Quality Payment Program Year 3 (2019) Final Rule Overview Webinar
Thursday, November 15, 2018

Hello, everyone. Thank you for joining today's Quality Payment Program Year 3 Final Rule Overview webinar. CMS subject matter experts will discuss specific requirements for both the Merit-based Incentive Payment System and Advanced Alternative Payment Models for the 2019 performance year, also referred to as year 3. The presentation will be followed by a Q&A session, where you will have the opportunity to ask questions. Now I will turn it over to Adam Richards, health insurance specialist in the Center for Clinical Standards and Quality at CMS. Adam, you may now begin.

All right, great. Thank you. And welcome, everyone, to today's overview of the year 3 policies of the Quality Payment Program, which you'll hear us refer to interchangeably throughout the day as year 3 and the 2019 performance year. I want to start by thanking each of you for taking the time to join us today and, really, most importantly, for the work that you do each day for our beneficiaries. In the spirit of National Rural Health Day, I'll also extend a special thanks to those of you who are practicing in rural areas. We have a jam-packed agenda today, so I want to usher us along. However, before we dive into the content, I do want to level-set with you all. This webinar is specific to the Quality Payment Program. We will not be covering other areas of the 2019 Physician Fee Schedule, such as evaluation/management codes, virtual care, et cetera. If you are interested in these topics, I highly encourage you to register for our MLN, our Medicare Learning Network call, on Monday, November 19th, at 2:00 p.m., which will cover everything under the PFS for 2019. So, you just need to navigate to the MLN page on cms.gov for more information and to register for that call. Okay, disclaimer aside, moving forward, I'm going to jump in to slide 3. As I mentioned, we have quite a bit to cover today. So, we'll start just with a general overview of the Quality Payment Program. We do want to talk a little bit about some of our results from the 2017 performance year prior to getting into year 3 policy. I think we have some exciting data to go over. Then we'll break into the Merit-based Incentive Payment System track of the Quality Payment Program, where my colleagues Molly MacHarris and Elizabeth Holland will cover our policy changes. We'll move into the Advanced Alterative Payment side, where my other colleague, Dr. Corey Henderson, will cover those policy changes. And then we'll wrap up with some discussion about where you can go for help and support, as well as try to take your questions. You know, we're going to do our best with the time we have allotted to explain the key concepts and deep-dive where appropriate. We know that some of you are seeing this information for the first time and this is going to be potentially your first year in the program. Also, if we don't get to your question, please do not get discouraged. You know, this event is really meant to kick off our educational series on year 3. So, there will be plenty of additional opportunities to connect with us in the very near future. So, moving right along to slide 4 and then slide 5. So, basically this is our overview of the Quality Payment Program, really, to kick things off here. Quality Payment Program -- we are required by law under the Medicare Access and CHIP Reauthorization Act of 2015 to implement an incentive program. For those of you who have been with us, you are very well aware of MACRA. For those a little newer to the program, we do just want to give a little bit more background. So, again, MACRA, a piece of bipartisan legislation signed into law, I guess, three years ago at this point, April of 2015. And why do you really need to know about this? Well, for a couple different reasons. One, it helped repeal the sustainable growth rate formula. I won't go into detail on this today. We'll have some

additional information and opportunities to discuss this in the future, as I mentioned earlier. But it also required us -- CMS -- to implement this incentive program -- so, the Quality Payment Program -- really with the goal of changing the way that we incentivize clinicians in establishing a framework to establish value over volume and ultimately move us away from the fee-for-service system, where we have been previously basing payment on volume of services and not necessarily value. So, as part of the Quality Payment Program, we have two very distinct tracks, the Merit-based Incentive Payment System and Advanced Alterative Payment Models. We won't get into detail here because you're going to learn all about these two tracks in just a few minutes from our subject-matter experts. So, I do want to charge along to slide 6. We'll talk a little bit about what we consider our strategic objectives or our strategic considerations in guiding the Quality Payment Program. Again, I won't go through these in great detail. These have been in place since the 2017 performance year. Really, our foremost priority is improving beneficiary outcomes. That's at the very top of our list. But ofcourse we also focus on ways to reduce burden, programmatic burden for clinicians, maximize participation, even ways to increase the adoption of Alterative Payment Models. Again, all of these strategic objectives have guided our policy and decision making over the last few years. And I think this is actually a really nice segue into our next section, where we talk a little bit about the 2017 performance year data. So, I'm going to jump ahead to slide number 8. So, what we have here and what we've heard from stakeholders and a number of clinicians and support staff is we really just want to know how the first year of the program went. How'd you guys do in the inaugural year? So, recently -- just last week, actually, last Thursday -- Administrator Seema Verma released a blog on the 2017 performance and the Quality Payment Program. And we also put out an infographic that highlights the information that you're about to see over the next several slides. So, on slide 8, this is really just taking a look at a high-level snapshot of our payment adjustments and where clinicians fell in the payment adjustment spectrum. I will say we were extremely happy to see that 93% of MIPS-eligible clinicians received a positive adjustment or a positive adjustment with the adjustment for exceptional performance, which is really fantastic. And overall, 95% of clinicians avoided a negative payment adjustment, which for the first year of a program is substantial. So, as you can see a little bit about the breakdown of the payment adjustments, where folks fell, what the maximum adjustments are related to the overall payment adjustment percentages. Also, on this slide, we do call out that, on the APM side, the Advanced Alterative Payment Model side, that we did have over 99,000 clinicians become Qualifying APM Participants and qualify for the APM incentive payment, that 5 percent incentive, which, again, is really fantastic. So, overall, we are pleased with the participation that we saw in the first year of the program. Moving forward to slide 9, a little bit of a deep dive into our scoring for year one of the program. What you're seeing on slide 9 is our mean and median national final scores for the Merit-based Incentive Payment System. I won't get into all of what's listed here, but I will say, just at a high level, our mean for MIPS eligible clinicians was 74.01 points out of a maximum 100 points, which then we break down by clinicians who did and did not participate in an APM. And you can see the difference there. You'll also see the median for MIPS eligible clinicians. The median score for 2017 was 88.97 points, again, breaking it down then, individuals who participated in APMs versus not participated in APMs. So, on slide 10, very quickly, this is a breakdown of our individual versus groups. That's what we consider our submitter type -- so, how many clinicians submitted data to us, not necessarily how many clinicians, but for those clinicians who submitted data to us as individuals versus as groups, how

they scored from the mean and median range. As you can see, I think both groups, both individual and groups, did very well in the first performance period. And I think this aligns to our next slide, slide 11, which focuses on the breakdown of practice size and location. So, as you can see on slide 11, we do have a breakdown for small/large practices, those practices that are in rural locations, and those practices that are small and rural. Overall, again, many clinicians did very well in 2017, which is remarkable. It's something that we did and we were hoping to see. And I think one of the key takeaways here is just by looking at the mean scores across the board, whether you're small or large. A number of clinicians with these scores and over the next three years, over our next few performance periods, can still succeed in the program, just based on our thresholds. And Molly's going to talk about that in just a few minutes. So, at this point, that wraps up our just quick data overview section. I do want to charge ahead, so we're going tojump right into the Merit-based Incentive Payment System side of our changes for year 3, and I'm going to turn it over to Molly to lead us through.

