So, if clinicians do everything that's required under improvement activities, they would get the full 15 points there. The scoring for improvement activities, I'll go over in more detail a little bit later on, but we have not made any significant changes to how scoring would work. We still rank all improvement activities with either a medium or high weight. And generally, clinicians would need to do four medium activities or two high-weighted activities to get to those 15 points. There are a few exceptions to that. Another avenue to get to 15 points is to meet the advancing care information performance category base score. That would give a clinician approximately 12.5 points toward their final score. And then, in addition to that, if they submit one quality measure that meets the data completeness threshold of 50%, that would get them at or above the 15-point mark. An additional area to get to 15 points is, again, to meet the advancing care information performance category base score and then submit one medium-weighted improvement activity. Again, that would be enough to get a clinician to either at or slightly above the 15-point performance threshold. And then the last example we have noted here on the slide -- but there are many other ways to get to this 15-point performance threshold -- is to submit all six quality measures under the quality performance category and ensure that they meet the data completeness criteria, which, again, is 50%. So, let's move on to the next slide -- Slide 20. So, just a brief summary of the proposals of Year 2 and how they relate to the transition year. So, as you'll note, just looking at the bottom first, for clinicians to do nothing, and when their final score

is at zero points, they would get the maximum negative payment adjustment, which in Year 2, counts for 5%. Then, moving up, what we have proposed to set the performance threshold at, for the second year, is 15 points, which is a slight increase from where it was in this first year, 3 points. Then, moving up again, for clinicians whose final score falls between 16 and 69 points, they would be eligible to receive a positive MIPS payment adjustment. And then, at the top of the table here, those clinicians whose final score is at or above 70 points, not only will they receive the MIPS payment adjustment, they will also receive an additional adjustment for exceptional performance. So, let's move on to the next slide -- Slide 21. So, our submission mechanisms that we have available for MIPS. All of these are exactly the same for Year 2 as they are for Year 1. We have made no changes here. And then, moving on to Slide 22, the one proposed change that we've made, related to submission mechanisms, is to provide additional flexibility on the number of submission mechanisms a clinician can use. So, what we allowed in the first year was that, across performance categories, clinicians could use different submission mechanisms. So, for quality, a clinician could submit their information using a registry. For improvement activities, they could attest to their activities. And for advancing care, they could use their EHR if they wanted to. But within a performance category -- so, for example, within the quality performance category -- if someone wanted to use their EHR and a registry, that wasn't technically feasible. We've now been able to work through the technical issues and, therefore, we are proposing this additional flexibility. So, again, within a performance category, we're proposing that clinicians could use multiple submission mechanisms to meet the maximum number of measures and activities required under that category. So, let's move on to the next slide -- Slide 23. So, another area where we have made proposals for MIPS is related to facility-based measurement. So, facility-based measurement is the ability for us, over here at CMS, to assess clinicians, within the context of the facilities at which they work under, to appropriately assess their quality and cost. So, what we have proposed for this first year is to define clinicians as facility-based if, as an individual, they have 75% of their services within the in-patient hospital or the emergency room. We have defined groups of facility-based clinicians as 75% of those clinicians of individual who meet that. And for this first year -- again, since we're just rolling our facility-based measurement -- we're looking to align the facility-based scoring with the Hospital Value-Based Purchasing program. And how this would work is that, for the purposes of the quality and cost performance categories, we would take the fiscal-year 2019 Hospital VBP measure set and apply the Total Performance Score that is assigned to a hospital to a clinician's quality and cost performance category. Let's move on to the next slide -- Slide 24. And so, from here, I'll start talking through, in more detail, the proposals we've made, related to the four performance categories. So, starting first with quality. So, as I mentioned earlier, we are continuing to propose to have quality count for 60 points and to have cost count for zero points in the second year. We've kept our requirements for the quality performance category of six measures, one of which would need to be an outcome measure. If an outcome measure is not available, clinicians would need to select another high-priority measure. For our data completeness threshold, we've, again, proposed to keep it at 50% for the second year, but we have proposed to increase it to 60% for the third year -- so, for the 2019 performance period, for purposes of the 2021 payment adjustment. We have made a few proposed changes to how we score clinicians under the quality performance category. First, what we're keeping the same is to maintain a 3-point floor for measures that cannot be scored against a benchmark, or for measures that do not meet case minimum. We have

