

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Moderator: Jill Darling**  
**November 9, 2016**  
**2:00 p.m. ET**

Operator: Good afternoon, my name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Physicians, Nurses, and Allied Health Open Door Forum.

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 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Ms. Jill Darling, you may now begin your conference.

Jill Darling: Thank you, (Amy). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communication. Thank you for joining us today. We've got one good agenda topic today. So, before we begin just one quick announcement. This is Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at [press@cms.hss.gov](mailto:press@cms.hss.gov). And I'll hand it off to Dr. Rogers.

(Dr. Rogers): Thanks, Jill. It should be an interesting Open Door Forum as we discuss the rule and we'll probably get some very good questions. We got a lot to talk about so I'll pass it on, thanks.

Jill Darling: And we have Jean Moody-Williams who will go through the overview of the Quality Payment Program.

Jean Moody-Williams: Hello everyone and thank you for joining in on the call today. As mentioned, I'm Jean Moody-Williams. I am the Deputy Center Director for the Center for Clinical Standards and Quality. And we have responsibility for much of the implementation of the Quality Payment Program and have been working over the past many months to develop the rule both at the proposal rule stage and now at the final rule stage. And many of you know that we went about this in a very different manner than we perhaps sometimes do although we always seek input and use that input as we're developing our rules and as we evolve them.

We took an approach where even before we started writing anything. We conducted hundreds of listening sessions and heard from thousands of folks around the country. I think we had even 6,000 sessions or heard from 6,000 people before we started writing the rule. We got about 4,000 comments in on the proposed rule and then we finalize.

But one thing I wanted to mention is that what we finalized was – as final rule with comment that we are still accepting comments on the rule through December 19th of this year, 2016. And in particular, we'll use the comments that we received to inform our educational materials, the development of our website, and as well, any future rule-making because before you know it, it'll be the time to begin to think about the second year of the Quality Payment Program. So, those comments that we received from you, we will use them to continually involve the program.

So, I'm going to just give you some highlights of the rule. And before I do that, just to make you aware that everything that I'm going to mention today can be found on our website which is [qpp.cms.gov](http://qpp.cms.gov). Again, [qpp.cms.gov](http://qpp.cms.gov). And if you haven't had the opportunity to visit this site, I encourage you to do so. There are a lot of information there about the program on all the (tabs). But if you go to the education and tool section, you'll also find information about other webinars that we are going to – that we have been or will present which will give you much more detailed information that I'm going to into today. And also, those webinars we have all our policy experts in attendance so that they will be able to answer your more detailed questions than I might also be able to do today.

But for example, the Quality Payment final rule Medicare Learning Network call is going to be on November 15 and you can register through there. And then all of our past presentations and slides that we used for those presentations are located there as well as I look at – look through there.

So, just reminder about the Quality Payment Program and how it really came about is that many of you will remember that it really came about through bipartisan legislation known as the Medicare Access and CHIP Reauthorization Act of 2015 also known as MACRA. But through the development of our rule-making and talking to clinicians and patients, we have coined the program as the Quality Payment Program to really reflect what the intent is as we implemented it.

But it did replace the flawed sustainable growth rate process which – as you're aware each year had to be fixed to avoid a payment cut. And as a matter of fact, in 2015 could have resulted in the 21 percent payment cut. And so, rather than going through – continue to go through each year trying to fix that, Congress implemented MACRA.

And as a result it's been combined at least three programs, the Physician Quality Reporting System, PQRS, the Value Modifier and the Electronic Health Records Incentive Program into one program known as the Merit-based Incentive Program or MIPS.

And in addition, use this opportunity to promote delivery system reform or alternative payment models to move it. So paying primarily based on billing codes and fees that may or may not really reflect the kind of care that clinicians want to be able to provide to their patient.

So these are kind of payment models provide a way to really look at providing care in a different manner, more coordinated care and paying for that care in the same manner of the coordination.