Thanks, Adam. And thank you again, everyone, for being here today. So, as Adam said, we have a lot of information to cover, so let's go ahead and jump right in. So, I am on slide 13. So, I'm just going to hit on a couple basics for the MIPS program, and then I will be going through all of the details of our year 3 policy changes. So, as reflected on slide 13, just as a brief reminder, as Adam mentioned, prior to the passage of the MACRA legislation, there was the SGR, sustainable growth rate methodology. There were also three legacy programs that clinicians had to deal with. That was the PQRS program, the Physician Value Modifier program, and the Medicare EHR Incentive Program for Eligible Professionals. When MACRA, the law, passed, it repealed and sunset these programs and created a consolidated program called MIPS, which, as reflected on slide 14, assesses clinicians' performance on four performance categories. Again, those include the Quality performance category, Cost, Improvement Activities, and Promoting Interoperability. The Promoting Interoperability performance category deals with the usage of Certified EHR technology. And so, what we do under MIPS is we assess clinicians' performance on these four specific performance categories. Each of these performance categories have weight associated with them. For the third year of the program, Quality counts for 45 points, Cost counts for 15 points, Improvement Activities counts for 15 points, and Promoting Interoperability counts for 25 points. You'll note that that sums up to a total of 100 possible points. That is important because, depending upon what a clinician's performance is on those four categories, that will create their final score. And that final score we will compare to something called a performance threshold. And we ideally want to have clinicians' final score at or above the performance threshold. When your final score is at or above the performance threshold, that means you're either getting a neutral payment adjustment -- meaning no impact to your charges in the 2021 payment year -- or a positive adjustment, which means you could get additional monies attributed to your claims. I'll be going over this in more detail, but just wanted to call that out. And the other piece I should mention is that the finalized performance threshold for year 3 is 30 points. So, that's the number that we would ideally like to have all clinicians' final scores be at or above. So, let's move on to slide 15 to talk through some of our terminologies. Just as a brief reminder, you'll hear me mention throughout this presentation the terms "TIN" and "NPI." TIN refers to the Taxpayer Identification Number that you received through the IRS. The NPI deals with your National Provider Identifier, which you received after enrolling within Medicare. When we talk about clinicians under MIPS, we talk

about a unique TIN/NPI combination. And this is important because there could be scenarios where if you, as a clinician, practice at multiple clinics, you could have multiple TIN/NPI combinations and you could either be considered MIPS eligible or MIPS excluded under any of those. So, I would highly encourage all of you, if you've not gone to our website yet, please go to qpp.cms.gov. We have a lot of information on that site, as well as the ability for you to look up your eligibility information. We have information on the site right now dealing with year 2, and we are working on updating the website with eligibility information for year 3. We're hoping to have that out as close to the beginning of the performance period as possible because we do recognize that that is important for you all to have that information so you can make successful performance decisions. Another piece I'll just call out -- and, again, Adam mentioned this previously -- for year 3, that refers to the 2019 performance period. So, actions that would be occurring in 2019 -- that will impact your payments in 2021. By law, the total amount of payment adjustment subject to a scaling factor is 7 percent in the third year. And let's move on to slide 16 -- so, just a high-level timeline for the MIPS program. Again, the performance period is calendar year '19. The data submission would occur in the first calendar quarter after 2019. We would issue feedback in calendar year 2020. And then your claims would be adjusted beginning in 2021. Okay, so, let's go ahead and move on to slide 17 and then 18 to start talking through some of the eligibility changes in the third year of the program. So, we did make a few eligibility changes, as reflected on slide 18. You can see that we still have those clinicians that could be eligible, which includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Just as a reminder, when we talk about physicians here at Medicare, we mean not only MDs and DOs, but also dentists, podiatrists, optometrists, and chiropractors. We also finalized the clinician types for inclusion in the third year of the program of clinical psychologists, physical therapists, occupational therapists, speech-language pathologists, audiologists, and registered dieticians or nutritional professionals. So, move on to slide 19, some of the other eligibility changes that we made are related to the low-volume threshold exclusion. So, as a reminder, we have -- So, the steps that we take to determine who is eligible under MIPS. First, we look at what I covered on slide 18, to see whether or not you are an eligible clinician type. We also then look to see if other exclusions would apply that would exclude you from the MIPS program. We do still have our exclusion that deals with if you are newly enrolled to Medicare during a performance period, you could be excluded. You also could be excluded if you have significant participation in an Advanced APM. But we also have our low-volume threshold exclusion, which I want to spend time talking about today. So, what has changed and what has remained the same for the low-volume threshold exclusion? So, the things that have remained the same are that we will still look at a total amount of monies that clinicians bill, as well as their number of patients. Those values are still set at $90,000 in allowed charges and 200 patients. But we've also finalized a third criteria of 200 covered professional services. And one of the common questions that we've received since we've issued the rules is, what do we mean when we say "service"? So, when we say "service," we are equating that to one professional claim line. And so, an example of that is your typical Medicare beneficiary will likely have an annual visit where they would see a clinician. That beneficiary also could have other instances where they would need to see their clinician, such as, they fall sick, they would need a prescription refill, to discuss a known issue, any sort of thing that could occur throughout the year. So, for example, if the doctor sees their patient more than one time throughout the

year, the way that this would count is the one unique instance where the clinician sees the patient will count as one towards the number of beneficiaries' count. But if you see the patient, let's say, for five separate occurrences through the year -- for their annual checkup, maybe they needed to come in for some other services -- those five separate visits would each count as a service. So, it would count as five services towards the number of services count. Let's move on to slide 20 to talk a little bit more through the low-volume threshold. So, as I had mentioned previously, some of the steps that we take to determine whether or not you're eligible are what is included on the prior slide of whether or not you're an eligible clinician type. And then to be eligible, you would need to meet or exceed all three of the low-volume threshold elements. So, you would need to bill $90,000 or more annually, see 200 or more patients, and provide 200 or more services. And the moving on to slide 21, you can be excluded by falling under the low-volume threshold if you do not meet those three items -- so, again, if you do not bill more than $90,000, if you do not provide services for more than 200 patients, or if you do not provide 200 covered professional services. If you do not meet those items, you are excluded from the MIPS program. One of the other changes that we've made for the third year held over for the low-volume threshold I'll talk about on slide 22 is the ability for certain types of clinicians who meet one or more of those low-volume threshold elements to opt-in. So, what happens if you are excluded, but you want to participate in MIPS? So, you have two options. You can volunteer to participate. And if you volunteer to participate, we would still provide you performance feedback, but you would not be eligible or able to receive a MIPS payment adjustment. So, again, that's the money that we provide. And you would not be eligible to receive either the positive payment adjustment or the negative adjustment. And then what we've newly added for year 3 is the ability that if you meet one but not all three of the low-volume criteria that you can opt-in. So, let's move on to slide 23, where we have a chart that explains this in a little bit more detail. So, let's talk through the rows here. So, the top row, the red row -- so, this is if you fall below all three elements. So, if you bill less than $90,000, you see less than 200 patients, you provide less than 200 services, you are excluded. So, what that means for you is that you are not considered to be a MIPS eligible clinician. You do not have a choice to opt-in. What you can do is you can either decide to remain excluded and do nothing, or what we would encourage you to do is to volunteer to participate where you can still receive feedback on the MIPS program. Then, looking at the bottom row on slide 23, the green row -- so, these are clinicians that are considered to be MIPS eligible. So, that means they fall in above all three of the low-volume threshold elements. So, these clinicians also do not have a choice to opt-in or to volunteer to participate. These clinicians are considered MIPS eligible. And to avoid that negative payment adjustment, they would need to ensure that their performance results in a final score at or above 30 points. So, then the opt-in eligible population are those that would fall in those kind of yellowish rows in the middle there. So, those clinicians would meet one or more of the low-volume threshold elements, but not all three. And so, they have a choice. They have a choice to either decide to be MIPS eligible and opt-in, which again means you can get the payment adjustment associated with it, or you could choose to not opt-in, and you would be considered excluded and you would be considered to be a voluntary reporter. So, let's move on to slide 24 to talk through a real example. So, in this example, we have a physical therapist who wants to participate in MIPS as an individual. And as you can see here, this physical therapist -- she billed $100,000 in charges. So, that's above $90,000, so she has that. She also provided 201 covered professional services. So, again, that's above our 200