proposed to change, however, the number of points that a clinician would receive if they failed data completeness. So, again, data completeness is proposed at 50% for the second year. We've proposed to decrease the number of points that a clinician would receive, from 3 points to one point. The exception for that is if clinicians are part of a small practice. If they're part of a small practice, they would still be eligible to receive 3 points if they fail data completeness. And let's move on to the next slide -- Slide 25. A few additional policy proposals that we've made under the quality performance category deal with topped-out measures. So, topped-out measures are measures that have performance at a high-enough rate where we can no longer measure any variants or variability within a clinician's performance. And so what we did in last year's rule is we proposed a definition and finalized the definition of what a topped-out measure is. And we identified, in all of our MIPS measures and their benchmarks, which measures were considered to be topped out. So, what we're proposing to do for this second year is, with a small subset of measures, to start beginning to apply a scoring cap. So, generally, topped-out measures can receive up to 10 points. The scoring cap would limit the amount of points that a clinician could receive for the topped-out measure, from 10 points to 6 points. And again, we're proposing this scoring cap just for a very small subset of measures. I believe, in total, it's only around five or six measures that will have this scoring cap applied. Additionally, we are proposing a topped-out measure life cycle. We realize that there are a number of measures that are topped out. And it can take a significant amount of time for new measures to be developed and adopted into the program. So we are adopting a 3-year life cycle for removal of a topped-out measure. And generally, how this would work is, the first year, a measure is simply identified as topped out. Then, for the second and third years, we would apply the scoring cap of 6 points to the topped-out measure. And then, in the fourth year, the measure would no longer be present within the program. So, let's move on to the next slide -- Slide 26 -- to talk through the cost performance category. So, as I've mentioned a few times, we are again proposing to have costs count for zero points for the second year of MIPS. We've still heard a significant amount of feedback from stakeholders on concerns related to the cost measures that are available. We are listening to those concerns, and we are doing a number of things to address those. Specifically, we are in the process of developing new episode-based measures. Part of the process that is involved with developing those new episode-based measures is the ability of the clinician community to provide to us more direct feedback on how these episode-based measures should be constructed and how they would apply to their practices. For the cost performance category, we are again proposing to include the Medicare Spending Per Beneficiary measure and the total per capita measure. We are proposing to remove the previous set of episode-based measures that was previously finalized. Again, we are working on developing new episode-based measures in a much more transparent manner, with much more clinician involvement in how those measures are developed. We do intend to provide feedback on these newly developed episode-based measures at some point later on in this year -- closer toward the fall timeframe, and then at some point next year, as well. Let's move on to the next slide -- so, the improvement activities performance category. Only a handful of changes here. Improvement activities will, again, count for 15 points toward the clinician's final score. There's no change in the scoring. As in all activities, will still receive a medium or high weight. Typically, clinicians will need to report on either two high-weighted activities or four medium-weighted activities to get the maximum number of points. The exception to that is for those clinicians that are considered to be non-patient-facing, part of a small practice or rural practice or a HPSA. Their

activities are double-weighted. So, what that means is, those clinicians would have to do only one high-weighted activity or two medium-weighted activities. We also are proposing to continue to apply for those clinicians that are part of an APM or part of a patient-centered medical home, that they would receive 50% of the total amount available. We are also proposing additional activities. We've added around 15 or 16 new activities to the improvement activities inventory. We've also proposed a handful of changes to some of the existing activities, including applying credit for using appropriate-use criteria. We propose to expand the definition of a certified patient-centered medical home to include the CPC+ model. And we've also proposed to clarify that the term "recognized" is equivalent to the term "certified." And we've also made a proposal related to patient-centered medical homes that, for clinicians to receive the full amount of improvement activity points there, the total number of sites that would need to be part of a patient-centered medical home would need to be 50% if they are participating in MIPS as a group. Moving on to Slide 28. Additionally, we have proposed, as part of our new set of improvement activities that we're proposing to add, we've indicated which of those would be eligible for the advancing care information performance category bonus. Let's move on to the next slide -- Slide 29. So, the advancing care information performance category. We've made a number of proposals here. The first is, we've heard feedback from clinicians and stakeholders that while many have moved towards the 2015 edition of certified EHR technology, not all clinicians have. So we're again proposing to allow for flexibility in the second year to allow clinicians to use either the 2014-edition certified EHR technology or 2015-edition certified EHR technology. We are, however, proposing bonus points for those clinicians who use purely 2015-edition certified EHR technology. We also are proposing to expand options beyond the one immunization registry reporting measure for 10% for the performance score and allow reporting on a combination of other public-health registry measures that may be more readily available for 5% each towards the performance score. Remember, under the advancing care information performance category, there's a base score, a performance score, and then bonus points available. We also have added a decertification hardship for eligible clinicians whose EHR was decertified, as authorized by the 21st Century Cures Act. We also have added in a new category of exception for MIPS-eligible clinicians that are part of a small practice or part of a HPSA practice, where they can have the advancing care information performance category reweighted to zero and have those points redistributed to quality. We also have proposed to change the deadline for the significant-hardship exception application, to December 31st of the performance period. This proposal is proposed to apply for this year, as well. And then moving on to Slide 30, just a few additional proposals we've made for the advancing care information performance category. So, again, the 21st Century Cures Act has authorized some additional hardship exceptions. I went over a few previously. There is, additionally, a hardship exception for those clinicians that are part of ambulatory surgical centers. And if they are ambulatory surgical center-based eligible clinicians, their advancing care information performance category can be reweighted to zero and generally redistributed to quality. Let's move on to Slide 31. Just a few additional scoring changes we have proposed. So, as authorized by the law MACRA, we are required, by the second year, to start assessing improvement for clinicians. So, generally, have they improved from the prior performance period to the current performance period. We're proposing two different ways of measuring improvement for the quality performance category and for the cost performance category. So, for the quality performance category, we are proposing to have improvement be measured at the performance-category level. We realize there is a lot of variability and flexibility in how clinicians

