

CENTERS FOR MEDICARE & MEDICAID SERVICES  
Quality Payment Program National Stakeholder Call.  
October 14, 2016  
11:00 a.m. ET

OPERATOR: Good morning. My name is Amy and I will be your conference operator today. At this time, I would like to welcome everyone to the Quality Payment Program National Stakeholder Call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I will now turn the call over to Ms. Susie Butler. You may begin.

Susie Butler: Thanks so much, Amy, and thanks, everyone, for joining us for today's call especially with short notice. I appreciate that so much of you could make time in your schedules to join us today. I'm the Director of the Partner Relations Group here in the Office of Communications at CMS. And today you're going to be hearing from four of our distinguished leaders that are active in both the policy here at CMS as well as in healthcare and are practicing as well.

So, I'd like to introduce in order of their speaking is Dr. Mandy Cohen, who is the Chief Operating Officer at CMS; Dr. Kate Goodrich, the Director of the Center for Clinical Standards and Quality; Dr. Mai Pham, who's a general internist and the Chief Innovation Officer at the Center for Innovation – Centers for Medicare and Medicaid Innovation, sorry about that; and Jean Moody-Williams, who is the Deputy Director for Policy at CCSQ or the

Center for Clinical Standards and Quality, and also the Chief Marketing and Strategy Officer for the Quality Payment Program. She's also a registered nurse.

So with that, I want to turn the program over to Mandy to get started. And thank you for your patience as we delayed for just a few moments. Mandy, it's all yours.

Mandy Cohen: Thanks, Susie, and good morning to everyone. So we're keeping you on your toes here and doing a morning release, which we know is unusual for CMS. But we wanted to make sure we had a full day to be able to talk with you all about the rule we're very excited not just to talk about the policy, which will go through in detail, but also to launch our new website related to the program. And we've learned some lessons about website launches here at CMS. And so, morning seems like a good time to launch the site.

So we're excited for that. So while we're going through things if you want to scroll through the site, it is QPP, the Quality Payment Program or [qpp.cms.gov](http://qpp.cms.gov) so take a look. We've been doing a ton of user testing, talking to clinicians for months and months, not just about the policy, which we'll talk through but also about how we can best communicate about a policy that's really important to how clinicians practice and how they're going to interact with CMS. So, we hope that you like this first iteration of where we landed with the website, and we'll look forward to additional feedback.

So before I turn it over to my very distinguished colleagues to go through a lot of the meat of rule, I just wanted to step back and let you know about some of the process we went through here and how we arrived at this final rule today. So, after we put out the proposed rule, I think many of you know and participated in the many, many different outreach sessions that Jean Moody-Williams and others ran making sure that we understood exactly where concerns were and how we could address them. We got 4,000 comments on the rule, and more than or nearly 100,000 folks attended our outreach session. So, we definitely feel like we got a very good sense of where everyone was, and some concerns and feedback as well as things that you like about the rule.

And so what you're seeing today is our attempt at creating a new day for us here at CMS in partnership with the clinician community about how we're going to think about quality and payment moving forward. I think the policy released today is really just a first step in the multiyear journey, where we are focused on a transition here. And I think the way we constructed the policy really embraces that. But we also need to take advantage of that transition time and this multiyear journey to make sure we are putting in place the best things that we can to make sure that all clinicians can be successful in this program and deliver high quality care to our beneficiaries which is at the center of all the work that we are all doing.

So a couple of things about how we approach the rule and then I will turn it over to Kate Goodrich, who is really the leader of all of this work. How we approach making these final decisions, again, with a lot of your feedback and concern, is, first, always start it with a focus on the patient. And as you know that we are wanting to make sure we're paid for what works, that we are focusing on high quality care for our beneficiaries. And I think you will see that throughout the rule.

Second, we wanted, as I mentioned, to start out gradually, and we wanted to make sure that folks had the opportunity to understand the program. We think that the website we launched today will be a down payment on our commitment to help through that process and what we can do there.

Third, we also wanted to make sure we created a pathway for more participation in advanced alternative payment models. You'll hear Dr. Pham talk through how we are working through that and I think have created a lot of new opportunities over the next several years.

Fourth is making sure that we were landing in a place that was flexible for the various types of practices that folks have across the country whether it's small in rural practices. Whether it's specialty practices or primary care, we wanted to recognize that the fact that we need to build in flexibility for folks as well as adapting particularly for smaller practices and make sure that everyone can be successful in delivering quality care for all of the beneficiaries.