So this program will impact about 600,000 clinicians across the country. And the effective date is January 1st of 2017 and so we know that that is rapidly approaching. But the one thing I want to really emphasize on this call and you

probably seen this in many places is the "pick your own pace" portion of the rule, which means that – the program will start January 1st on 2016. However, you can choose to participate in a number of ways.

And so as you long as you submit something one quality measure at least or one performance improvement activity or the basic requirements of the Advancing Care Information category which include five components, you can avoid a negative payment adjustment in the first year of the program. And that is extremely important because we really are expecting that very few clinicians will receive a negative payment adjustment in the first year of the program. We're calling this kind of the test year where people can start to participate in one way or another to be successful.

So if at least you test the program and you submit one of those items, quality measure or advancing – and improvement activity or something under the Advancing Care Information, also formally known as – under the Meaningful Use activities, then you would be able to avoid the negative payment adjustment.

And when we look at who's actually participating in the program it would be Medicare Part B clinicians that bill more than \$30,000 a year and provide care for more than 100 Medicare patients are here. So either those things apply to determine if you would be eligible to participate.

But the clinicians that are included in the first year include the physicians which we use the Medicare definition of that which would often include chiropractors and podiatrist, physician assistants, nurse practitioners, clinical nurse specialist and certified registered nurse anesthetist if they meet those thresholds.

We have also excluded however if this is your first year participating in the Medicare program, then you will be excluded and you can prepare for the next year participation. Or if you are participating in an Advanced Alternative Payment Model, then you can also be excluded from MIPS.

And so when I start for questions, if there's any questions about who should be participating and now I'm happy address those.

Now just a little bit more about to participate. So, I already talked about and encouraged everyone to at least try to test the system. We really are expecting that there would be very few people, clinicians that get a negative payment adjustment.

However – and so that is fully available to you. However, we are encouraging that you do more than test the system particularly if you've been participating in PQRS or Meaningful Use or Value Modifier to this point, it really – would be – both you and us to be able to do a shared test other system if you participate it more fully.

So that could mean a partial year participation in which you report for any consecutive 90 days and that would be reporting after January 1st of 2017 up to about October of 2017 so then you still have 90 days remaining the rest of that year. And then you have up until March of 2018 to submit your data for consideration, so you got till March of 2018 to submit and you can submit for any 90-day – consecutive 90 days period.

Now there will be about to choose participate for the entire year. And I know those that are in registries for example that may have outcome measures that require look back period or some other outcome measures that require more time to collect sufficient numerator data to make a difference on the measure, so that if anyone chooses to start participating as of January 1st, 2017, that's perfectly fine and we encourage that. And then you would still submit your data when required in March of 2018.

Now, we've got several questions about, well, how does it impact my payment depending when I choose to participate?

So I think pretty well explained if you submit just one thing, you will avoid a payment adjustment. You would be considered probably neutral or that could be a small payment adjustment.

If you submit for 90 days or a year, and even those case is you really could get modest payment adjustment. You would be fully participating. But it would just depend on how you score. If you have enough information and your numerator/denominator to be scored, then that would determine what percentage increase you would get.

And the way that it works at least if you get three points and if you submit anything you will get three points. And you would qualify perhaps the neutral or positive. Anything – if you submit enough information to get up to 70 or more points, and then you would get potentially a positive payment adjustment.

And the way this works because I know there's a little bit confusion about what is the budget neutral program, so how you doing that? And it's true there's a component of this budget neutral. But then remember there's a 500 million that's available through the MIPS program that we can distribute and that's for the first year and then the next four years there after, or if you're in Alternative Payment Model there's a 5 percent bonus that you can get from that.

So there's really total of about a billion dollars in the first year of the program that can be taken into consideration as we look at our incentive. So, we do encourage people to choose to participate. We have heard those that say, well, I'll just take the hit. I won't bother. But with the minimum requirements and the opportunity to get an adjustment, a positive adjustment, we really think that we encourage those that can to participate.