can participate under the quality performance category. And our improvement-scoring approach for quality will be based on the rate of improvement, such that higher improvement results in more points for those who have not previously performed that well. Whereas, for the cost-performance category, we are proposing to measure improvement at cost at a measure-by-measure level. And the improvement-scoring approach that we're using for cost is based off of statistically significant changes. As you'll note -- I've mentioned a handful of times already -- that we are proposing to have cost again count for zero points in the second year. So what would happen here is that we would still perform the calculations on what improvement would look like. But, again, since cost would count for zero points, it would not contribute to anyone's final score. Rather, we would provide this information as an informational basis only. Moving on to Slide 32. One of the additional scoring bonuses that we have added -- or that we've proposed to add -- is for those clinicians who treat the most vulnerable and complex and sick patients. So, for those clinicians who treat those patients, we are proposing to apply bonus points of up to 3 points, using the HCC risk score approach. We are, additionally, seeking comment on whether we should apply an alternative methodology using patients' dual-eligible status. And then, on Slide 33, the additional set of bonus points we are proposing to add is for those clinicians who are part of a small practice. So, again, our definition of a small practice is for clinicians that are part of a practice that has 15 or less. For anyone who is in a small practice, as long as they participate in one performance category, they would get an automatic additional 5 points toward their final score. We also are interested in, however, receiving feedback on whether or not we should offer these bonus points for clinicians who practice in rural areas. And then, moving on to Slide 34. So, just summarizing the MIPS scoring proposal. So, again, as I've mentioned a handful of times here, the performance category weights for the second year, we're proposing to have exactly the same as they are in the first year. The quality would count for 60 points. Cost would count for zero points. Improvement activity counts for 15 points. And advancing care information counts for 25 points. We are newly proposing bonuses for clinicians that are part of small practices. Also for those clinicians who treat complex patients. We also are proposing additional bonus points within the advancing care information performance category for those clinicians who use 2015-edition certified EHR technology. We also are proposing additional hardship exceptions under the advancing care information performance category, where that category would generally be reweighted, in most instances, to quality. And then, lastly, we are proposing a new hardship extenuating-circumstances category for the entire MIPS performance categories. There is one that exists today under the advancing care information performance category, but we realize that extenuating circumstances, such as natural disasters, may exist that would apply for all of the performance categories. So, that summarizes all of the MIPS proposals. So, at this point, I'll turn the presentation over to Greg Woods.

Thank you, Molly. I'm going to talk through the proposed policy changes related to Alternative Payment Models in this year's proposed rule, if we can move forward to Slide 36. Just as a reminder, Alternative Payment Models are innovative approaches to paying for healthcare that incentivize quality and value. The MACRA statute defines Alternative Payment Models fairly broadly. Under the statute, Alternative Payment Models include CMS Innovation Center models, the Medicare Shared Savings Program, demonstrations under the Health Care Quality demonstration program, and other demonstrations required by federal law. However, to be an Advanced Alternative Payment Model, which is the primary kind of Alternative Payment

Model that we focus on in this rule, a model must meet, by statute, the following three requirements. First, an APM must require participants to use certified EHR technology. Second, it must provide payment for covered professional services, based on quality measures, comparable to those used in the MIPS quality performance category. And if either, must be a medical home model expanded under CMS Innovation Center authority -- and I will note that, to date, no such models have been expanded under Innovation Center authority -- or, alternatively, require participants to bear a more-than-nominal amount of financial risk. In order to qualify for a 5% Alternative Payment Model incentive payment and to be a qualified APM participant, or QP, model participants must receive a certain percentage of their payments for covered professional services or see a certain percentage of their patients through an Advanced APM during the associated performance year. In last year's final rule, we established criteria -- we established standards, I should say, for each of the criteria I just described. In general, we are maintaining those criteria -- those standards -- in this year's proposal, but we are making some minor tweaks. So, moving on to Slide 37. Firstly, in last year's rule, under the third criterion that I mentioned -- the "not more than nominal risk" criterion -- we propose two ways that Alternative Payment Models can meet that criterion. They could either put exposed participants to a total risk of 3% of the expected expenditures an APM Entity is responsible for under the APM, and that standard risk is finalized for all performance years. They could also expose participants to at least 8% of the average estimated Parts "A" and "B" revenue of those participating APM entities. And that standard, we finalized only for performance years 2017 and 2018. In last year's final rule, we also requested comment on whether we should extend that standard further or make changes to that standard in future years. In this year's proposed rule, we are proposing to extend that 8% revenue-based standard for an additional two years, through performance year 2020. So the standard will remain unchanged. We are also, again, requesting comments on whether we should continue to maintain that standard or whether it would be appropriate to adjust it upwards or downwards. Moving on to Slide 38. In addition to the general nominal-risk standard that I just discussed, in last year's rule we also finalized a special standard for medical home models. Medical home models are Alternative Payment Models that have certain specific features that are listed on this slide. They include, the participants must include primary-care practices or multi-specialty practices that include primary care; participants in medical home models must empanel each patient to a primary clinician; and they must meet at least four of seven additional elements on the menu listed here, that are common to medical home models. Medical home models, as I said, are subject to a different, and generally more flexible, standard in order to meet the financial-risk criteria and to become an Advanced APM. We are proposing two changes related to the medical home financial-risk criterion. And if we move to Slide 39. Firstly, in last year's rule, we finalized that for performance year 2018 and all performance years thereafter, the medical home standard would only be available to APM entities with fewer than 50 clinicians in their parent organization. In this year's rule, we are proposing to maintain that standard. However, we are proposing a limited exception to that standard. Specifically, we are proposing to exempt Round 1 participants -- which is a current participant -- in the Comprehensive Primary Care Plus model, which is currently the only model that qualifies under the medical home standard as an Advanced APM. Entities with more than 50 clinicians in their parent organization, who are participating in the Comprehensive Primary Care Plus model in Year 1, currently, will continue to qualify under the nominal-risk standard of the medical home models. All future participants in the Comprehensive Primary