threshold. But during the year, she only saw 100 patients. So, this clinician is not automatically eligible. Instead, she has a choice on whether or not to opt-in. And moving on to slide 25, when you decide to opt-in, I do want to be clear that that choice -- once that has been made, it is irrevocable, and it cannot be changed. So, again, if you are considered to be an opt-in clinician, you have a choice to either participate in the program and be considered MIPS eligible and all of the things that come along with that -- the eligibility rules and the payment adjustments. Or you can choose to be excluded, which means you would not have the ability to potentially earn a positive adjustment. I do also want to call out a user research opportunity for our opt-in policy. As we talked about within the final rule, we really want to ensure that the mechanism on how we receive these opt-in elections is in a low-burden manner. So, as we talked about in the final rule, we do anticipate that those clinicians that are opt-in eligible -- they will need to make this affirmative or -- so, either an affirmative decision -- "Yes, I want to opt-in" -- or, "No, I do not want to opt-in, I want to be considered a voluntary reporter," prior to submitting data to us. But we recognize that there are a multitude of ways that we, CMS, could actually receive that communication. So, we really do want to work with all of you. So, if anyone is interested in participating in user research with us, please reach out to the e-mail address that's on the slide here, and we would love to work with you. Okay, so, hopefully that helps clarify the way that the MIPS eligibility works, who's eligible, and then also how the low-volume threshold exclusion opt-in policy works. If there are additional questions on this, I'd be happy to talk through those during the Q&A period. Let's move on to slide 26. One other eligibility change that we made within the final rule is we consolidated our determination period. So, as folks may recall, we had a number of determination periods for our low-volume threshold as well as our special statuses. The way that these worked in prior years is they ran on a September-to-August timeframe and each of these had a separate determination period. What we've done in this year's rule is we did a bit of clean-up and alignment. First, what we did is we shifted the timeframe to fall on a fiscal year -- so, October through September. We feel that that is easier to communicate. We also have consolidated a number of the determination periods for not only MIPS low-volume threshold determinations, but also for our special statuses. I do just want to remind folks, though, that if you are a MIPS eligible clinician with a special status, which could be if you are non-patient-facing, if you're part of a small practice, a rural practice, you're hospital-based, et cetera, that does mean that you are MIPSeligible. It just means that you have special scoring rules that can apply to you. Typically, those special scoring rules are that you have additional bonuses or that you may have to do a little bit less under a performance category. Again, all of the information related to your MIPS eligible, including whether or not you are eligible, whether or not you could opt-in, and your special status -- that will be part of our lookup tools, which are on our qpp.cms.gov website -- as close to the beginning of the performance period as possible. So, please stay tuned for more information on that. Okay, so, I think everyone should hopefully understand the eligibility basis. So, let's move on to slide 27 and 28 to start talking through the ways that you can participate. So, as reflected on slide 28, we do still have our same three participation options in year 3. That includes participating as an individual, as part of a group, or as part of a virtual group. Just as a reminder, if any of you are interested in participating as a virtual group, by law we must receive those elections prior to January 1st, so we would need to receive those elections by December 31st of this year. Moving on to slide 29, I did want to spend a little bit of time talking through some of our revised terms that we have

when we talk about how data can come in to us. So, one of the things we found after the first year, after our experiences from the first year, was that the way that we talked about how data submissions occur in our policy did not actually reflect the way that our system was designed based off of all of the user research and feedback that we've heard from all of you. What we found was that our policy actually was more limiting than what we technologically can offer. So, we didn't feel it was appropriate to make our systems more restrictive. Instead, we wanted to ensure that our policies and, therefore, all of our communications more accurately reflect the ways you can participate. So, that was the reason why we made these changes to these terms. Is it never our intent to create confusion, but we did not feel it was appropriate to continue to talk about things as an all-for-one submission mechanism when there are further flexibilities. So, moving on to slide 30, the new submission terms that we have which replaces our all-for-one terms submission mechanism includes a collection type, which deals with a set of Quality measures, a submission type which deals with the way that the data comes in to us here at CMS, and a submitter type, which deals with who can submit that data. One of the examples that I like to use here is using our old terms. We would talk about the registry submission mechanism. And we would talk about all at once both registry, Quality measures, the act of a registry submitting data on a clinician or a group's behalf, and also the role that the registry as a third party has. And what we've found, again, is that that was more restrictive than what our system was designed to do. So, for example, in year 3, what you can do to submit your data to us is you can of course still continue to work with a third party such as a registry, but we've also found that a number of organizations do have the technical capabilities to either log in and upload their data to us directly, log in and attest their data to us directly, or use our direct submission type, which typically deals with usage of an automated programming interface, which is a computer-to-computer exchange. And by using these new terms and by replacing our words of registry measures with MIPS CQMs, those measures are not restricted only to clinicians who work with a registry. So, again, just wanted to re-emphasize that the changes in our terms here is really meant to provide further clarity and further flexibility on the ways that clinicians can submit their data to us. And as reflected on slide 31, these are the options that are available to folks wanting to participate in MIPS as an individual. And then on slide 32, these are the options available to folks wanting to submit their data to us either as a group or as a virtual group. Okay, let's keep moving on to talk through the performance categories. So, let's jump to slide 34. So, first our performance period -- there's no change in our performance period from year 2 to year 3. Quality and Cost are both set at 12 months, and Improvement Activities and Promoting Interoperability are still set at 90 days. Our performance category weights -- there was a change here. So, as I mentioned earlier, our performance category weights for year 3 of the program is where Quality counts for 45 points towards your final score, Cost counts for 15 points, Improvement Activities counts for 15 points, and Promoting Interoperability counts for 25 points. So, moving on to slide 36, let's start talking through some of the changes we made within the performance categories. So, first, starting with Quality, as I've mentioned a couple times now, Quality counts for 45 points towards your final score in year 3. We do still have the same basic participation requirements here, which are that, under Quality, clinicians would need to select six measures, one of which would need to be an outcome measure. If an outcome measure is not available, please select another high-priority measure. The definition of high-priority measure includes, of course, outcome measures, patient-experience measures, patient-facing measures, appropriate-use measures, care

