# The Quality Payment Program – Webinar Transcript

**January 5, 2017**

Laurie Fink: My name is Laurie Fink and I am the Quality Insights communication specialist for the MACRA/MIPS initiative, which is focused on helping practices successfully transition to the new payment systems and models. We will get started with today's program in just a moment, but first a few housekeeping items.

All participants enter today's webinar in a listen only mode. Should you have a question during today's presentation, we ask that you please type it into either the chat or the Q&A box to the right of your screen. We will answer as many questions as we can at the end of today's program.

The webinar is being recorded, and the recording will be posted on the quality intakes website along with a copy of the slide deck, most likely by tomorrow morning. You should have already received a copy of the slides via email, but if for some reason you did not or if you were a late register, I will make sure and send everyone a link to where the resources are posted as soon as they are available.

It is now my pleasure to introduce you to our first speaker, Annese St. Louis. Annese has been a health insurance specialist with the Centers of Medicare and Medicaid Services since 2009. She started her career at CMS Central Office working in Medicaid and then went on to work in CCSQ, where she was the lead for the healthcare associated infection portion of the 10th and 11th scopes of work.

She currently provides outreach and education related to MACRA and the quality payment program in Region 3. Prior to coming to CMS she worked at various major private health insurance companies providing nursing case management and utilization review.

Annese is a registered nurse with over 24 years of clinical experience and still provides direct nursing care at an area hospital. She graduated from the University of Maryland at Baltimore, where she was inducted into the Nursing Honor Society, Sigma Theta Tau.

Without further adieu, I will now hand over the presentation to Annese.

Annese St.Louis: Thank you, Laurie.

Good afternoon, everyone. Thank you for joining our presentation today on the quality payment program. Before we get started, I wanted to let you know that my colleague, Patrick Hamilton, is also on the call and will help with questions during the Q&A session. Now let's get started.

In October 2016 the MACRA legislation was finalized. This legislation repealed the sustainable growth rate and helps clinicians focus on care quality and making patients healthier. Out of this legislation the quality payment program or the QPP was born. The QPP is part of a broader push towards value and quality. Clinicians can choose how they want to participate in the QPP based upon their practice by specialty, location or patient population. The two tracks that clinicians may choose are MIPS, the Merit Based Incentive Payment System, or Advanced Alternative Payment Models.

As I just stated, under the QPP there are two tracks for clinicians, MIPS and advanced APMs. What specifically does MIPS do? MIPS combines the Three Legacy Program, which many of you have been participating in to date, into a single improved reporting program. The programs include PQRS, which is the Physician Quality Reporting System, the Value Modifier Program and Medicare EHR Incentive Program. The last period for these three separate reporting programs was January the 1st of 2016 through December 31st of 2016. The PQR past payment adjustments will end in 2018.

What is MIPS? There are four performance categories under MIPS, and these categories are quality, cost, improvement activities and advancing care information. As noted on the slide, these four categories move the Medicare Part B clinicians to a performance-based payment system and allows clinicians flexibility to choose the activities and measures that apply most to their practice, and it aligns reporting standards with advanced APMs as much as possible.

When does the MIPS payment piece officially begin? The first performance period for MIPS will be January the 1st, 2017 through December 31st, 2017. Remember that during the first performance period, eligible clinicians have the pick-your-pace option to determine their level of participation. The first payment year for MIPS where eligible clinicians will have their payments adjusted will be in 2019, and it will be based on the first performance period of 2017. This keeps in line with CMS's traditional two-year look-back period.

Who is eligible for MIPS? For the first two years those that are eligible for participating in MIPS are physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who bill under Medicare Part B. Please keep in mind that these Medicare Part B clinicians must bill more than $30,000 a year and provide care for more than 100 Medicare patients a year.

For the third and future years under MIPS, CMS can expand those that are eligible to include occupational therapists, physical therapists, clinical social workers, dietitians, et cetera. Those clinicians that are not currently eligible to participate in MIPS for the first two years do have the ability to volunteer to report. One of the reasons why clinicians may want to choose to volunteer to report is that you are currently participating in PQRS and you want to gain some experience under MIPS before you are required to do so.