Care Plus model, and in addition, all future participants in other models that qualify under the medical home Advanced APM standard, will be subject to the 50-clinician cap. Then, moving on to Slide 40, we're making one additional change to the medical home "more than nominal risk" standard. In last year's rule, we finalized, the total potential risk that an APM Entity must bear under the medical home standard would gradually ramp up, over the course of several years, starting at 2.5% in 2017 and ramping up to an ultimate level of 5% in performance year 2020, and it would stay at 5% thereafter. In this year's rule, we are proposing to make that ramp-up more gradual. Specifically, we are proposing that in 2018, the average estimated total risk would need to be at least 2%, under the medical home standard. It would then ramp up 1% each year until it hits 5% in 2021 -- in performance year 2021. So, the ultimate endpoint of 5% remains unchanged. However, we would get there one year later, and the ramp-up would be a bit more gradual. I will note that the direct impact of this immediately will be limited. As I said earlier, the Comprehensive Primary Care Plus model is the only model that currently qualifies under the medical home nominal-amount standard. However, this does leave the agency additional flexibility, should there be modifications or additional models that qualify under the medical home standard. So, that summarizes the changes that we've made to the Advanced APM standards. Then, moving on to Slide 41, we have made several proposals in this year's rule around the All-Payer Combination Option. Just as a reminder, the All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become qualifying APM participants or partial QPs. QP Determinations under the All-Payer Combination Option is based on an eligible clinicians' participation in a combination of both Advanced APMs -- that is to say, APMs within Medicare Fee-For-Service Other Payer Advanced APMs -- that is to say, Advanced APMs through another payer, including Medicaid, Medicare Advantage, or commercial payers. QP determinations, as we finalized last year, are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option. In other words, clinicians who qualify as QPs under the Medicare Option will not need to rely on the All-Payer Combination Option. However, eligible clinicians who do not quality under the Medicare Option have the opportunity to participate in the All-Payer Combination Option and become a qualified APM participant through that alternative pathway. And just as a reminder, by statute, the All-Payer Combination Option is available beginning in the 2019 QP performance period. So, moving on to Slide 42. Again, as a reminder of what we finalized in last year's rule, the criteria for determining whether a payment arrangement through a non-Medicare payer -- so, through a Medicaid, Medicare Advantage, or commercial payer -- qualifies as an Other Payer Advanced APM or similar, but not identical, to the comparable criteria used within Medicare. Specifically, in order to qualify as an Other Payer Advanced APM, an Other Payer payment arrangement must require at least 50% of eligible clinicians to use certified EHR technology; it must base payments for professional services on quality measures that are comparable to MIPS; and it must either be a Medicaid medical home model that meets criteria comparable to a model expanded under CMS Innovation authority -- and again, just as a reminder, no Innovation Center medical home models have yet been expanded; or, alternatively, require participants to bear more than a nominal amount of financial risk. And as with Medicare, we are largely leaving these standards in place. However, we are proposing some changes. Moving on to Slide 43. As a reminder, in last year's rule, we finalized that, in order to meet the third criterion -- the "more than nominal risk" criterion -- an Other Payer payment arrangement had to at least expose its participants to marginal risk of at least 30%; a minimum loss rate of at least 4%; and total risk of at