And so, I've gone through kind of the scoring. But I did want to just mention the areas that will be included in the Merit-based Incentive Program if you are submitting data. And the first one of course is the quality measures. And under the quality performance category this replaced the Physician Quality Reporting System; that will 60 percent of the final score.

So, if you select six measures they'd be worth 10 points each. There are about 300 quality measures that you can select from. You would submit those for your – at least 90-day period or year how you're choosing to report that and

those would be determined and it is – we also noting that one of those six measures should be an outcome measure or a high priority measure.

And those are – if you go to the QPP website, there's a tool there that can help you select basically, you know, specialty or areas of interest. We had – we also have specialty specific, measure sets available. The readmission measure will be calculated for you. You don't have to calculate that and that will be group to a clinicians greater, you know, 15 or greater clinicians and its sufficient number of cases to do that.

Now, one thing to point out those used in the CMS web interface would have to submit for the entire year. That is required for those measures. Under the Advancing Care Information does replace the Medicare EHR Incentive Program. There is much more flexibility. And what you've choose to report there and what's the ultimate goal is over the course of the next year is not to – is to really look at how you use the EHR to support care in you office.

And so that it's really the use of the EHR that we're working toward to – versus as we heard when we're travelling around a check-the-box approach that was not done to be very valuable.

And so, as we look there, there are five basic requirements that if you can meet those, that will satisfied the pick your own pace requirement, but then there are additional measures that are there that you can select that could increase your score in the area of Advance Care Information.

The other category being the improvement activities. And really this came about – this is new. It wasn't among our other programs, but it came about as clinicians noted that they were doing a number of activities to improve the quality of care or the efficiency of their practice or the flow of their practice that may not be captured in the quality measure or an EHR measure and that they ought to be some way to recognize that and that's what this category is about.

So there are over 90 plus activities under the sub-category that you can select from and they are kind of weighted as medium or high. So the high where

you get 20 points each for those and the medium you would get 10 points. So you could select for medium. You select two high. You could select a high and two mediums and get to the 40 points.

Now, we also heard as we were doing our proposed rule that there needed to be consideration for small practices. Small practices, those in rural areas or those that underserved populations that may not have the resources or the ability to participate in the number of improvement activities.

And so for clinicians that are small in rural practice, we have made the allowance that if you can participate in two of the improvement activities you would get their full points or you can select one and still avoid a payment adjustment. So there's a great deal of flexibility there.

So I will take questions on those categories. One thing I want to mention, of course, is the cost category also was coined to resource use. There are no reporting requirements for a final score in 2017 and there is no weight assign to the cost category.

However, we will be providing performance feedback reports to you so that you could began to gauge your performance in preparation for year two of the program at which time there will be a way assign to this category.

So, again, you don't need to submit data. You will get data and what we encourage you to do is to use that to analyze the cost and areas of potential improvement in your practice.

Now, we are seeking formal comments that I mentioned (those) things. I know we got a lot of questions about virtual group and while they were not implemented and this year's rule, as I said, we already starting to plan for subsequent years so we really encourage your comments on how we might go with that implementing virtual group.

Another area where we got comment was the term non-patient facing. There were those who got that this really – was not descriptive with the work that they did. So, any alternative terminology we are looking for. On the no volume threshold because we receive comments that said really, you know,

threshold is too low, but you have included clinicians that are not ready to participate. And so we increase the threshold to the 30,000 or 100 patients.

When we did that, we did likely exclude some who wanted to participate and we recognize that. So, you know, you had to kind of look at the trade-off there and that we had no ability to allow kind of to opt in voluntarily participate, but we are looking for comments on that to see if there are those that feel we should be pursuing maybe other areas to see if we can allow this opt in approach. And there are other areas that we are asking for comments as we go forth.

Now, I'm going to spend just a few minutes on alternate payment models to note that an alternative payment model was design in the statute and there are number of models that are come – that come from the CMS Innovation Center Models, then there's a Medicare Shared Savings Program, some aspects of that which we'll talk about and some other demonstrations that can be included as an alternative payment model.