And then lastly is really focusing on simplicity of the reporting process. And as I said, that is going to be a multiyear journey here, and that will need a lot of partnership from all of us as we move forward to think about how, you know, we are going to do our work and how we can move forward to make sure that reporting is as seamless to everyone's care for patients as possible. And so that is what we are focused on. Again, I'll encourage you guys to look through the website, [qpp.cms.gov](http://qpp.cms.gov), not only is there just information about the rule so that, I think, it's easily digestible, but there are some fun tools on there that I encourage everyone to play around with and look at.

The one in particular that I think will be really impactful right out of the gate is a shopping cart related to quality measures. So now, all in one place, you can go and search through all of our quality metrics. You can sort them by what's most clinically relevant to someone's practice and has all the specs from the measures, and it allows you to do, have like a shopping cart, put them aside, download them and think through. So I think this is will be fun little tool for, you know, the folks, you know, to geek out here on some of the quality metrics, but I think also helps folks engage in this and it not be so mysterious and scary, and hopefully can be shown how it can be seamless to what folks are already doing, how it's similar to maybe what they've been doing in PQRS reporting in the past. And what I will commit today is also that this will be an evolution. You will see more features and more things on the site over time as we continue to build out that site and make it a place where we hope it will be a destination for clinicians to come to learn about this program and to interact with CMS.

So with that, I'm very excited to turn it over to my wonderful colleagues, the women of CMS who really make this place run. That first person will be Dr. Goodrich, who's going to walk through some of the details of policy.

Kate Goodrich: Thank you, Mandy, and good morning everybody. Thank you so much for joining today. Happy MACRA day or QPP day, I should say. So I do want to reemphasize something that Mandy said which is the time that we took I think in an unprecedented fashion to listen to our stakeholders, in particular the clinician community, from all the different specialty societies to the nurse practitioners and physician assistants and also to patient and consumer groups

who very much have a stake in this transformation of policy within the Medicare program.

So, we heard clinicians loud and clear not only in our multiple webinars and listening sessions that we actually got out of our offices and went into physician practices and clinical nurse practitioner practices, and we heard what they had to say about what was working but most importantly about what wasn't working. And we heard the concerns that people felt like they needed more time to understand what was coming before them and to get ready with their IT systems and understanding the quality measures and so forth. And so we announced few weeks ago Pick Your Pace. It's sort of a high level and we now have more detail around that, that we can share today.

So the final rule that we published today on the website that Mandy mentioned continues this principle of listening and learning from clinicians. It is a final roll with comment. And there are a number of areas within the rule that we are seeking additional comment that can inform the program going forward. I will also note that there is a very handy 24-page executive summary on the website along with the very large rule that is, quite frankly, around about 2,400 pages. But there's an executive summary that actually does dive in to a lot of the details that I think you'll find very helpful.

So CMS is really giving all clinicians an opportunity for a strong start to the Quality Payment Program. If you or your practice participates in the current Medicare quality reporting and EHR incentive programs, so PQRS, Meaningful Use, and the Value Modifier, you will find that the new MIPS program, or the Merit-based Incentive Payment System, is simpler, it's easier.

If you see Medicare patients but you have not been participating in any of our quality programs, there are number of paths that you can choose from to get started. So, you can pick your pace in one of about four ways. Number one, you can avoid a payment penalty by simply meeting the program requirements by submitting a single quality measure or a single practice-based quality activity or the required measures for Advancing Care Information. You can really just submit one thing to test your system, to test if you're ready, and you will avoid a payment penalty.

If you report at least 90 days of information, of quality information, Advancing Care Information and so forth, then you can get a small bonus. And if you've been participating, again, in PRQS and Meaningful Use or if your systems already, you've been getting ready for the Quality Payment Program. You can report more than 90 days and up to a full year, and then you can get slightly larger bonus under that scenario. And then CMS also created an easier pathway for participating in Advanced Alternative Payment models, which I'm going to defer to Mai to talk to you about that.

A couple of other changes from our proposed rule to highlight for you. We did hear very consistently from the clinician community concerns about the readiness of the Resource Use Measures that we had proposed. And so as part of our transition to get people ready for the program, we have finalized that we are weighting the resource user cost category at zero percent for the first year. We anticipate that it will go up in future years. But for the first year, it is at zero percent. Clinicians will receive feedback on their cost measures, so we still will be giving people information about that, but it will not play in to their final score.

We also took a lot of time to try to reduce the burden of reporting within the MIPS program. So, for example, in the proposed rule, we had 11 required measures under the Advancing Care Information category, and we finalized just five of those measures. For improvement activities, we proposed a maximum of six improvement activities for everyone although four improvement activities for small practices and folks in rural regions. And we finalized the maximum of just four improvement activities and two for the clinicians who are in small practices or in rural areas.

So, that gives me to my final point which is that we heard so much from many, many stakeholders including clinicians who are in solo practices or small practices or health professional shortage areas. The concerns that they had about their ability to be successful when they don't necessarily have the resources that larger practices have.