least 3% of the expected expenditures the APM Entity is responsible for, under the APM. In this year's rule, we are largely proposing that standard. We are maintaining the marginal risk and the minimum loss rate requirements. However, we are adding an additional revenue-based standard for total risk. And this is to align with the Medicare standard. So, in addition to meeting the total-risk requirement by exposing participants to at least 3% of the expected expenditures the APM Entity is responsible for, payment arrangements by other payers can also meet the standard by exposing the participants to total risk of at least 8% of the revenue that they receive from that payer. And again, this is to align with the Medicare standard. An Other Payer arrangement would qualify as an Other Payer Advanced APM if it met one of those two standards -- those are two different options -- to meet the total-risk standard. So one doesn't replace the other. We are simply proposing to add an additional pathway to comply with the "more than nominal risk" criteria. Moving on to Slide 44. In last year's proposed rule -- in last year's final rule -- excuse me -- we finalized that QP determinations under the All-Payer Combination Option would be made either at the APM Entity level or, in certain and limited cases, at the individual eligible clinician level. And that was to align with how we were conducting QP determinations under Medicare. As we looked further at the details of implementing the All-Payer Combination Option, we decided to propose a policy change here. We are proposing, in this year's rule, that QP determinations would be made at the individual eligible clinician level only. What's driving this proposal is that we recognize that the participants within a Medicare Advanced APM may not be the same as the participants with an APM offered by Medicaid or a commercial payer or a Medicare Advantage plan, and that it may be difficult to make an apples-to-apples comparison within the All-Payer Combination Option. Therefore, we think it's simplest and most equitable to make the determinations at the individual eligible clinician level. So, that's our proposal. We are requesting comments on that proposal and also on whether there are situations where it would be appropriate to make QP determinations at the APM Entity level. Moving on to Slide 45. Last year, we finalized that eligible Clinicians or APM entities would be responsible, ultimately, for reporting information about payment arrangements to determine whether they met the criteria to be an Other Payer Advanced APM and, therefore, could be considered and could receive credit under the All-Payer Combination Option. In this year's proposed rule, we are proposing to maintain the eligible clinician-initiated process, where eligible clinicians can report information about payment arrangements in which they are participating. However, we are also proposing to add a voluntary payer-initiated process. Under this process, payers would be able to report information to CMS about the payment arrangements that they offer to clinicians, and CMS would then determine, and would publish, whether or not, in fact, those payment arrangements met the criteria and, therefore, were Other Payer Advanced APMs. Again, there would be two processes here. The payer-initiated process would be voluntary. And in the event that a payer did not submit information as part of the payer-initiated process, eligible clinicians would still have the opportunity to submit information about payment arrangements that they participate in. We are seeking comment on that process. Moving forward to Slide 46. I would note that, just as I described, prior to each All-Payer QP performance period, we would make Other Payer Advanced APM determinations based on the information that would voluntarily be submitted by the payers. And so clinicians would have access to that information prior to the performance period in question. I would also note that we are proposing to roll out the payer-initiated process on a gradual basis. So this process would be available for Medicaid -- including Medicaid managed-care plans --

Medicare Advantage, and multi-payer models where Medicare aligns with other payers that are run by CMMI. In each of those buckets, the payer-initiated process would be available for performance year 2019. And then we intend to add remaining payer types in future rule-making in future years. I will note that APM Entities -- again, APM Entities and eligible clinicians -- would still have the opportunity to submit information regarding payment arrangements in which they are participating, in the event that the payer had not already done so. And there's extensive detail, in the preamble language, about both the timelines, the guidance, the format for submission that both payers and clinicians would be required to use through each of these processes. And we're requesting comment on all of those details. So, that summarizes the proposed changes under the All-Payer Combination Option. Lastly, I want to talk just briefly, moving forward to Slide 48, about the APM scoring standard. Just as a reminder, the APM scoring standard was an option that we finalized last year. It offers a special, minimally-burdensome way of participating in MIPS for eligible clinicians in APMs who do not meet the requirements to become QPs. This could either be because they are eligible clinicians who are participating in APMs that are not Advanced APMs, such as the Medicare Shared Savings Program, Track 1. It could also apply to eligible clinicians who are participating in certain Advanced APMs but do not meet the QP threshold and therefore are required to participate in MIPS or become partial QPs, and therefore have the opportunity at their discretion to participate in MIPS. As a reminder, this special scoring standard only applies to what we refer to as MIPS APMs. In order to be a MIPS APM, an APM must meet the following three criteria. APM Entities must participate in the APM under an agreement with CMS; APM Entities must include one or more MIPS-eligible clinicians on a participation list; and APM must base payment incentives on performance, on cost/utilization and quality measures. Moving forward to Slide 49. In the 2017 rule, we finalized different scoring weights that were different from standard MIPS for models participating in the APM scoring standard. And specifically, within the APM scoring standard, we finalized different scoring weights for ACO models, including the Medicare Shared Savings Program and the Next Generation ACO Model, which were assessed on quality -- and quality was weighted as part of their final score -- and other MIPS APMs, which, for 2017, had quality weighted at zero. In last year's rule, we signaled our intent to weight all MIPS APMs on quality, starting in program year 2018, and that's what we're proposing to do in this year's rule. As this table shows, for performance year 2018, all MIPS APMs -- we are proposing to weight all MIPS APMs 50% on quality, 0% on cost, 20% on improvement activities, and 30% on advancing care information. And then moving to Slide 50. For those models -- so, the non-ACO models that were not weighted on quality for 2017 -- we are proposing additional details on how we will generate a quality score for those models in 2018. Participants in these models will be scored, under MIPS, using the quality measures that they are already required to report on as a condition of their participation in their APM. So participants in those models would not be required to separately report any quality information as part of MIPS. We are proposing one other significant change with respect to the APM scoring standard. As a reminder, in last year's rule, we finalized that in order to be included under the APM scoring standard, an eligible clinician needed to be participating in a MIPS APM on one of the three snapshot dates which we established, which aligned with the snapshot dates that we're using for Advanced APMs to determine QPs. Those dates were March 31st, June 30th, and August 31st. For certain MIPS APMs, and for MIPS APMs only -- so specifically for full TIN APMs, such as the Medicare Shared Savings Program -- we're adding a fourth snapshot date -- or we are proposing to add a

fourth snapshot date -- of December 31st in 2018. What this would mean is that, if we finalize this proposal, is that it would allow certain participants who joined those APMs that qualified, including the Medicare Shared Savings Program, between September 1st and December 31st to benefit from the APM scoring standard and to receive the MIPS score that's associated with their APM Entity. So, with that, that concludes the summary of the APM sections of the proposed rule. And I will turn it back to Adam Richards.