So – Alternative payment model was an approach that's developed partnership with the clinician community that really provides added incentives to clinicians that are moving away from kind of strictly fee-for-service basic care and can apply to specific term or conditions episode to care bundles or population, integrative population-based programs. And it can – and there are several out there, but not APMs or Advance APMs.

And so in order to be the Advance APM, the statute did give parameters that we must follow. And one is that the APM must require participants to use certified EHR technology. It must provide for quality measures that at least the astringent as those that were using in MIPS. And then it must be a medical home model expanded by the CMS Innovation Authority or required the participants to their some type of nominal risk.

And so I think the first two are fairly self-explanatory. So, we won't spend a lot of time on that, the EHR, the measures that are at least do the measures that are required by the APM in which should be at least as comparable to

MIPS and those that we have already determine to be Advanced APMs meet those criteria.

And so the other – then the third would be the risk category and it would be those medical home models that have been expanded which we have not expanded any of the models to date, which would mean that it was a normal part of our Medicare program, so that would not a fact.

But there are models that meet the nominal risk which in the rule we define as – and let me just say risk, which I think we know. But just to clarify, when we're looking at financial risk, we're looking at actual expenditures exceed the expected expenditures and then you have to do maybe one of three things, pay back the difference in some portion or your payment maybe reduce or payment maybe withheld. So there are some risks to the clinician's office.

And then we further define what that would look like. So, 8 percent of the average estimated total Medicare Part A and B revenue, or 3 percent of kind of the total cost of care or expected expenditures.

Now, rather than have you figure out which of the models meet those qualifications, we simply published which one is dead. And so, you're probably seeing the rule that the comprehensive end stage renal disease to side of risk arrangement meets that, the Comprehensive Primary Care Plus or CPC Plus, Shared Savings Program Track 2, Shared Savings Programs Track 3, the Next Gen ACO Model and oncology model, the one with two-sided risk. Those meet the Advance APM requirement.

Now, we also heard that clinicians wanted more. They wanted additional opportunities for APM. And so, there is a Physician-Focused Payment Technical Advisory Committee that is meeting to look to see what additional models they maybe able to recommend to the secretary.

Additionally, we did announce that we anticipate models for the Comprehensive Care for Joint Replacement will be moving into a particular model advancing care through Episode Payment Track 1 model, some new voluntary bundled payment models. Vermont actually initiated in all payer

ACO model, Maryland has one and then we're looking at ACO Track 1 plus model that would qualify.

So, those are – that those are ways that if you are in those programs, then you would be exempt from MIPS and you would get the – whatever the incentive is available through your advance Alternative Payment Model, plus a 5 percent bonus that would also be available.

And what – our intent is to make sure that you know what – where you fall so that by the time that March 18th rose around in 2018, you will know whether the APM that you're in qualifies or that you as a participant qualify.

We're going to snapshots. We're going to look at March 21st, 2017 and see if you've met some of the thresholds, which involve patient, patient amounts or dollar amounts. If you've met that threshold, you'd be notified that you're an advance – you are qualified professional in Advanced APM. You do not have to report to MIPS. We'll do it again in June 30 to see who we get then. In case you hadn't met in March 31st then we'll do it again August 31st in case you had met it in the prior two times. If we tells you in the prior two times that you've met it, then you've met, but we'll continue to look through August 31st.

So you will know by the time that March was around, whether you have to participate and report to MIPS or not and there will be some considerations if you're in, in Alternative Payment Model. If it's not consider an Advance Alternative Payment Model, you will not likely have to report additional quality measures at that time we will take the measures that's in your APM.

So, I think I'll stop there. And one other thing to mention, though, there is support available. I did mention the Quality Payment Program website, [qpp.cms.gov](http://qpp.cms.gov). That is a very important site. As a matter of fact, we've on the phone with the clinician on just this past Friday and one other things that we need to do and hopefully those of you on the phone could help us do if continually get the word out.