coordination, efficiency, and we've also finalized the addition of opioid measures. To reach those six measures, clinicians can either choose from a broad set of 257 Quality measures or specialty-specific sets of measures. We also have implemented the Meaningful Measures initiative under the Quality Payment Program, with the goal of that really ensuring that we are focusing on the highest-priority areas for Quality measurement and assessing measures that are vital to advancing our work and improving patient outcomes. So, as part of that, we did remove a number of measures that are either low-bar, topped-out, or duplicative. And we also were able to add 8 new measures, 4 of which are patient-reported outcome measures, 6 of which are high-priority. Moving on to slide 37. We do still have our bonus points available that we've had in year 2. Those still are in existence for year 3. We did finalize our change of moving to small practice bonus from the final score level as it existed in year 2 to the Quality performance category in year 3. So, again, to be eligible and to receive this bonus, you would first need to have the special status definition of being a small practice. And then you would just need to submit data on at least one Quality measure. If you do that, then the small practice can receive 6 points within the Quality performance category, which for the majority of small practices will equate to 5 final score points. Moving on to slide 38, there were no changes to our data completeness requirements. So those are still set at 60% for year 3. Moving on to slide 39, we did finalize our policies for a few special scoring considerations we found from our initial lessons learned on the first year of the program. The first deals with scenarios where measures may be impacted -- excuse me -- by a clinician guideline change during the performance period. In this scenario, where there is a measure that has been impacted by such a change, if the clinician is not able to report on an additional measure, we would reduce the total number of points from 60 points to 50 points for the majority of clinicians -- so, essentially reducing the number of measures that you would have to do from six to five. The same scenario would apply for groups who register to report the CAHPS for MIPS survey and then, through no fault of their own, do not have a sufficient beneficiary sample. If the group does not have the ability to report on another quality measure, we would reduce their Quality performance category denominator, which in some instances is at 60 points, down to 50 points -- so, again, reducing the number of measures clinicians would have to do. Moving on to slide 40, we still have our improvement scoring requirements. This is something we are required to do by law. And then moving on to slide 41, the last piece I'll touch on for Quality is our topped-out measures policies. So, we do still have our policies for identification of topped-out measures, our life cycle for identification and removal of the measures, and our scoring cap. We also finalized policies for measures that have really high levels of performance, where the average mean is that 98 to the 100th percentile range. Those measures that are extremely topped-out we would propose for removal in the next available rulemaking cycle. We also clarified within the final rule the QCDR measures. Those are the measures that Qualified Clinical Data Registries, or QCDRs, can get approved by us here at CMS and offer to their clients. Those are excluded from the topped-out measure life cycle. Okay, let's move on to slide 42, to talk to through the Cost performance category. So, for Cost, the changes that we made here is the increase in the contribution to the final score from 10 points in year 2 to 15 points in year 3. We do still have the Medicare Spending Per Beneficiary and Total Per Capita Cost measures, but we also have finalized 8 episode-based measures. And then as reflected on slide 43, we finalized our attribution policies for the episode measures, both for the procedural episode measures, as well as the acute inpatient medical condition episode. Let's move on to slide 44, where I want to talk to you

all about a new participation option in the third year of the program called facility measurement. So, facility measurement is something that we talked about in last year's rule, year 2, but we weren't able to actually implement this option until the third year of the program. And we had to fill in some additional policy details. So, let's move on to slide 45, where I can start talking through this. So, the first thing that we do to determine for facility measurement is we first determine whether or not someone is eligible. So, what we do there is, a clinician would have to first be considered MIPS eligible. Then they would have to furnish 75 percent or more of their covered professional services based off of three Place of Service codes. Those are the inpatient hospital Place of Service code, which is code 21, the on-campus outpatient hospital code, which is Place of Service code 22, and emergency room, which is Place of Service code 23. So, again, clinicians would have to have 75 percent or more of their covered professional services on those three Place of Service codes. We would also look to make sure that those clinicians have at least one single service billed with Place of Service code 21 or 23. If those of those two items are true, then a clinician would be considered facility-based. The way that we apply this to groups is that 75 percent or more of the clinicians that are part of the group would need to be considered facility-based. Let's move on to slide 46. So, now we've talked through how we identify who is facility-based. Now let's talk through how we determine what hospital you are associated with and then how you can participate. So, to determine how we attribute the hospital -- so, for the clinician, we attribute you to the hospital where you provide the majority of services to your patients. For the group, we attribute the group to the hospital where the majority of the facility-based clinicians are attributed. There are some instances where someone could be facility-based but we are unable to attribute them to a hospital. In those instances, those clinicians would not be able to partake in the facility measurement option. So, then talking through how you can participate. So, we did consider that both across our year 2 policies, as well as our year 3 policies, whether or not we should require facility-based clinicians to actually make an election on whether or not they wanted to be facility-based. What we've heard from stakeholders was that if we had the technical capabilities to not require an election that we should go ahead and do that. And after a lot of additional internal conversations, working with our technical teams, we do have the ability to not require an election for facility measurement, and we can automatically apply the facility measurement policies and scorings to clinicians. So, what this means is that if you are considered to be a facility-based clinician -- again, if you have 75% or more of your covered professional services on those three Place of Service codes, you also have one site of service on Place of Service code 21 and 23, you are facility-based -- if we can then attribute you to a hospital, what we will do is we will look at your hospital total performance score and we will translate that total performance score to your Quality and Cost performance categories. We also then would look to see, do you as a clinician have other Quality or Cost performance category data that has separately been submitted? If you do not, we would, again, just automatically apply the Quality and Cost performance associated with your hospital's total performance score. If your performance is higher, however, on the separate data submission for Quality and Cost, we would apply that. And then for groups to be able to participate in facility measurement, we would need to receive some sort of data submission for another performance category, either for Improvement Activities or Promoting Interoperability, to be assessed for this as a group. I also do want to call out that we are planning on providing a facility-based preview to all facility-based clinicians. We anticipate that that will be able to be made available by the

first quarter of calendar year 2019. And what that facility-based preview will show is, one, whether or not you are facility-based for year 3, and then we will also share with you what your performance was under the prior Hospital Value-based Purchasing total performance score so you can get a sense of, from that prior period, what your Quality and Cost performance categories would look like. Let's move on to slide 47 to talk through just a few more items for facility measurement. For the measures we are using for facility-based for year 3 are those measures that are part of the 2020 Hospital Value-Based Purchasing program. Again, for that facility preview I was just talking about, we will be using the measures and performance associated with the prior year's performance. So, that would be based off of the 2019 HVBP program. And, again, that preview is something that we feel will help clinicians make their participation options and whether or not they want to pursue facility measurement or if they want to participate separately under the Quality and Cost performance categories. Moving on to slide 48, I believe I've talked through all of the items here. The only other piece I do want to highlight is that there are some rare instances where we can identify you as a facility-based clinician, we can attribute you to a hospital, but that hospital may not have a HVBP total performance score. In those instances, those clinicians also would not be able to participate in facility measurement. Okay, let's move to slide 49 to talk through the Improvement Activities performance category. So, we made just a few minor changes here. We added a few new Improvement Activities. We removed five, and we modified one. And we also removed the certified EHR technology bonus that aligns with the Promoting Interoperability performance category because, as reflected on slide 50, we have made a number of changes to the Promoting Interoperability performance category. And so at this participate I'm going to turn the presentation over to Elizabeth Holland to talk to us about those changes. Elizabeth?

Thank you, Molly. So, we did an overhaul of this performance category. You may remember that it used to be called the Advancing Care Information performance category, but now it's called the Promoting Interoperability performance category. We did this to focus more on interoperability, health information exchange, and providing patients access to their health information. We also wanted to align the requirements of the Promoting Interoperability performance category with the requirements of the Promoting Interoperability program for eligible hospital and CAHs, which used to be called the Medicare EHR Incentive Program. We have eliminated the base and performance scores, and we've retained very minimal bonuses, mainly just for brand new measures. And we also must report each measure under each objective or claim exclusions if applicable. People have asked how to claim exclusions. For a measure, you would submit a zero, but you'd also have to submit the exclusion because for certain measures there are multiple exclusions, and you would have to select the one that applies to you. Okay, next slide. So, as I mentioned, there's one set of objectives and measures, and these are them. There's four objectives, and all the measures are required except for the two brand new measures, the Query of Prescription Drug Monitoring Program and the Verify Opioid Treatment Agreement. Those are both worth 5 points. You would submit a numerator and denominator, but as long as your numerator is at least one, you would get the 5 bonus points. For everything else, all the other measures, the points are assigned through the calculation of numerators and denominators, and we'll get to that in a second. I also neglected to say that the two new measures are optional, so you do not need to submit them in 2019 if you do not or cannot do so. The one exception from the numerator and denominator submission is for the Public Health and Clinical Data Exchange measures. So, for those, you need