Great. Thanks so much, Greg, and thanks to Molly, as well, for covering the MIPS side of the program. We're going to spend the next few minutes to talk about resources for the Quality Payment Program. But, first, before getting into that, I hope everyone was taking copious notes. But if not, don't worry. We will working to post the slides and the recording in the coming weeks. We do encourage everyone to go to qpp.cms.gov and sign up for the Quality Payment Program LISTSERV for alerts on when these resources become available. Again, that qpp.cms.gov. Sign up for the LISTSERV, and we'll make sure that we notify you when the recording and the slides are posted. So, if you move to the next slide, please. And just quickly to talk resources. So, for 2017 and beyond, in the Quality Payment Program, we do have free resources available to clinicians who are participating in the program. As you can see on this infographic, we have a number of options available. Beginning with small practices, we have the Small, Underserved, and Rural Support initiative out there for clinicians and practices with 15 or fewer clinicians. And priority for small practices in medically underserved areas, health-professional shortage areas, and rural locations. Likewise, we also have the Quality Innovation Networks and Quality Improvement Organizations for our larger practices -- really, those with 15 or more clinicians. So both of those options are available for clinicians who are participating in the MIPS side of the program. We also have the Transforming Clinical Practice Initiative that's available. Clinicians have the opportunity to sign up with one of our Practice Transformation Networks, again, to receive free technical assistance. Moving onto the very bottom right-hand corner, some additional resources available, certainly for those in Alternative Payment Models and Advanced Alternative Payment Models, we do have the APM Learning Systems, and you can receive support and guidance through your models support in-box. And of course, we do have the Quality Payment Program website, qpp.cms.gov. There's also a direct line to contact us. If you have any questions, concerns, please feel free to reach out, either by e-mail or by phone. Both of those pieces of information are listed on the screen. Again, this information and these resources, it's all free. It's free to those clinicians. We certainly encourage you to take advantage. If you'd like a little more information on the technical assistance that we have, we do have a resource guide available on qpp.cms.gov, under the "Resources" section of the site. So, if we could go to the next slide, please. And I just want to talk one more time about submitting comments on the proposed rule. Again, please submit your comments to us through the formal process. There is a 60-day comment period. Again, August 21, 2017, is when the comment period closes, so please make sure to circle that on your calendar. On this slide are the instructions for submitting comments to use formally. As you can see, we've listed out the different methods by which you can submit your comments -- go to regulations.gov; by regular mail; by express or overnight mail; by hand or courier. And please, when commenting, refer to file code CMS 5522-P. We're going to leave this slide on for just a minute or two, just so you can write down that information. Again, if you have any questions or need additional information, please go to qpp.cms.gov. We do have information on there dedicated to not only the 2017 transition year but

certainly the proposed rule. And you'll be able to find all this information on the site. So, I'll just give that another minute or so, so you can copy all the information down. Again, please remember August 21, 2017, is the deadline for submitting comments. That is a 60-day comment period on the proposed rule. Okay, we are going to go to the next slide, please. And again, we will be posting the recording and the webinar slides. And as I said, if you sign up for the LISTSERV, we'll make sure that you're notified. At this time, we are going to enter into our question-and-answer session. Certainly, to ask a question, please use the phone number that is listed on these slides. Again, we'll do our best to try to answer your questions, clarify any confusion that there may be. But, again, if you are going to submit formal comments, please do so through the formal process. We are going to take a question out of the chatbox, just to get us started, while folks are dialing in to the phone. So, if we could please take that first question.

Yes. I think we'll start with questions about virtual groups, since we've received a few of them. First up, the question is, "For virtual groups, if, as individuals, the members of the virtual group would be below the low-volume exclusion, but together in your virtual group, you would collectively be above the exclusion, can you participate as a virtual group?"

Hi. This is Lisa Marie. When we think about virtual groups, there are two types of individuals or groups that are able to form a virtual group. So, again, it's solo practitioners, and it's groups, where groups have 10 or fewer eligible clinicians. So, if you are a solo practitioner but they're wanting to form a virtual group or join a virtual group, or if you're a group that has 10 or fewer, if you do not meet the low-volume threshold at the individual level -- or at the group level -- you're not eligible to participate in MIPS as a virtual group.

Great. Thank you so much, Lisa Marie. I do want to -- I know we have some folks waiting on the phone line, so I do want to switch over to the phone lines for some questions.

At this time, if you would like to ask a question, please press star, then the number 1 on your telephone keypad. That's star, then the number 1 to ask a question. Our first question comes from Terese Kegg.

Hi. Thanks so much for the call. I find it very, very helpful. I have a question for you on ACI bonus points for improvement activities that use CEHRT. So, for 2018, will this only be applicable if you use EHR as your submission method like it is for 2017? Or will it be available if you use Registry?

Hi. This is Molly. I believe it will work the same in 2018 as it is for 2017, but let me just stop there to see if Elizabeth or any of our other advancing care information SMEs are on and want to state something different.

Unfortunately, I don't believe we have our advancing care information folks. So this is something that we can certainly take back and double-check and get you an answer for.

Great. Thank you.

Thank you.

Your next question is from the line of Kim Sweet.