Who is excluded from MIPS? Clinicians newly enrolled in Medicare. Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year. Clinicians who have a low-volume threshold. Basically that means that you charge less than or are equal to $30,000 a year or see 100 or fewer Medicare Part B patients a year. Another set of clinicians who are excluded from MIPS are those participating in advance APM.

This slide just lists an eligibility scenario. Basically, if you look at the bottom, it says that if a clinician bills for 29,000 in one year and saw 101 Medicare patients, that clinician would be exempt from the program because both eligibility requirements were not met. Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, aren't newly enrolled and are not a qualifying APM participant or partial QP that elects not to report to MIPS. The threshold for individual MIPS-eligible clinicians regarding non-patient facing is more than or equal to 100 patient-facing encounters in a designated period.

After hearing input from many clinicians, CMS allows for 2017 to be called a transition year for the QPP, where clinicians can pick their pace regarding their QPP participation. In order to make the best decisions for yourself or your group, clinicians should assess their readiness and decide how and when they'll participate. They can choose to participate in 2017 as a test year, a partial participation, or they can choose full participation, and they can also choose to participate in an advanced APM.

Let's talk a little bit more about each option. For those clinicians who choose to use 2017 as a test year, this allows them to experiment with the program and prepares them for broader reporting in 2018 and 2019. Clinicians must submit some data after January 1st, 2017. Now, what does "some data" mean? It means that clinicians must submit one quality measure or one improvement activity or five advancing care information measures. This option makes clinicians eligible for a neutral or a small payment adjustment.

For the partial participation, clinicians can choose to report to MIPS for a period of time of less than the full-year performance period but for a full 90-day period at a minimum. Please note that the last day that you can start reporting for this option is October the 2nd, 2017. The data that clinicians who choose this option must report are more than one quality measure, more than one improvement activity or more than the five required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

For full participation, clinicians should report to MIPS for a full 90-day period or ideally the full year and maximize the MIPS-eligible clinician chances to qualify for a positive adjustment. In addition, MIPS-eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the

first six years of the program. Full participation in MIPS means that clinicians should at least meet these following criteria, report six quality measures, report four medium-weighted or two high-weighted improvement activities and report five advancing care information measures.

There isn't any set difference in bonus amounts between 90 days and the full year. However, for quality measures in particular it can be pretty difficult to meet the outcome measure requirement with only 90 days, and the same is true for other high-priority measures. We anticipate that clinicians who report for a year will have higher scores due to more reliable data and the ability to get bonus points for these types of measures, but if you report only 90 days and are a high performer, you can also get higher positive incentives. There's nothing built into the scoring methodology that automatically gets you lower scores or fewer points for 90 days. It's just likely to pan out that way for some clinicians.

Eligible clinicians have two options for participating in MIPS. They can participate individually, which means that the clinician reports under a unique tax identification, or TIN, a national provider identifier number, or they can report as a group, meaning that two or more clinicians with a unique NPI have reassigned their billing rights over to a single TIN. It's important to note that if clinicians participate as a group, they will be assessed as a group across all four MIPS performance categories.

What are the MIPS performance categories? Again, they're quality, cost, improvement activity and advancing care information. The specific category weights assigned to each of these four categories as defined by the MACRA legislation equal up to 100. Each MIPS-eligible commission's final score will be based off of a zero to 100 point scale. For the first year, aka, the transition year, quality will account for 60% of the composite performance score, or 60 points. Cost will account for zero percent to allow clinicians to gain some familiarity with the MIPS program. Improvement activities will count for 15% or 15 points, and advancing care information will count for 25% or 25 points.

Let's take a closer look into the performance categories. The first category we'll talk about is quality. This replaces the PQR as the quality portion of the value modifier. Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks. The quality performance category, worth 60 points, was created to add clinician flexibility to focus on the measures that are truly important to beneficiaries. Each eligible clinician will select six measures, which is a current decrease from what is required under PQRS. Additionally, under PQRS, clinicians are required to report on nine measures that cover three national quality strategy domains.