to choose two. And you choose two, and they can be reporting to any two registries. They don't need to be two different categories. So, for example, if you're submitting to two different clinical data registries, that would count as two. And if you submit to two, you get 10 points. Also, if you submit to one and claim an exclusion, you would get 10 points. And if you submit two exclusions, you would get the 10 points redistributed to another measure, and that would be to the Provider to Patient Exchange measure. Okay, next slide. Okay, so, this goes through some of the things, the scoring. You need a minimum of 90 days in your performance period, or it could go all the way up to a year. You must submit the Prevention of Information Blocking Attestations. You must submit a "yes" to the ONC Direct Review Attestation, if that's applicable. And you must submit a "yes" for the security risk analysis measure. You may notice that this is the overall requirements for the category, but you do not earn a separate score for this anymore. And as I said, you have to submit the required measures or claim exclusions. And I will say that you need to have 2015 edition CEHRT in 2019. The functionality of the CEHRT needs to be in place for the entire performance period. The certification needs to take place no later than the last day of the performance period you selected. Okay, next slide. Okay, so, I think I said most of this already. Performance based scoring is at the individual level. Your numerators and denominators are yes/no. The scores are added together. And exclusions -- the points are allocated to other measures. And we spelled out the other measures, that they're re-allocated to in the final rule. Next slide, we're going to go through a scoring example. So, these are all the measures, and you'll see that in this case, there's the maximum points for each of the measures. And then you submit the numerator and denominator. What we do is we take your numerator and denominator and convert it into a performance rate. And then we multiply that by the maximum points for that particular measure. So, for example, the e-prescribing is worth 10. They earn 80%, and so they would earn 8 points. Next slide, please. What we do is then we add up all those points. In this case, it was 78. It is multiplied against the value of the performance category, which still is 25. And so, in this case the clinician would have earned a 19.5 out of the 25 performance category points. Okay, next slide. So, we do still have re-weighting. All the re-weighting examples that we had for year one and two are still in place. So, we still have re-weighting for hospital-based, ambulatory surgical center-based, and certain clinician types. But we did also add this year -- because of the new clinician types that Molly mentioned, we are extending the automatic re-weighting to all those new clinician types. So, in addition to the ones that we were already re-weighting for year one and two, we are adding these for year three. Now I'm going to turn it back over to Molly and slide 58.

Thanks so much, Elizabeth. And let's go ahead and jump to slide 59, just a few more items from me on MIPS, and then we can turn it over to Dr. Corey Henderson to talk through APMs. But before we do that, so as reflected on slide 59, we do still have our complex patient bonus in the third year of the program. It's the exact same requirements and criteria as year 2. We will automatically calculate this for all clinicians as long as data is submitted for at least one performance category. And this is based off of HCC risk scores and score based off of the percentage of dual eligible beneficiaries. Moving on to slide 60, so again, and I've mentioned this a couple of times, but I do really want to reemphasize this because this is where they money comes into play, and we all, of course, care about that. So again, in year 3, the performance threshold is now at 30 points. Again, that is the number that a clinician's final score would either need to be at or above to either get a neutral or positive adjustment. Scores that fall below

30 points will be getting a negative payment adjustment. We also changed the additional performance threshold for exceptional performance, that bonus, from 70 points in year 2 to 75 points. As a reminder, that additional performer bonus has a separate bucket of money that we can distribute those bonuses under. And then also remember, by law, the payment adjustment has increased from 5 percent in year 2 to 7 percent in year 3, subject to a scaling factor. So, let's move on to slide 61 for the last slide for me on MIPS. So, just to reemphasize these points I just made, let's start by looking at the year 3 table and starting from the bottom up, scores that are between zero and 7 1/2 points by law must receive the maximum negative adjustment of 7 percent. So again, while we really want everyone's final score at 30 points or higher, we would really encourage folks to ensure that their final score is at least above 7 1/2 points. Otherwise, you statutorily -- meaning by law -- you must receive the maximum negative adjustment at 7 percent. If your final score range is from the 7 1/2 to under 30 range, it will fluctuate somewhere between -7 percent and zero percent, again subject to that budget-neutrality scaling factor. Looking at the green row, 30 points, that's our neutral payment adjustment. And then moving to the light bluish row, so clinicians whose final score is 30 or greater will be getting a positive adjustment. That positive adjustment by law can go -- can be 7 percent, subject to a scaling factor. The scaling factor is 3. And then the top row is the additional performer bonus. Again, that reflects clinicians whose final scores are at 75 points or greater. That means that they would be getting the MIPS payment adjustment as well as monies that we can offer based off of that separate bucket of exceptional performer bonuses. Okay, so hopefully, everyone has a clear understanding of the MIPS year 3 performance requirement. So, at this point, I'm going to turn it over to Dr. Corey Henderson to talk through APMs. Corey?

Great. Thank you, Molly and Adam. And I wanted to just let everyone know that I'm going to try to get through this section as thoroughly as possible but not waste a lot of time, so, we do have some other presentations on the resource library, that if you'd like to learn about APMs or get some more background information, you can find those there. But I'd like to leave enough time for everyone to be able to ask two questions and see if we can get through some of the questions. So, here's an overview of Alternative Payment Models. The APM is pretty much how we describe them. The APM is really a payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care, and just what we're saying is specific conditions, care episodes, or populations are just some of the ways that we look at APMs. We also offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs. They still win, in a way, of monetary value by when you sign the participation agreement, there are some incentives that you may gain for different models that you may participate in. Next slide, please. Slide 64. So, as we talked about the incentives, the Advanced APM offers two key incentives. Not only do you get the Advanced APM specific rewards, but you're also eligible for a 5 percent bonus that goes to the TIN, whoever you assign your billing to. And as an organization, pretty much one of the ways you can look at this is when we talk about APMs, we talk about the APM entity, so we're talking about the whole group. So, you will usually find that all QPs or those who are eligible -- we'll talk a little bit about that -- for the 5 percent bonus, everyone in that group usually gets the same designation. Next slide, please. One of the other key benefits of being an Advanced APM, one is that we're looking at the Alternative Payment Model must use CEHRT EHR technology; two, that it provides payment for covered professional services based on Quality measures, and here's the key word, comparable to those used

in the MIPS Quality performance category; and third, that it is either a Medical Home Model expanded under CMS Innovation authority -- and currently there are none expanded under the CMS Innovation Center authority -- or that it requires participants to bear more than a nominal amount of financial risk. And a good benefit here is that because you do those three things, you would not be required to participate in MIPS if you have QP status, which means you're elevated to the highest level of participation based on thresholds. And I'll give a little more background as we go through the slides. Next slide, please. So, as we talk about Advanced APMs, some of the things that we described in just what I was sharing with you is that there is an APM entity. That is really the organization or the group that you would be going through or the entity that signs up and participates. And then there are participants within that group. The Advanced APM is the APM, the model itself that meets those three criteria I just described. The affiliated practitioners are those that work with or participate with the APM Entity. We identify them and some contractual arrangement with the entity, and there's a list of those. And that's your practitioner list of the practitioners on that group or in that group that are compiled. We also have the MIPS APMs. The MIPS APMs are a little different from the Advanced APMs in that they do have some participation in an Alternative Payment Model, but how we identify them is that they are MIPS eligible clinicians who are scored under the APM scoring standard, so they're not in the Advanced APM, but they do do work in the APM. So, they still have some level of participation in MIPS, but it's all done through the group level or the APM entity level. And a benefit there is that they do get some additional scoring points, so they will not be eligible for the Qualifying APM Participant designation, which we were talking about the QP, so again, the QP would be eligible under the Advanced APM to receive a 5 percent bonus, whatever Advanced APM incentives there are, and they would not have to participate in MIPS. The participation list is pretty much the APM Entity -- that's those who -- we have a list of those who are participating. And then finally, the Qualifying APM Participant -- I like to say this multiple times so that you hear it more than once -- again, it's the eligible clinician determined by CMS who has met or exceeded the relevant QP amount or the patient count, so there's a dollar amount, and then there's a patient count threshold. If you do one or the other, and we would determine you for that performance year. Underneath the snapshots, we'll talk about to be considered an Advanced APM Entity Qualifying APM Participant. So, you have to be an Advanced APM, and then you can also be qualified to receive the 5 percent bonus and not have to participate in MIPS. Next slide, please. So, that’s the last background slide. You'll find here a list or a current list of Advanced APMs, so 2019. What you'll also find is that we have on the qpp.cms.gov page, if you go to APMs, you'll find that there's another list in which we list the Advanced APMs. We also list the MIPS APMs. We have on the resource library a document called the Comprehensive List of APMs. There's a designation under each column that allows for you to look and see if that is designated as a MIPS APM or as an Advanced APM. And if you do not see either designation, then they're just an Alternative Payment Model. So, there's a designation there for each of the models that we list, and we update this list as we add more APMs or as their designations change, so that's a great resource for you. Again, it's on the resource library to help you determine what's an Advanced APM, what's a MIPS APM, and where do I fall on that list? Next slide. So, these are a little more advanced, and we'll talk about some of the rules and policies. You can go to the next slide. So, for 2019, pretty much what we did was we went from, as I talked about before for the Advanced APM, there was a CEHRT requirement that at least 50 percent of clinicians in the APM Entity must be using CEHRT. So, we just increased