And so our rule does recognize the importance of small and rural practices. The steps that we're taking to address their concerns are, number one, raising the threshold to exclude more small practices that will probably exempt an estimated 380,000 clinicians who just don't see that many Medicare patients. As I mentioned already, we reduced some of the reporting requirements under the improvement activity category for small practices. We are increasing the number of advanced APMs that will be available to small practices. And finally we are conducting significant technical support and outreach to small practices using about – a program that we will be announcing soon that will allow for \$20 million a year over the next five years that is targeted at providing that frontline, boots on the ground, technical assistant specifically for small and rural practices, and those in health professional shortage areas.

So now, I'm going to turn it over to Dr. Mai Pham to talk with you about our finalized policies around advanced APMs.

Hoangmai Pham: Thank you so much, Kate, and let me add my thanks on top of Kate's and Mandy's for so many of you joining us today for this very exciting rollout. We – you know, I want to pull us back a step and remind all of us that MACRA is but one tool in our broader efforts at Delivery System Reform.

We believe that advanced payment models have lots of benefits for patients and clinicians, and the QPP/APM bonus is one of those. But it's always – it's really important to us to emphasize that we really want you to select the payment model that best matches your vision for how to deliver care. And then all of the other pieces will hopefully fall into place.

So in terms of what we have finalized in the rule regarding alternative payment models, first of all, let me again acknowledge and emphasize what Mandy said that we – we're very grateful for all of the time and energy that many of you spent with us telling us about your concerns and your anxieties and your hopes for this rule and these particular provisions around APMs.

So we try to take much of that into account. And I wanted just emphasize a couple of key provisions. First of all, we heard you loud and clear that the initially proposed levels of financial risk for the nominal risk standard under

advanced APMs was a little bit intimidating and – so we revisited those and found ways to offer multiple paths for models to become advanced APMs in particular the final criterion around nominal risk levels allows the model to qualify based either on the percentage of the total cost of care benchmark or based on the percentage of your clinical Part A and B revenue that's represented by that risk. We can share more details on that if you like.

So based on these standards and on the finalized standards around the other APM criteria regarding user certified technology, tying of payment to quality metrics similar to MIPS, et cetera, we are expecting as much as 20 to 25 percent of physicians to be in the advanced APM pathway within QPP in 2018.

So, in addition to making sure that we refined the advanced APM standards in appropriate ways, we also took a broader look at all of the possible strategies we could invoke for creating more opportunities for you to enter advanced APMs.

So, in that regard, we took several approaches. One is that we will – we are actively retrofitting some existing models so that they can become advanced APMs and have those participants become eligible for the bonus. Second, we are actively considering the reopening of some current models for additional application rounds because we understand that now with the QPP rule finalized people have more factors to consider in their decision making and more clinicians may be considering these models now when they weren't before. And then not least – oh, mlevels of risk than in current ACO models but that will still meet the nominal risk standard for advanced APMs. And then not least, we will continue to develop other new models particularly as Kate said those that are targeting small practices and specialist clinicians whom we very much want to engage.

So with that, I'm going to turn it to Jean to talk about our technical assistance effort and to close out and then we'll be happy to take questions. Thanks.

Jean Moody-Williams: Thanks, Mai, and hello everyone. I'm going to add my thanks not only for joining this call but for all that you've done over the past several



months to help us to get to this point. We've attended many of your meetings and you have allowed us to sometimes be very intrusive by setting up stations to do our user research or taking over your breakfast time to do listening sessions and all of those kinds of things that really helped us in our outreach effort.

So, we will continue to engage just as relentlessly as we did to get to this point because the work now begins. We have every confidence that clinicians that choose to participate and we hope that most will be successful. But as Mandy noted participation and even just awareness that this program exists is key. And that's not something that CMS is going to be able to do in isolation alone.

We're going to have to depend on all partners that are on this call to help us with that engagement and the extensive outreach so that your members and your consumer, your doctor or your nurse practitioner is even acknowledgeable about the existence of the program and how to participate. And so there will be more information to come on that, but along with that, we know you need information to be able to really effectively transmit the purposes and criteria of the program.

So, we will be putting out information on a number of learning sessions that we'll be holding. The first one will be coming up on October 26. We will be doing – a policy team will really kind of walk through the regulation through a webinar and we'll be getting a check-back on the website. We'll be getting you that information as soon as it's available.

One of the other things we heard from you in our partner meetings that Susie helps us to run was that you wanted train-the-trainer opportunities. And so we've been working on that as well in which we not only just go into the content, but some of the thought behind and interactive sessions, knowledge checks and open check features, all those kinds of things as we do some instructional learning and train-the-trainer efforts, so then you could go out to the field and feel confident as well. So we will have the information coming to you on that.