This clinician did not had – he knew that there was a change coming, but had no idea what the change was and couldn't find the information that he was looking for and have become very frustrated. And we were able to sit down with him taken to the site. And once he got to the side he said, "This is exactly what I was looking for." He didn't have time to spend a lot of time on the phone with us, he said, you know, "I can look at this in my leisure. I'll call back if they have questions." So that's the first thing, just getting that information out.

But the second thing is once you've been to the site and you still have questions, I encourage you to call the number that's there or send an e-mail to the e-mail address that's there and we have subject matter experts that can get back to you with you particular questions.

As a matter of fact, after this call today, if you have very specific questions, please send them to that box. I may not be able to answer your very specific questions, but if you send it to that box you will get a response.

And then on top of that, we have more intense technical assistance available to the Transforming Clinical Practice Initiative and they are still accepting practices that want to join them. There is no cost to join them. And the only thing required is the commitment to want to move toward advanced payment models at some points in the future. There are goals that each of the clinicians working through this Transforming Clinical Practice Initiative have agreed to. They get technical assistance on how to reach those goals. They get data. They get the benefit of hearing from other clinicians and best practices that are going on, that are moving their practices along and when things aren't going quite the way you expect, it gets benefit of coaching and to help move it or to get stuck somewhere to help you get on unstuck. So there are lots of benefits to being in that Transforming Clinical Practice Initiative.

If you're not quite ready to think about moving toward an APM that might not be the route for you, but the Quality Improvement Organization have been trained and giving data and information that would be able to help you as well. So, there are a number of opportunities.

And very shortly, probably, you know, our first of year or so, we will also have contractors that were provided by law to be able to help small underserved and rural clinicians of 15 or less and they will get dedicated technical assistance particularly for those practices that are small underserved or rural areas. And so, you'll be given more information about that.

So let me stop to see if there are any question that I maybe able to answer or if not, I'll direct you to that site that I mentioned so that you can get your specific questions to answer.

Jill Darling: Thank you, Jean. (Amy), please open the lines for a Q&A, please.

Operator: As a reminder, ladies and gentlemen if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow up to allow other participants time to questions. If you require any further follow up, you may again press star one to rejoin the quo.

Your first question today comes from the line of (Susan Huckman) of (A.S. Smith). Your line is open.

Jean Moody-Williams: Hello? (Susan)?

(Susan Huckman):Hi. I'm sorry. I understand that providers can report et cetera, et cetera, but where can we go to actually look at the measures, see the codes associated with the measures so that we can start to add them to our computer systems, start reading them and understanding which ones are going to best for our practices, can you go into a little bit of that detail?

Jean Moody-Williams: Sure. And I don't know have you had the opportunity to visit the measure tool?

(Susan Huckman): No.

Jean Moody-Williams: OK, great. Well, not great. So let me – I think you going to like that tool. So if you to the QPP website and – m pulling it up myself so I can

direct you to the spot. One second, so all right. So if you're at the qpp.cms.gov website and you will see something that says explore measures. And if you click on that, it will – and you read through it is going to take you to a tool and that will allow you to explore the quality measures. And it's a kind of a shopping cart function in many ways where you can put in the measures that you're interested in or this specialty, it will then allow you to select measures that maybe appropriate for your practice. And then once you do that and you can look at as many as you like, it will allow you to also download the specification and the codes for those measures.

So you – let's say you moved six of them over there, then you'll see something that says download CSV and with that it will give you that information.

(Susan Huckman):OK. So I have spend a little bit a time. I actually did look at this website and I never saw the actual like codes. So maybe I just need to spend some more time on that website.

Jean Moody-Williams: Yes, once you select some measures and you'll see download CSV, it should give you the information.

(Susan Huckman):OK. All right, thank you.

Operator: Your next question today comes from the line of Terry Garfinkle of Partners HealthCare, your line is open.

Terry Garfinkle: Thank you. I wonder if you could tell me if there is an advantage to reporting under MIPS for more than 90 days, specifically a full year reporting in all of the domains.