that to 75 percent. And we're trying to allow for more people to kind of move to the direction of using the CEHRT and meeting that requirement on the Advanced APM. So, for 2019, we finalized to 75 percent of eligible clinicians in that APM Entity must be using the CEHRT. Next slide. Here again, another final policy -- we don't have to really talk about 2017, 2018, because I believe the most important part is going forward for 2019, beginning in 2020, is that we're looking at when you go to look at the list of measures, the key thing there is that it must be on the MIPS final list, that it's endorsed by a consensus-based entity, or that they're otherwise determined to be evidence-based, reliable, and valid by CMS. And if you look in the rule, we'll actually have a list of those measures under the different APM models that you will find. So, you can look at the models and the measures that you're going to be reporting on, but much of that is determined when you do sign up for that Advanced APM participation. Next slide. So again, here are the outcome measures. We're looking at, again, that they are on the MIPS final list, endorsed by a consensus-based entity, or otherwise determined to be evidence-based, reliable, and valid by CMS. We're just trying to make sure that everyone knows that when they're looking at the measures they're reporting on, that you don't just pick a measure and say, "Well, it was on the MIPS list." It also has to be a measure that we determine with these other two criteria if that measure is outside of the MIPS final list. And this begins in 2020. Next slide. So, as we move forward, we're also looking at maintaining and not changing the 8 percent revenue-based nominal amount standard through performance period 2024, and a lot of people were happy about that because it didn't cause any more worry about the amount of risk that they had to take. Next slide, please. So, we'll talk a little bit about the All-Payer and Other Payer Combination Option. Next slide. On slide 74, you'll see that there are two combination options that we're beginning in 2019. One is what we've always been doing, which is the Medicare option. The other is what we call the All-Payer Combination Option. The best way to look at that is if you combined your participation in Advanced APM with Medicare and then you also bring in Other Payer Advanced APMs that are offered by other payers, and once we make that determination, we combine the participation in both, and you can be determined to be an All-Payer Combination Option Advanced APM meeting that QP status, again, calculating both of those participation. Next slide, please. But you must be in an Advanced APM through Medicare first. Here are the four different types of Other Payer Advanced APMs we will consider. Those are Medicaid; Medicare Health Plans, including the Medicare Advantage; payment arrangements aligned with CMS Multi-Payer models; and also other commercial and private payers. And we will make that determination, and we provide that information also under the qpp.cms.gov if you go to the APM section. And we are increasing those pages, so you will have a page for APM overview, MIPS APMs, Advanced APMs, and then All-Payer, Other Payer, as you want to learn more. Next slide, please. Much of the information I'm sharing, because I did see a lot of questions, and we'd like to make sure you get as many answers as possible. And here you'll also see that there are certain criteria that were previously aligned with the Advanced APMs -- that we require at least 50 percent of eligible clinicians use the CEHRT requirement to document and communicate clinical care information; two, that they base payments on Quality measures that are comparable to those used in the MIPS Quality performance category; and three, the difference here that it's not the Medicare Medical Home Model, but it's the Medicaid Medical Home Model -- that uses criteria comparable to a Medical Home Model expanded under CMS authority. And everything underneath that is pretty much about financial risk, how we aggregate expenditures and exceed expected aggregate expenditures. And that, you can learn more about by going to our pages under

APM. Next slide. So, we can move forward to the next slide. This is just where we talk about the final rule policies that align the two. And pretty much what you're going to find under the Advanced APM is also going to be aligned with the Other Payer criteria. We increased the CEHRT beginning in 2020 to 75 percent for eligible clinicians in an Advanced APM entity. Next slide. Here again we're also modifying the CEHRT use criterion that allows for other payers or eligible clinicians to submit evidence that CEHRT is actually being used as a required threshold. Whether or not the CEHRT is in use explicitly required under the terms of the Other Payer arrangement. So, it may be separate or outside of the terms, but as long as it's submitted and it meets the criteria, we will count that. Next slide. And this is all done under determination when we make the determination for the Other Payer, All-Payer Advanced APM. Here we make no change, and again, we aligned ourselves with the Advanced APMs to maintain the revenue-based nominal amount standard for Other Payer Advanced APMs at 8 percent through performance period 2024. You can go to the next slide, please. Here again we're allowing all payer types to be included in the 2019 payer-initiated process for the 2020 QP performance period. Previously, we had a staggered process. We're now trying to make sure that everyone gets an opportunity to participate to meet the QP status, again, reducing burden so you don't have to report through MIPS. You also get the 5 percent bonus if you're calculated to be, determined to be a QP. Next slide. Here we also maintain annual submissions, and what we get is we streamline this process when initial submissions are made that the payer and/or eligible clinician provide information on the length of the agreement. And the reason why we need that information is so that you don't have to keep submitting the same information. If we have the information, the information stays the same across the time period of the duration, then we ask that in subsequent years, that if there are no changes to the payment arrangement, the payer and/or the eligible clinician will not have to annually attest or resubmit the payment arrangement for determination, so again reducing burden. Next slide. All right, we'll go to slide 83. We're looking at TIN level QP determinations. Beginning in 2019, to allow for QP determinations under the All-Payer Option to be requested at the TIN level as we do now for the Medicare option in addition to the APM Entity and eligible clinician levels. Next slide, please. You can go to the next slide. This is going to talk about the MIPS APMs and the APM scoring standard. So, as we wrap up here and talk about this section, I just wanted to share that the most important part about MIPS APMs is again, at the entity-level participation, and then those determinations when you go to, as Molly said, go to the eligible clinician look-up tool, you will find your information there. We'll share with you what we know about you. But you'll also see that that level of participation is done through that group, so when we're looking at determinations and MIPS participation, everything is done through the group level. So here, we're going to reorder the wording of the criterion to state that APM "bases payment on Quality measures and cost utilization." Previously, it was flipped around. And it made it sound as if we were saying that there was a cost utilization and Quality measure before. It was kind of worded weird. So, we switched it around so we can give it a little more clarity that the cost utilization part of the policy is broader than specifically requiring of a cost utilization measure, so adding some clarity there. Next slide. And on slide 86, we're going to align that the Promoting Interoperability reporting requirements under the APM scoring standard so that MIPS eligible clinicians and any MIPS APMs, including the Shared Savings Program, can report Promoting Interoperability in any manner permissible under MIPS, so again, aligning ourselves as a full program across the Quality Payment Program at either the individual or the group level. Next slide, please. So,

thank you guys for hearing me out about the Alternative Payment Models. I'm going to pass it back over to Adam, and if you have more questions, please go to the qpp.cms.gov page. And feel free to look up any of our previous presentations about APMs. We'd be glad to answer any questions later, too. Thank you.