And then there'll be a number of other things you have requested. When you go to the website, you'll see fact sheets and we have put them as much as we could into plain language as you requested so that it is easily understood.

But even with that, we know that this is an evolving process. So, we will be looking for your comments on the rule as Kate already mentioned. But also on our materials, we want to get feedback as soon as possible. We're using a very agile approach even in our content. And we – so that we can change things that need to be changed as well as on the website, what is it that the users like about the site, what's unclear, how can we help – navigation processes as well.

And then for the technical assistance, if you go to the site there and look under Where to Find Help, there will be a sheet there that begins to talk about some of the avenues available with the Transforming Clinical Practice Initiative there, the Quality Innovation Network, and there are number of advanced payment model learning systems that are available. And we look forward to the technical assistance that will be given that's particularly focused for small and rural, and underserved areas.

We know that you have been participating in multiple partner calls, and we will continue that. And so you'll get notices on those meetings. And that's one of the ways we can get your real time feedback in addition to the other mechanisms that are available.

So that is, I think, what we just wanted to really note that the engagement doesn't stop, and you'll be hearing a lot more from me and others here at CMS as we move forward. Thank you.

Susie Butler: Thanks, Jean. And as a reminder, that website we've been talking about is [qpp.cms.gov](http://qpp.cms.gov). So make sure you're checking that out. And, Amy, if you could remind everyone how to queue up to ask their questions, we'll open a line for questions now.

Operator: At this time, if you would like to ask a question, please press star then the number one on your telephone keypad.

Your first question today comes from the line of (Jen Whittaker) of Humana.  
Your line is open.

(Jen Whittaker): Hi, I just wanted to ask if we do get continuing education for being on the conference call. Thank you.

Jean Moody-Williams: We – not for that particular conference call. However, we are looking into modules that would allow for continuing education. We did know that that was a request. So this is more of an overview and instructional, but there will be modules later.

(Jen Whittaker): OK, yes. It's called the National Association of Social Workers. Thank you.

Operator: Your next question today comes from the line of (David Forrette) of (Calypso). Your line is open.

(David Forrette): Hi, good morning and thank you for the call this morning. Now that we have the final rule, I imagine many people on this call are involved in application for the direct technical assistance funding. I was wondering if you could speak to the timing of when you expect those awards to be made.

Jean Moody-Williams: Thank you for that question, and as you know I'm sure and we we're really excited about the number of applicants. It is in the procurement process, and it is moving along very nicely. I can't give an exact date but we do see that forthcoming very soon.

Operator: Your next question today comes from the line of Ann Brown of Methodist Healthcare. Your line is open.

Ann Brown, your line is open.

Ann Brown: I'm sorry. I was still on mute. My question is will CPC Plus be reopened as one of the current models for application for an APM?

Mandy Cohen: That is one of the existing models that we are actively considering reopening, yes.

Ann Brown: And my other – just to be sure I understood. For the first year, QRUR will or resource use will be at zero percent; that the 11 quality measures will be reduced to five, the six CPIA reduced to four.

Kate Goodrich: This is Kate. Thank you for that. So, yes, for the first year the resource use measures which are the cost measures that come out on the QRUR reports, they are weighted to zero. We do still intend to give clinicians feedback next year on those measures but they will not count toward their final score.

The 11 measures that you mentioned was actually under the Advancing Care Information category. There are 11 measures available so people can report on all of them if they want to. But we reduced the numbers that are required for them to report on down to five. Certainly if there are other measures in that portfolio of 11 that are relevant for their practice they can get extra points for reporting on those additional measures. And for improvement activities, we proposed a maximum of six in order to get the maximum score under that category, and we finalized the maximum of four in order to get the maximum score in that category.

Ann Brown: Great. Thank you very much.

Operator: Your next question comes from the line (Charlene Ryan) of Long Island (Anes) – sorry. Your line is open.

(Charlene Ryan): It's (Charlene) from Long Island Anesthesia Physicians. I had a question. This isn't a large anesthesia group. They're hospital-based, and we do actively participate and, you know, currently participate in PQRS. But we've done a lot of research and we have a lot of questions on how things will specifically relate to anesthesia because there are so many differences for them. These are hospital-based clinicians, they're not patient-facing, you know, they do not follow up with patients, and I had read that there were going to be, you know, possibly some subsets for anesthesia that they might be exempt from cross-cutting measures and even in terms of the Advancing Care Information performance. You know, there are certain things – you know, we deal in three hospitals. One of them, only one of the three, you know, does their anesthesia

records online. We don't have any control over that. It's all hospital based. So where can we go for, you know, some guidance with these questions?