Yes, hi. Thank you for taking my call. My question, as well, is about virtual groups. I think it's a little confusing, and especially when you mention solo practices. So, a virtual group, if you have a solo practice, they can join other practices to become a -- to join in to a virtual group? And those practices that are not solo, must they only be in their practice, under that Tax Identification Number, to be in a virtual group? So, it's kind of like a two-part question there.

Hi. This is Lisa Marie. So, first question, you can be a solo practitioner in which there is a TIN, and under that TIN, there's only one NPI associated with that TIN. So, yes, a solo practitioner -- one solo practitioner can join with another solo practitioner to become a virtual group. It could be a solo practitioner joining with a group in which the group has no more than 10 eligible clinicians part of that group. So, when you think about a virtual group, it's basically a combination of TINS, which are Taxpayer Identification Numbers. So it can be any combination of those, whether it's a solo practitioner or a group forming that virtual group. Does that answer your -- I know that was part of your first question? And can you repeat your second question?

Yes. With a virtual group, if your practice has 10 clinicians under the same Tax Identification Number, would their virtual group just be them, or could they also include another practice under, that would have a different Tax Identification Number?

So, a single group cannot be considered a virtual group. So that group would need to either join with another group in which there are no more than 10 eligible clinicians associated with that group. So, again, a group is a TIN, and there can be no more than 10 NPIs associated with that TIN. So, yeah, there could a group to join a solo practitioner or another group. So, again, it has to be a combination of 10. So more than one TIN forming that virtual group.

So, the virtual group can be multiple TINs, but within one TIN, you can have more than 10 NPIs?

Correct. Well, so, that group -- when you think about a group, we're talking about small groups here. So your group under your TIN, there are no more than 10 NPIs associated with that TIN. So we're talking about small groups here and solo practitioners forming these virtual groups.

Great. Got you. Thank you very much.

You're welcome.

Your next question is from Sandy Marks.

Hi. Thank you. I actually have two questions. One is, Table 86 indicates that nearly 77% of eligible clinicians will get the exceptional payment adjustment -- meaning they would get 70 or more points. We wondered if that's correct and how that's possible that it's so high. And the other one is, the regulations on page 790 say that if a MIPS-eligible clinician is scored on fewer than two performance categories, he or she receives a final score equal to the performance threshold. So I wondered how that relates to

the requirement that you meet a score of 15, because it sounds like, if you are scored on at least one performance category, you're going to get a score equal to the performance threshold.

Hi. This is Molly. So, I'll take the last question first. So, what you're referencing there is actually a policy we finalized in last year's rule, which is that we defined a final score, which was previously called a composite performance score, as a composite -- meaning that you would need to be able to score a clinician on at least two performance categories for them to be eligible to receive a final score. What that means, though, is that it doesn't necessarily mean that a clinician has to participate in more than one or more performance categories, except they could have participated in more than one performance category. So, what we would do is, in the very rare instances where a clinician is not eligible or able to participate in two performance categories, then we would assign them a final score that is equal to the performance threshold. So what that means is that they would then receive a neutral payment adjustment. And then, for your first question, regarding, I believe, the system information included in our regulatory impact analysis, I don't have that portion of the rule open in front of me, but I can generally tell you that some of the assumptions that went into the regulatory impact analysis include receiving the most up-to-date data that we have available here at CMS, that we based it off of our revised eligibility runs, which have been fed into our lookup feature that's available on qpp.cms.gov website. We also built in a number of participation assumptions into how we would anticipate that clinicians would participate. And again taking into consideration additional historic data that we have available. So we built in assumptions that clinicians who previously met meaningful use, that they would be able to perform under the advancing care information performance category. We also built in assumptions that clinicians who previously participated in the PQRS program, they would at least do something under the improvement activities performance category. We, of course, also built in the quality performance category based off of the historical PQRS data we had. Some of the reasons why we're seeing some of the scores at that level also include the different proposals for eligibility that we've made in this year, specifically related to the proposed increase to the low-volume threshold. And then I also went over two additional scoring bonuses at the final-score level that we have proposed -- the complex patient bonus and the small-practice bonus. So, when you take all of those into consideration, that is what came out of our data model. I would be remiss not to caveat and flag all of that with that this is based off of the most recent data available to us and based off of the proposed participation assumptions that we have, depending upon the feedback that we receive through the comment process on this proposed rule, what it would look like in the final rule, and those assumptions could be different. I hope that helps. Thanks.

Great. Thank you, Molly. We do have just a few minutes left, so we're going to go into kind of a rapid-fire question-and-answer session. So, please, if you could just ask one question. We do have a few folks on the line we want to get through, or at least try to get to. We do also have our policy experts working within the Q&A right now. So if you want, you can post your question there, as well. So let's take the next call, please.

Your next question is from Kevin Dearing.

Yeah, hi. Thank you. My question was answered in the previous response. Thanks.

Your next question is from Christina Kasonski.

Hi. This is Christina. I was just hoping you guys could explain a little bit more about the data-completeness requirement. I didn't understand it.