All right. Thank you, Corey. I also want to thank both Molly and Elizabeth for covering the MIPS side of Quality Payment Program. Charging right along, because we do want to get to your questions, so I just want to talk a little bit about our help and support that is available. So, we're seeing a lot of really great questions. Again, I know a lot of folks will be new to the program, certainly going into the 2019 performance year with the new clinician types that Molly mentioned earlier being added to the program. So, I highly, highly, highly recommend taking advantage of these free support services. Our support teams are standing by to help you get started. These are reputable organizations. They've been working with us for the last two years. Please take advantage of this free help. Especially, we saw a few comments come in concerned about small and rural practices. While we're doing our best from a policy perspective to continue offering certain flexibilities for clinicians in small and rural practices, we've also established what we call our small, underserved, and rural support initiative. Again, this is for our smaller and rural practices that have 15 or fewer clinicians. Please take advantage of that help. It's free. It's available now. Of course, we have, outside of small, underserved support, we also have support that is specific to larger practices as well as for those organizations and practices that are ready to begin thinking about moving into an Alternative Payment Model through our Transforming Clinical Practice initiative, all really fantastic resources, and as Corey mentioned just a few minutes ago, I highly encourage you to visit qpp.cms.gov, visit our resource library. There's a lot of great pages on there. And if you have not done so already, please subscribe to our listserv. It is on the main page of qpp.cms.gov. This is where we will communicate with you all of the forthcoming releases for the 2019 performance period. Moving on to slide 89, just a quick plug. The first two years of the Quality Payment Program were really shaped from our interaction with all of you. We want to continue that trend moving forward and continue that collaborative effort, so if you are interested in providing feedback to us on the Quality Payment Program experience, more specifically on qpp.cms.gov, please take the time to send us some notes at the e-mail listed on the slide. We'd love to have you participate in one of our user feedback sessions. They generally range from 30 to 60 minutes, and they can be done in the convenience of your office, home, location, wherever you're at. We try to work with your schedule and be as flexible as possible, so if you're interested, shoot us a note. This is a really great opportunity to have your voice heard and help us continue to improve the program into future performance years. Okay, and with that, we're going to move into our Q&A session. We're working through the questions in the Q&A chat right now. There's a lot of them, but we want to hear from you, so I'm going to turn it back to the moderator for the instructions on how to dial in, and then we'll go from there.

We are now going to start the Q&A portion of the webinar. You can ask a question via chat or phone. To ask a question via phone, dial 1-866-452-7887. If prompted, provide conference ID number 6993775.

Okay, fantastic. We'll give folks 30 seconds to dial in to that number. I just wanted to tackle something that we did see quite a bit throughout the chat. I know a number of you were asking about year 3 and when the lookup

tool will ultimately reflect eligibility, facility-based, opt-in options, so we are working very hard to have that available as early on in the performance year as possible. That is our goal this year. So, I just want to let you all know that that is what we're targeting, to have it as soon as we open the 2019 performance year. Again, if you do sign up for our QPP listserv, you'll know as soon as everything's on there and we're ready to go, so you can check your eligibility for year 3. So, another reason to sign up for our listserv.

Hey, Adam, this is Corey. I just wanted to answer one question that may be a question that comes up for several. There was a question on the chat about the QP thresholds. And someone asked about the fourth snapshot. So, we already have up on the eligibility tool the second snapshot of QP data. And that will take you through January 1, 2018 through June 30, 2018. And that will give you an idea of where you are in the QP calculation and/or determination. We do have three snapshots -- March 31 -- that's January 1 to March 31; January 1 to June 30; and then we have a third, January 1 to August 31. Those will look for the Qualifying APM Participation. Currently, that third snapshot should be being calculated once we have the 90-day run-out period for those claims. But the fourth snapshot is not related to QP. It's related to the full TIN models, and the only full TIN model we have right now is the Shared Savings Program. And that will help those MIPS APM participants that have joined Shared Savings Program after those time periods of August 31 to be included in that group to receive the APM scoring standard. So again, the fourth snapshot of December 31, it is still there, but it is not related to Qualifying APM Participation. It is related to just being a participant receiving the APM scoring standard so we can give you recognition and benefit of your participation.

Okay, great. Thank you so much, Corey. I agree, that was a trending question, so thank you for tackling that. Okay, folks, we're going to turn it over to the phone line. Please, one question per person. We're going to try to get through as many as possible. I think we will extend it by about five or so minutes just to try to take questions, so let's get started.

Our first question comes from the line of Jason Shoshire of UNC Health Care.

Hi. Can you hear me?

Yes, we can.

I have a couple of quick questions. And my first is -- and everything I'm asking is related to large groups or tax IDs. So, the first is, there seems to be major confusion with the PI category, so for some of the new provider types, like PTs, OTs, when you're reporting as a group and you're all in the same edition of CEHRT, can you or can you not carve out those providers from the PI category?

This is Elizabeth. If they're using CEHRT, their data needs to be included in the group submission.

So, the only way you can carve them out is if they're not on your edition of CEHRT.

Or if they're reporting as an individual.

Okay. Thanks. So, second question, really quick, "For Improvement Activities, and this is outside of the PCMH measure, as long as one provider within the entire group is doing the activity as in years past, the entire group can get credit? Is that still correct?"

Hi. This is Angela Foster, the improvement activities lead. And yes, that is correct.

Okay. Thank you. It would be helpful in the future if you included details like that in the FAQ sheets.

Thank you for that tip, and I will carry that back to my team.

Great. Thanks.

Thank you.

Our next question comes from the line of Stephen Besch of Ingenious Med.

Hi, guys. Thanks for taking my question. I might be clinging to some older terminology, and that might be confusing, but I'm having trouble reconciling what's being said about an issue being classified as hospital-based, based on 75 percent of their charges being under an in-patient Place of Service code and how that jives with being classified as facility-based automatically specifically with the re-weighing of the PI category and how that applies to groups because [Speaks indistinctly] 75 percent of clinicians meeting facility-based criteria means the group is facility based. But then somebody asked a question in the Q&A box and said that they were wondering if... Sorry. "For a group to have the PI score re-weighted, every eligible clinician must qualify for re-weighting?" And the answer was, "Yes. All must qualify for re-weighting, either through automatic re-weighting due to specific status or through the proved hardship exemption." So, I'm confused. Is it 75 percent, or is it 100 percent? Or am I just confusing what "facility-based" and "hospital-based" means? If that question makes sense.

Hi. This is Molly. I'll take the first part of it, and then, Elizabeth, please feel free to jump in here. So, a couple of things. First, the term "facility-based" and then the term "hospital-based," those are two separate definitions, two separate special statuses. So, to be facility-based, that's where 75 percent or more of your covered professional services are based off Place of Service codes 21, 22, and 23. And then, Elizabeth, please jump in here if I misstate this. To be considered hospital-based, it would need to be based off of Place of Service codes 21, 22, 23, and I believe it's 19. Is that correct?

Correct.

So that's the first distinction, is that there are two separate terms. Being hospital-based refers specifically to the Promoting Interoperability performance category and in some instances, so when you're hospital-based, you could not be able to complete that category and would have re-weighting. For facility measurement and that definition, that deals with further flexibilities and participation options that you can have under the Quality and Cost performance categories. I hope that helps. Thank you.

Thanks, Molly.

Thank you.

Our next question comes from the line of Megan Farp of Wilmington Health.