Kate Goodrich: Those are great questions. And this is Kate Goodrich so I'll address those. So first of all, I would definitely steer you to our website we've been talking about. There's a lot of great information in there. But I think I can also address to your specific questions around the quality measures as well as the Advancing Care Information category. I'll start with that one.

Under Meaningful Use, certain clinician types were exempt from Meaningful Use. Anesthesiologists were one of those clinician types, who were mostly exempt because they were hospital-based clinicians. There is still an opportunity under MIPS to apply for hardship exception because – especially if you are hospital-based clinician like anesthesiologist. So we anticipate that the vast majority of non-patient facing clinicians such as anesthesiologist, even though, of course, you do see patients, we have sort of put folks under that category but that would include pathologist, radiologist, et cetera, would be exempt from that category. And then the percent or the weight of that category gets redistributed to quality is what we have finalized.

As for the quality measures, certainly we do understand that anesthesiologists don't do longitudinal follow-up for the most part. There are a number of quality measures in the program that probably will look familiar to you because they were also in the PQRS program. And if you go to our measure shopping cart that Mandy mentioned, you'll see those there. And so those are available.

We did not finalize the proposed rule for a cross-cutting measure. We heard from a number of specialist that they felt like the way we had designed it was not as relevant for them. So we understood that and are taking a pause on that particular policy. And we didn't finalize it. And so you don't have to worry about that one. I also believe that the ASA may have a qualified clinical data registry or is working towards the qualified clinical data registry ...

(Crosstalk)

Kate Goodrich: Right, exactly. So that's certainly another option for anesthesiologists.

(Charlene Ryan): All right. Thank you very much.

Operator: You next question comes from the line of (Matthew Smith) of Himformatics. Your line is open.

(Matthew Smith): Hey, I had two quick questions. The first was do I understand this correctly that in the proposed rule they talked about budget neutrality. But if I am a group and I submit for 90 days, then even if my composite score isn't as good as maybe, you know, others, I'm not going to – I'm not subject to a negative adjustment. I just may – get a neutral adjustment. Is that fair?

Kate Goodrich: Yes, sir, it is. So, the way we've designed the first year of the program is essentially if you submit any information to us that you will avoid a payment penalty. And I would add around the issue of budget neutrality. There are certainly features of the program that are budget neutral, but I think one thing to keep in mind is that there is, of course, the added incentive for participation in Advanced APM, the 5 percent bonus. And there is an additional \$500 million per year for six years that was part of the legislation to reward high performers. So that's above, you know, the budget neutral piece of the program.

(Matthew Smith): Wonderful. And regardless of the APM piece, if there is a large group that is, like I say, a few of them are part of an APM model but the TIN itself are not, what guidance would you give them as far as how to report? Does that make sense?

Kate Goodrich: Yes, I think so. So just to say back to you, you have a group practice and some folks are participating as part of an APM. For those that are not participating in an APM, they would need to participate in the MIPS program. I'll defer to Mai on anything to say about the folks who are participating in the APM.

Hoangmai Pham: Yes. It's just important to remember that there are different kinds of APMs. So there are Advanced APMs and APMs that are not Advanced APMs. And then among the Advanced APMs, there are some of – some APMs that we call – actually in both categories, there are APMs that we call in the rule MIPS

APMs. Those AP – for those APMs, what you are thinking of would apply which is whatever they reported through the model we will use that in order to calculate their MIPS scores if they don't happen to qualify for the APM (inaudible)

(Matthew Smith): Sure.

Hoangmai Pham: But APMs that are not MIPS APMs will have to report regularly through the MIPSs mechanism and they have the same reporting options there as other reporters to MIPS. And we can offer you a lot more detail offline about that.

(Matthew Smith): Yes, that actually – that – I just want to make a clarification, that's perfect. Thank you very much.

Operator: Your next question today comes from the line of Mark Segal of GE Healthcare. Your line is open.

Mark Segal: Yes, thank you very much. I've got two quick questions. One, on the issue of doing 90 days versus a full year, will there be a, you know, benefit of financial incentive to report more than 90 days? So that's my first question because at least the summary information, the website, is a little unclear on that. And then secondly, at what point will the QPP website have the kind of measure specifications that's available now on the EHR incentive website? Thank you.

Kate Goodrich: Hi, Mark. This is Kate. Thanks for the question. So, I think whether or not the bonuses are higher, I think that's what you're asking, for folks who submit more than 90 days compared to folks who submit 90 days, I think that is dependent upon their performance. So it could be that with a greater amount of information. You know, you may have more reliable measurement. And so, in theory, folks who submit more data could get higher bonuses for this first year. But I think that really again depends upon their performance on those measures that's really what's going to determine the range of their bonuses.