Under MIPS there is no requirement that clinicians would have to choose measures that cover a certain number of domains. Rather, they are encouraged to choose measures that span as many domains as possible. Out of the six measures, one must be an outcome measure. If an outcome measure is not available, clinicians would need to select from another high-priority measure.

A high-priority measure is defined as an outcome measure, appropriate use measure, patient experience, patient safety, efficiency measure or care coordination measure. Clinicians can either select from the approximately 300 measures that will be available or select a specialty set of measures that CMS created together with multiple specialty societies. There are three additional population health measures that are automatically calculated for all clinicians.

Next category is cost. The cost performance category is worth zero percent of the clinician's final score for the first performance year. Clinicians will be assessed based upon administrative Medicare claims data, including specific episode measures for Medicare patients only and only for patients that are attributed to them. Therefore, there is no reporting requirement necessary for clinicians.

Improvement activities. This category will be new to most clinicians. It's worth 15% of the clinician's final score and assesses how much a clinician participates in activities that improve clinical practice. Examples include how well a clinician shares in decision-making with their patient, improves patient safety, coordinates care and increases access for patients. The improvement activity category also includes incentives that help drive participation and certify patient center medical homes and are alternative payment models.

Clinicians will have the flexibility to choose from about 90 activities under nine subcategories, which are expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an APM, achieving health equity, integrating behavioral and mental health and emergency preparedness and response.

Since this category is pretty new, we do expect to get a lot of questions about this particular category, but it does require that no clinician or group has to report more than four activities. Additionally, there are special considerations for practices with 15 or less clinicians, rural or geographic health professional shortage areas, non-patient facing APMs and certified medical homes.

The improvement activities performance category score is comprised of a selection of activities that were deemed either medium-weighted or high-weighted. Activities with a medium weight are worth 10 points each. Activities with a high weight are worth 20 points each. The maximum allowable number of points that clinicians may earn in this category is 40 points.

There is one very important distinction to note within the category for clinicians who are in the small practices, the rural practices, practices in the health professional shortage area and non-patient-facing roles. The number of point assigned to each weighting are different for these clinicians, so the medium-weight activities for them are worth 20 points, or the high-weight activities are worth 40 points. Clinicians who practice in a patient-centered medical home, medical home model or similar specialty practice automatically receive full credit for this category.

Advancing care information. Clinicians are more familiar with the components of this advancing care information category because it's similar to the EHR incentive program. For example, the measures found within the advancing care information category are based upon the measures adopted by the EHR incentive programs for Stage 3 in 2015. This category is not exclusive to physicians. It applies to all eligible clinicians participating in the MIPS program either as an individual or a group. Additionally, advancing care information eliminates the all-or-nothing reporting criteria that was found under the EHR incentive program and replaces it with a greater degree of flexibility for clinicians to choose the measures that fit their practice and patient.

Clinicians need to understand that in order for them to report any of the measures under the advancing care information category they must use certified EHR technologies. Depending on the edition that you use, there will be different objectives from which the clinicians can choose to report. You can use the 2014 certified EHR technology or the 2015 edition.

The next two slides, I'm just going to click through. They actually list some objectives and measures for your convenience.

Okay. This slide talks about the percentage for the advancing care information. If you notice in the second little box there, the hospital-based MIPS-eligible clinicians can choose to report under the advancing care information performance category, and also for those clinicians who face a significant hardship and are unable to report under this measure, they can apply to have their performance category score weighted to zero, and it will be put into, re-weighted to different areas.

Calculating the final score under MIPS. When you calculate the final score, CMS will multiply the score for each performance category by the assigned weight of the category, then adds the weighted scores to derive a value between zero and 100%. I just want to note that we are not getting into the weeds of the scoring in this presentation. However, further presentations we definitely can go into depth about the scoring if that is requested, and we are sure that it will be. In this presentation we're not going to do that. I just want to give you an example of the equation's logic.

The final score equals clinician quality performance category score times the actual quality performance category weight plus clinician cost performance category score times actual cost performance category weight plus the clinician improvement activities performance category score times the actual improvement activity performance category weight and clinician advancing care information performance category score times the actual advancing care information performance category weight times 100.