Hey. My question is for 2018, we're currently a Track 1 MSSP. Our plans were to go to Track 1+ in 2019. But under the Pathways to Success model, I think we would be a Level 3 Basic MSSP with a 7/1/19 start date. What does that mean as far as like our AAPM status under MIPS, and would we be considered an AAPM, or how does that work?

This is Corey. I'm not sure if we have anyone from Shared Service Program. Do we? Because I know that --

Yes. Rabia Khan is on.

Okay, here we go.

Yes, so under the Pathways to Success and what has been finalized with MIPS Quality Payment Program's final rule in relation to it is that the changes in the tracks that would be considered an Advanced APM are Basic Level E and Enhanced. And those who are carrying over as a Track 1+ or Track 2 or Track 3 ACO. So those would be the ones considered to meet that criteria. And if clinicians are determined to be a Qualifying APM Participant at any of the three snapshot dates, they would maintain that and be eligible for that incentive payment. But if I understand you're saying you want -- you're thinking of transitioning as of July 1, is that correct?

Yeah, we're currently a Track 1 MSSP. And we had planned to do 1/1/19, but now we're going to do July 1 under the new model.

Right. So, to be considered for QP status for that Advanced APM payment, for those starting July 1, you would have to meet, like I said, when the Advanced APM track of the changes that are being considered, the basic level and the enhanced would be the track to transition to become an Advanced APM. And there would be one remaining snapshot date, which would be August 31, where there would be a determination whether at the ACO level you exceed the Qualifying APM Participant threshold.

Got it. Thank you.

Thank you.

Our next question comes from the line of Julie Wilson of Allstretch.

Hi, Julie.

Yes. I wanted to ask a question regarding the status of being on a 2015 CEHRT for Certified EHR Technology. It was really clear around the Promoting Interoperability category for that requirement, but for the Quality category, I was seeing some questions flow about needing to also be on 2015 CEHRT by January 1, 2019, to earn a score for the Quality and to continue to qualify for the end-to-end electronic bonus. Could we just receive some clarity on the Quality category and requirements for 2015 edition CEHRT, please? Thank you.

Sure. This is Molly. So, we have a unified definition of what edition of certified EHR technology is required under the Quality Payment Program. So, we've actually received a couple of questions on this today. So, thank you to all of you who have flagged this for us. So, to be clear, for both the Quality performance category as well as the Promoting Interpretability performance category, 2015 edition certified EHR technology must be used for the Quality Performance category. If you were using your 2015 certified EHR technology, that would be for using the ECQM collection type. And this is actually an existing requirement from a prior year where we had our unified definition of certified EHR technology across the program. We felt it was appropriate to clarify this within the final rule. And so, thank you again to all of you who have mentioned this to us. I've seen a couple of e-mails on this today. So, we'll definitely work on making this clearer so clinicians can have a clear understanding of what they're required to do. So, I hope that helps. Thank you.

Our next question comes from the line of Kristin Heffernan.

Thank you. The prior question just answered mine, so thanks.

Oh, thank you.

Our next question comes from Michael Opsey.

Hi, this is Michael Opsey. Thank you for answering my question about the 2015 edition, whether it's required for quality or not. My next question is, if I'm a provider who meets one of the criteria, and therefore eligible to volunteer to report MIPS, how do I volunteer? And can I accidentally volunteer by continuing to report Level 2 CPT codes on claims?

That's a great question. So, the way that you would volunteer to report is... It's a little more simple than maybe people may think that it is. You essentially would just need to submit any sort of MIPS data to us, whether it's for the Quality category for Improvement Activities or Promoting Interoperability. What we will do is... So, as I talked about here today and then in past conversations, we have, again, in our qpp.cms.gov website, our look-up tool where clinicians can determine whether or not they're eligible. When we receive data from clinicians, because remember, under MIPS, no sign-up is required, so when we receive data from clinicians, and when we go to match that to whether or not the clinician is MIPS eligible, if they're not considered MIPS eligible, they are automatically considered to be a voluntary reporter. And again, what it means to be a voluntary reporter is that you can send to us, CMS, MIPS data, but you would not receive the MIPS payment adjustment whether it is positive or negative. So I hope that helps clarify the process for voluntary reporters. Thank you.

Just want to make sure that if I accidentally submit claims information, you're going to qualify that as a voluntary submission.

So, we will look across all data that we receive, whether it would come through the Part B claims collection type or submission type or through some of our other data submissions, and we will again first look to see, of that data that we've received for a specific TIN NPI, so for a clinician, is that clinician eligible or not? If they are eligible, and if they have submitted sufficient data to us where we can calculate a performance category score and they meet the requirements of a particular performance category, again, we would try to calculate a score for them, assuming they're eligible. If

they are not considered to be eligible and they're a voluntary reporter, we would still calculate the data to provide feedback, but that wouldn't result in the clinician receiving a final score and an associated payment adjustment. I'll just clarify one more thing, which may be a nuance to your question that other people have in their minds. We did finalize a change in year 3 of the program that beginning in year 3, only clinicians that meet the definition of a small practice -- so only those clinicians that have a small practice special status can submit the Part B claims collection type and have that data scored and be contributed to your Quality performance category score. If clinicians who are not considered to be part of a small practice still send to us Part B claims, Quality data codes or G codes, those codes will of course be accepted within our Medicare claims processing system, but we on the MIPS side of things will not use those codes to contribute to your Quality performance category score, again, unless you meet the definition of a small practice. I hope that helps a little bit more.

Thank you.

Thank you. Last couple of questions, folks.

Our next question comes from the line of Michelle Casullo.

Good afternoon. Just a quick question. I just wanted to find out if the submission as a group for all our clinicians, if they bill under a single tax ID number, but they're not part of an ACO or Medicare Shared Service Program, can they still submit as a group under the TIN, or do they have to submit as an individual for MIPS reporting?

Sorry. This is Molly. I think your question is, if a TIN is both part of a Medicare Shared Savings Program or...

No, if they're not. If they're no longer part of an ACO or a Medicare Shared Savings Program, can the TIN be reported still as a group? Or do they need to submit as an individual clinician?

That's really up to the practice, so you could all report as individuals, or you could report at the group level. In fact, group-level reporting is optional for you.

It is? Perfect. Thank you so much.

Thank you.

Our next question comes from Anne Brown.

Hi. I was wondering, is there going to be Medicaid added to MIPS in 2019 in anything other than the IPA model?

Sure. So, this is Molly. So, under the MIPS side of the Quality Payment Program, we do, of course, collect information on all payers. So, of course, the Medicare payer, but also other payers, including Medicare Advantage, Medicaid, and private payers. Beyond that, though, we are limited by our statutory requirements, what we do under law, that the overall MIPS program and the adjustments that are made are relative to cover professional services.

So, at this point, Medicaid as it exists itself would not be added to MIPS but be eligible if you had a Medicaid Patient-Centered Medical Home.

So, patients -- so, for clinicians that are considered to be MIPS eligible, they can and should still report and perform data on their entire patient population, not just their Medicare patient population. So, of course, Medicaid would be a part of that. But any additional expansions to Medicaid under the MIPS side of things would require a change within the law.

Okay. All right, great. Thank you.

Thank you.

Thank you. So, folks, that's going to wrap up our webinar today. We appreciate all the questions that you sent in. I know we've been trying to answer them in the chat room in real time. We also appreciate you calling in with questions for us. On behalf of all of our subject matter experts today, we do want to thank you for joining us. I also encourage you to visit qpp.cms.gov for additional 2019 resources and upcoming events. I also encourage you to sign up for our QPP listserv by going to qpp.cms.gov, scrolling to the bottom of the page, and just entering your e-mail. Again, we appreciate you joining us today, and we'll talk to you all again soon. Thank you.

Thank you. This concludes today's call. You may now disconnect.