Regarding the website, so if you go to the website now and you can actually download a CSV file on the quality measures that you put into your shopping

cart and those do have the specifications there, I think for the ACI measures it's not as detailed as what you currently have on the EHR incentive site.

As Mandy mentioned earlier in the call because of the way that we've developed this site, we are able to sort of rapidly add more information. And so we knew we couldn't get everything we wanted in the first release, but we know that we can rapidly add information, and we envision it over time really becoming a one-stop shop for folks to be able to obtain all of that information including what you've asked for around the ACI measures.

Mark Segal: Kate, could I ask a quick follow-up on that?

Kate Goodrich: Sure.

Mark Segal: So just get on the ACI measures where obviously, you know, we as vendors, you know, working with our customers need to make sure we've got the proper logic in place for measurement, do you envision that the – that at this point the specifications – for those measures that are coming for and, again, recognizing that we're now, you know, focusing in many cases on performance rather than a threshold. With that, the basic logic and specifications detailed last October is still in place unless otherwise, you know, kind of discussed in the final rule? Or, again, will we be likely looking at, you know, significant changes in kind of underlying measure logic? And if so, will we be able to find those changes by at least reading the final rule at this point?

Kate Goodrich: Right, great question. So we did not change the specifications of the measures that were finalized in the Meaningful Use rule last year. They are the same measures. What is changed is the scoring but the specifications are the same.

Mark Segal: Thanks very much. I appreciate it.

Kate Goodrich: Sure.

Operator: Your next question comes from the line of (Tammy Spriggs) of (Hoser Family Corporation). Your line is open.



(Tammy Spriggs): Yes. I work in a chiropractor's office, and we currently do participate with Meaningful Use and PQRS. We are a one chiropractic office. My question is just kind of scrolling down through some of the things on the website. I don't see anything here that would necessarily pertain to our practice. And we have had, you know, problems in the past or had to actually call in, in the past because we don't do prescriptions, we don't do labs or immunizations or anything like that, so there's some things that we just cannot participate or attest to. So my question is how would that affect us as chiropractors? And what we would need to do to participate continue in this?

Kate Goodrich: So thank you for that. And I just want to clarify, are you talking about the Advancing Care Information category in particular?

(Tammy Spriggs): Generally, just – I mean I don't see anything on the Quality Payment Program at all that mentions chiropractors or the specialty for chiropractics. So I'm just kind of wondering yes if ...

Kate Goodrich: Yes.

(Tammy Spriggs): ... that pertains to us. And if so, where that puts us?

Kate Goodrich: Right. So I'll have to double check because we're looking it up now. There are some categories of clinicians who currently participate in the PQRS program that are not eligible to participate to receive any bonuses or penalties in the first year. I believe chiropractors are in that category, but we're doubling checking that right now, is that right?

(Tammy Spriggs): Yes.

Kate Goodrich: OK. However, we do intend to – we say this in the rule and this is based upon the statute that those categories of clinicians like physical therapists, speech therapists, and so forth would be eligible for participation by the third year of the program and that's the way the law was laid out.

And I think – so certainly chiropractors and others who may have been participating in PQRS and want to continue to participate to gain experience are certainly able to do so. But their payment adjustment just wouldn't

change. It wouldn't be scored and changed like it would for folks who are eligible for participation.

And then the final thing I'll say for the Advancing Care Information category, again, there are certain types of clinicians even for the first year of the program who were exempt under Meaningful Use that exemptions did not necessarily carry forward for MIPS. But we have put together a hardship exemption category because we know that a lot of those clinician types such as potentially yourselves may not have measures within Advancing Care Information that are relevant for them, that are available for them. So we have a very simple process for folks to apply for a hardship exception based upon that fact, so that those clinicians who previously were not subject to Meaningful Use would not get penalized for that category under MIPS.

(Tammy Spriggs): OK, thank you.

Operator: Your next question comes from the line of Carol Coates of Montrose Memorial. Your line is open.

Carol Coates: Good morning. Thank you so much for taking my call. Just a follow-up on the hardships, if you are granted a hardship for the ACI category, did you finalize the reweighting to the other domains? I also wondered when will the benchmarks be published for the quality measures and as well – one other question. If you have multiple specialties in a TIN, can you report through a QCDR as well as a qualified registry in the same TIN? Did you finalize that operationalizing of how you report?

Kate Goodrich: Great. Thank for you those. So the first question you had was around hardship. For those who qualified for a hardship exception for ACI, we did finalize that we would re-weight that 25 percent to the quality category. So that's number one. Number two, your question around benchmarks. So the majority of the MIPS measures are measures that were in the PQRS program already. And so we have benchmarks for those. We do anticipate making those benchmarks public before the beginning of the performance period; so before January 1st. I don't have a date for you, but we understand that clinicians want to know that information before they begin reporting.