Jean Moody-Williams: So great question. We've got that a couples times. And, you know, it – is really going to depend. You could report for 90 days depending on the measures that you select and get and reach a fairly high performance score and get the positive payment adjustment.

It depends again on the measures that you select because if you're selecting an outcome measure that required six month worth of data and you've only

submit 90 then you probably not going to be to get that measure scored. And so, you've missed the advantage of being to get credit for that measure.

So, the likelihood of getting the full credit is when you report for the full year, because then you know you've done what you could. We also going to look at minimum cases submitted et cetera. But that does not necessary mean if you only submit for 90 days that you couldn't do well as well.

Terry Garfinkle: Is there any requirements to qualify for part of the \$500 million bonus? Do you have to report the full year or will even 90 day reporters who are – who have good scores, would they qualify?

Jean Moody-Williams: Well, it will depend if you meet the 70-point threshold because that's when you start to the – into the – on this poll. And there are some measures that might allow you to get there, to get the full 70 points.

So you could do it, the answer is yes, it could happened. But it's just going to depend on how you score compared to others and the measures that you selected.

Terry Garfinkle: Great. Thank you very much.

Operator: Your next questions today comes from the line of Kay Moyer. Your line is open.

Kay Moyer: Hi, thank you. This is Kay Moyer with the Infectious Diseases Society of America. It seems that the CPIAs are kind of wide open, so how will we know if something we do is a CPIA? For example is (following) your efforts for Bio preparedness, such as the preparer for an Ebola outbreak, would that count as an emergency response and preparedness CPIA?

Jean Moody-Williams: So, yes. We agree that there's not a lot of specificity around the CPIA activities. This is being the first year that we have implemented. We don't have specification manual that can go into. Well, this activity qualifies if one doesn't. I would say that if indeed that activity is serving the bulk of your patient is adding a public service emergency then it would likely qualify. And we – you would just attached to that that you – you're testing that you did

this activity and to the best of your knowledge this activity does what I just said.

Now, if there are questions about a specific activity we're happy to look at those as well. But what we believe will happen is over the course of that year we will start to read out those that really aren't improvement activities and add more specificity to those that are.

Kay Moyer: OK. Thank you very much.

Operator: And the last question in the queue right now comes from the line of (Christina Blanco) at Baptist Health. Your line is open.

(Christina Blanco): Hi. Thank you so much for taking my call. I had a question with respect to the 90-day period reporting. We intend to do multiple measures but my question is does – do they only to be from the same 90 days? For example, let's say I'm reviewing my data prior to submission and I see that one metric does very well first the beginning of the calendar year but, you know, another one does in the middle and another one is towards the end, can I pick and choose my data ranges or isn't just one solid data range for the metrics that will be submitted?

Jean Moody-Williams: So for the category. So for quality measurement it would be 90 consecutive days to be considered 90 days for all of those measures. You could still do some, you know, pick one here or there but then that's going to be look at as more of the one measure submission. So it is for that category, 90 consecutive days for all of the measures you're submitting.

However, I will say that you could have different 90 consecutive days for – if you wanted to pick one 90 consecutive days for your quality measures and another 90 consecutive days for your improvement activities and another for your ACI, you could do that. But once you selected your 90 days and we'd look for all the data for that period.

(Christina Blanco): Thank you so much.

Operator: And there are no further questions on the telephone line. So I turn the call back over to Ms. Darling.

Jill Darling: Thank you, (Amy). Dr. (Rogers), do you have any closing remarks today? Or he may have dropped off. But thank you Jean for your overview for the Quality Payment Program and we have some great questions.

So thank you everyone for joining today's call. And note that we will be having another Physicians Open Door Forum next week, November 15th. That will be specifically on the Physician Fee Schedule.

So thanks everyone. Have a great day.

Operator: Thank you for participating in today's Physician Nurses & Allied Health Open Door Forum Conference Call. This call will be available for replay beginning at 5 p.m. Eastern time today, November 9th 2016, during midnight on November 11th. The conference I.D. number for the replay is 4446-3964. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may not disconnect.

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