Hi. Sure. This is Molly again. So, the data-completeness requirement is for the quality performance category. And in the first year -- and we've proposed to keep it the same for the second year -- it's at a 50% rate. So, data completeness is the rate of reporting that we would expect to see for the quality measures. So, if you're familiar with any of the legacy programs, we referred to that rate previously as a reporting rate. So what that means is that, on a given measure, we would want to ensure that a clinician is reporting, or having complete data for, at least 50% of all of their eligible instances. So, what we're proposing for the second year is that, in those instances, we're on a measure-by-measure basis. If a clinician's data completeness falls above -- or rather, if it falls below -- 50%, if they are part of a large practice, they would get a minimum of one point. The exception for that is if a clinician is part of a small practice -- and again, a small practice is defined as 15 or less clinicians -- they would still get a minimum of 3 points if they fall below that data-completeness threshold. Thank you.

Your next question is from Mike Solatorio. Mike, did they ask your question? We will proceed to the next question. The next question is from Suzanne Falk.

Hi. I was wondering, regarding the improvement credit for all the different categories, specifically for cost, will that eventually work the same way as quality, where it is worth up to 10% of the category score, capped at 100%? And will you be eventually awarding improvement for the ACI and IA categories in the same way, as well?

Sure. That's a great question. So, for improvement, statutorily, we're required to apply it for quality and the cost-performance categories. We'll take a look at whether or not we would apply improvement scoring for the advancing care and improvement activities at a later point in time. But at this moment, no, we have not made any specific proposals for having improvement scoring work for the two, or have it applied for the two other performance categories. For having the improvement percentage points go up to 10 points, that would be something we would consider for a future year. So we welcome your feedback and any comments that you have on that. And just be sure to send that to us through the formal comment process that Adam has mentioned a few times.

Your next question is from Jocelyn Holyfield.

Yes. Hi. Good afternoon. Just wanted to go to Slide number 19. It says here that in transition year, the minimum point for quality -- is this the quality measure? -- is 3 points. And Year 2 is 15 points. In Year 2, what is the maximum points? Because this year, it is 3 points to 10 points. How about next year? Is it 15 points to how much, please?

Hi. This is Molly again. So, what's reflected on Slide 19 deals with the overall MIPS performance threshold, which is different from the scoring that exists under the quality performance category. So, under the quality performance category, each measure generally counts for somewhere between 3

to 10 points, 1 to 10 points. And then, again, we've proposed a scoring cap for some of the topped-out measures, where the maximum number of points they would be able to receive is 6 points. Those points would then go into calculating a quality performance category score, which can count for up to 60 points to a clinician's final score. So, remember, a final score can range anywhere between zero and 100 points. And that final score is what we will compare to the performance threshold. So, the performance threshold, again, that's that numerical point that, depending upon what a clinician's final score is, if it's above or below that, that will determine whether they're getting a positive or negative payment adjustment. So, in the first year, the performance threshold is 3 points, which means that, in the first year, a clinician can just do one quality measure, one improvement activity, or just the base elements of advancing care and hit that neutral point. In the second year, we're proposing the performance threshold to be 15 points, which means that clinicians would have to do a little bit more than one measure to get to the neutral point. I hope that helps clarify the differences between what goes into building up the quality performance category score and then the overall MIPS performance threshold and final score. Thank you.

Thanks, Molly. We're going to take one more question today.

Your last question will be from Philip Williams.

Hi. Thank you for taking my question here. My question sort of builds off of what Sandy was talking about. Knowing that the penalties in the previous programs, in their final years, added up to over 8%, and just looking at kind of the performance threshold now, I know that in the final rule and the proposed rule last year, the philosophy was discussed that half of clinicians and groups would fall below, and half of clinicians and groups would fall above the performance threshold as it was determined to be set. I just wonder, was there a change in philosophy, as to how that performance threshold was set, in making more winners than losers?

Sure. This is Molly. So, I would say what we learned when we issued the proposed rule last year, and after we did our numerous listening sessions and stakeholder-engagement sessions and really across the country, trying to get a sense of how these proposed policies would impact clinicians, what we heard really loud and clear was that clinicians needed more time to really understand the requirements of the Quality Payment Program and to understand what they have to do to participate. So that's why, in the first year, we finalized the really low performance threshold of 3 points and the pick-your-pace approach to really incentivize and ensure that all clinicians can participate in the program and that we really want awareness across the country of the program, to get participation up. But as we've moved into the second year, we are continuing our slow ramp-up of the Quality Payment Program to get more and more clinicians participating and having more of a focus not only on participation but also complete reporting, and complete reporting of performance information. So that's why, again, we set the performance -- or propose to set the performance threshold at 15 points. The piece that we do have awareness of -- and I think is what you're referencing -- is that we are required by law that by the third year, the performance threshold must be set at either the mean or the median, which we'll see what exactly that will end up being. But it could end up being somewhere in that 50/50 range. So I wouldn't necessarily say that our approach has changed. It's more that, based off of the feedback that we have heard, we've realized

that clinicians just need additional opportunities and flexibility to be able to participate in the program. Thank you.

Yeah.

Okay, well, thank you, ladies and gentlemen, for joining us today. A special thanks to our policy experts for being on today and presenting. If you did not have a question answered, we encourage you to please submit it to our Quality Payment Program at questions-- I'm sorry, I'm just going to pull up this website -- or pull up the address right now. Please submit your comments to qpp@cms.hhs.gov. All questions that were not answered today can go there. We'll make sure that we try to get you an answer of some sort as best we can. And please also remember to submit your comments to us by August 21, 2017. We hope to talk to you again soon. Thanks, everyone.

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