For measures that are new to the MIPS program that had not been part of the PQRS program, we obviously don't have benchmarks for those yet. So, what we finalized is that the benchmarks will be based upon the 2017 performance period. So those won't be known until some time in early 2018.

And then finally your question around group practice or a TIN that has multiple specialties. Under that scenario, if you wanted to report in multiple ways and this is may be one that we should follow up on the details of because I'm not sure I have been 100 percent right. If you want to report as a single group practice and you just want to report multiple measures some through a QCDR, some through a qualified registry, I believe we do have rules around that. I apologize I don't recall all the details of them but I'm happy to follow up offline with you.

The other option just to say is that if you've got multiple specialties in a group practice, certainly those individuals can report as individuals in that group practice. And each of them can choose their own pathway for reporting whether it'd be through a Registry or EHR, a QCDR, et cetera. But I'm happy to follow up offline on your question around the use of multiple different data submission mechanisms by a group.

Carol Coates: I would love that. Thank you very much.

Kate Goodrich: Certainly.

Operator: Your next question today comes from the line of (Michael Brody) of (Med Express). Your line is open.

(Michael Brody): Thank you very much. I have a question concerning the technical assistance that's going to be available. When Meaningful Use was first launched, the regional extension centers were tasked with providing assistance, and they were focused on primary care providers, and they were only funded to support primary care providers and specialists were left out in the cold. Is the new program going also to provide technical assistance to specialists? Or is it only going to be primary care provider-centric?

Jean Moody-Williams: The programs will be available to specialists, the primary care to any clinician that requires assistance. If you are participating currently, the Transforming Clinical Practice Initiative is still accepting participants, and they certainly work with specialists as well as primary care. They work with clinicians in rural areas, urban areas wherever. And if that is of interest and with that particular program, it's best suited for those who have an interest in progressing, transforming your practice, and moving, at least considering moving toward Alternative Payment Models. That's the best place to go for assistance.

If you are not quite at that point yet and just want to have more assistance and how to successfully participate in the program, and you are in a practice that is greater than 15 the QIO Program can provide assistance. And then the new contracts, when they come out, can provide assistance to those 15 or below with regardless of (inaudible).

(Michael Brody): Thank you.

Operator: Your next question today comes from the line of Carrie Cadwell of Four County Counseling. Your line is open.

Carrie Cadwell: Hi. I actually think my question has been answered in the process of this. I'm calling as a representative for behavioral health where we're kind of half in this and half out meaning that some people will phase in like clinical psychologists and LCSWs. And my concern is similar to what was expressed by the previous caller just that the technical assistance that's provided will be able to support all different kinds of specialist. I feel like the general consensus and behavioral health of the surrounding community mental health centers that I worked with and then also psychologist has been that it's been much more difficult for us to kind of grab a hold of these types of things and to move them forward in a really substantial manner.

So, that was mainly my concern. And what I hear is that they really should be some technical assistance that can address specialty care needs, including behavioral health which I think is a large factor here to consider.

Jean Moody-Williams: Yes, yes. That's correct. And I'll say as well is this is another place where we value your input on what's most helpful for you and for your specialty in the type of assistance we can provide. And we're happy to work with you to make sure that we're providing the services of value.

Kate Goodrich: And the QPP website has information about the types of technical assistance that Jean mentioned.

Operator: Your next question today comes from the line of Melanie Cook of ReportingMD. Your line is open.

Melanie Cook: Hi. I probably could find this in some of the material, but my first question has to do with the CBIA. You said that you have changed that from having a maximum of six activities down to four activities. Does that mean that there's a total of 40 points available for that instead of the 60 points previous? So that's my first question.

And my second question just is a clarification on if a provider is reportable, for example, for ACI but not quality, is that a possibility? Because I thought that if somebody was MIPS ineligible, then they would be not eligible to report on any of the categories under MIPS. But from a previous question and answer, you seem to say something different than that, so if you can clarify that?

Kate Goodrich: OK. Sure. This is Kate. Under the improvement activities category, to start, you are correct that there is now a maximum of 40 points for most clinicians. I do want to point out that for clinicians in solo and small practices, rural practices or in health professional shortage areas as well as non-patient-facing clinicians that there's a maximum of two improvement activities or 20 points.

And I'm sorry. Could you repeat your second question again? I'm not sure I got it right.

Melanie Cook: Sure. I guess – so what I understood on MIPS eligible provider means that they are eligible to report on for all categories. If they were, for example, not reportable, not eligible to be reported on for quality, but could be reported on for ACI, is that still a possibility?

Kate Goodrich: I got you.

Melanie Cook: As you were talking about the chiropractor earlier.

Kate Goodrich: Right.

Melanie Cook: And I just want to make sure that I understood what, you know, MIPS eligible versus MIPS ineligible really meant.

Kate Goodrich: Right. Got you. That's helpful. Thank you for clarifying. So, eligibility for MIPS is really not determined by how many categories are available to you or relevant for your practice. It's determined about by whether or not you bill Medicare Part B and you're exempt if either you're in your first year of participating in the Medicare Part B Program or you fall below – a low volume threshold, which is seeing fewer than 100 Medicare beneficiaries a year or billing less than \$30,000 to Medicare per year, or if you are a qualified participant and an Advanced APM. So everybody else then is eligible for MIPS.

Now, on your question about what if I can only report to ACI and I don't have any quality measures? What we finalized in the rule is that you have to at least to be able to report to two out of the three categories in order to get a score. So, it's certainly possible, although we think this applies to a small number of clinicians, but it could be possible that, as a clinician, you don't have any quality measures available to you and you can only report under ACI and the improvement activities category. In that case, you'd be weighted 50/50 for each category and be scored on those.

If you only have a single category available to you for whatever reason, again, we think this is a pretty small number but could happen certainly, then you would just get no adjustment at all. You wouldn't be scored but you would get essentially neutral so you wouldn't get up or down.

Melanie Cook: OK. That makes sense. Thank you so much.

Susie Butler: Amy, we'll take one more question, please.

Operator: Your last question for today comes from the line of Bethany Burk of AAFP. Your line is open.

Amy Mullins: Hi. This is Amy Mullins from AAFP. And, Kate, you had talked earlier about contracting the proposed rule and the final rule in three categories, except you didn't really touch on quality. And I know you mentioned the six measures for quality, but it didn't mention the three measures that were proposed that were going to be calculated in the background. So, could you comment on that?

Kate Goodrich: Yes. Thank you, Amy, great question. So, we proposed six measures that one measure had to be an outcome measure or other high value measure. And that one measure had to be a cross-cutting measure and that all clinicians would also be scored on two – sorry, three administrated claims measures. One is the hospital widely admission measure, and then two measures around ambulatory care-sensitive condition hospitalization.

And so, what we finalized is still six measures. One must be an outcome or other high value measure. As I mentioned before, we did not finalize the requirement for a cross cutting measure. We also did not finalize calculation of the two ambulatory care sensitive condition measures. We did finalize calculation of the hospital-wide readmission measure that is only for groups of 15 clinicians or more where there is a reliable sample size to calculate. Certainly, if they don't have enough patients to fall into the measure, we wouldn't calculate it for them.

Under the ambulatory care-sensitive condition measures, what we heard in our public comment was that those measures needed more work, particularly around risk adjustment for clinical comorbidities at the very least. So that is work we're doing. And we felt like those were valid comments. And so, we didn't finalize those two measures. Thank you.

Amy Mullins: Thank you.

Susie Butler: Thanks, Kate, and thanks, everyone, for participating today. Just a reminder, that website we've been referencing is [qpp.cms.gov](http://qpp.cms.gov). And also, if you were not able to join the top of the call, there will be a recording available starting

Monday. And just refer back to the invitation you got for this call to see the playback direction. And before we close totally, I want to turn to Jean Moody-Williams one more time to see if you have some additional comments.

Jean Moody-Williams: Yes. Thanks, everybody, for the great questions. And I know some hopefully will be clarified when you have the opportunity to really sit down and go through the regulation. Again, there is an executive summary as well which might be a good place to start, and then begin to the regulations Kate mentioned that there are a number of pages. But that's reflective of the fact that we received so many comments. And we wanted to address those comments. And so that explains a lot the length there. But we will be back in touch with you again to let you know about the training efforts. And in the meantime, we are looking to get real time comment back from you so feel free to reach out to us and we'll be happy to hear from you.

Susie Butler: Thanks, Jean. And one way to reach out, at the bottom of the invite, there was also an e-mail address. That e-mail address is [partnership@cms.hss.gov](mailto:partnership@cms.hss.gov). So, feel free to drop your comments there or I'm sure those folks who were speaking on the call today would love to hear from you.

So, thanks, everyone. We'll be in touch soon. Appreciate you making time for us this morning. Take care.

Operator: Thank you for participating in today's Quality Payment Program National Stakeholder Conference Call. This call will be available for replay beginning at 9 o'clock a.m. Eastern Time, Monday, October 17th, 2016 through midnight on October 19th, 2016. The Conference I.D. number for the replay is 98742975. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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