This next slide gives a good breakdown of the final scoring and corresponding payment adjustment. As you see, if you get more or equal to 70 points, you'll be eligible for a positive adjustment and eligible for an exceptional performance

bonus, which is a minimum of an additional 0.5%. For 4 to 69% you can be eligible for a positive adjustment but not for the exceptional performance bonus adjustment. Three points, you get a neutral payment adjustment, and for zero points that means that you do not participate at all; you send in no data, you do nothing, you will automatically get the 4% negative payment adjustment.

Lastly, I want to talk a little bit about additional adjustment factors for MIPS. In addition to the standard payment adjustment percentages there's a scaling factor that may be applied to positive adjustments only. Since the MACRA statute requires MIPS to be budget neutral, a maximum scaling factor of three was introduced to ensure compliance. This means that clinicians in the program who have performed well and receive a positive payment adjustment will be eligible to have their maximum payment adjustment percentage increased.

For example, in 2019 if a clinician receives a positive 4% payment adjustment, he or she could also receive up to a 12% adjustment based off the up-scaling factor of three. Aside from the budget neutral scaling factor there's an exceptional performer category with the incentive funding of 500 million annually. Clinicians who meet or exceed the established performance threshold for the year will be eligible to receive an additional adjustment factor of up to 10%.

Final scores of 70 or more qualify for additional payment. Additional payments start at 0.5% and increase with the final score. All together, in 2019 a high performing eligible clinician could receive a positive 4% payment adjustment with the three-point up-scaling factor for a total positive payment adjustment of 12%. That same clinician could also receive an exceptional performance bonus of an additional 10%.

This ends this section for me, and I'm going to turn it back over to Laurie.

Laurie Fink: Thanks so much, Annese.

I would now like to introduce our next speaker, which is Dr. Barbara J. Connors. Dr. Connors served as the Chief Medical Officer at the Centers for Medicare and Medicaid Services Region 3 and has served as the Acting Associate Regional Administrator for the Division of Survey and Certification in CMS Northeast Consortium Regions 1, 2 and 3.

As a Chief Medical Officer she's responsible for ensuring the provider community is cognizant of CMS healthcare quality improvement initiatives, reporting requirements and the provisions in the ACA that impact the provider community. Dr. Connors graduated from the New York College of Osteopathic Medicine and received her master's of public health from the Medical College of Wisconsin. She trained in internal medicine at Monmouth Medical Center. Dr. Connors is board certified by the American Board of Internal Medicine and the American Board of Preventive Medicine.

Thanks so much for joining us today, Dr. Connors. I will now hand the presentation over to you.

Dr. Connors?

Barbara Connors: Yes. Thank you and good afternoon, everyone. Thank you for attending.

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Laurie Fink: Dr. Connors, you should be able to advance your slides. If you'd rather I do it, though, I can take care of that.

Barbara Connors: If you could.

Laurie Fink: Sure. All right.

Barbara Connors: Let's talk about what is an alternative payment model, also known as an APM. That's an acronym you'll be hearing quite often. Alternate payment models are new approaches to paying for medical care through a Medicare program that incentivizes value and quality. APMs are developed in partnership with the clinician community and offer added incentives to clinicians to provide high-quality and cost-efficient care.

The CMS Innovation Center, otherwise known as CMMI, develops new payment and service delivery models in accordance with the requirements of the Social Security Act. Additionally, Congress has defined both through the Affordable Care Act and previous legislation a number of specific demonstrations to be conducted by CMS. These include CMS, CMMI Innovation Center models other than healthcare innovation award, MSSP, or the Medicare Shared Savings Program, demonstrations under the healthcare quality demonstration program and demonstrations required by Federal law.

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An alternate payment model is a payment approach. In the context of the payment approach, however, you would be changing how you would deliver care. It's not a fee-for-service, one-episode type of service that you would be providing. Although we call it an alternate payment model, it really is in context an alternate delivery of care model. I want you to think about the kinds of patients in your patient populations that you care for and think about how you would construct a model of care delivery for that patient population, and within that that is how you would be paid to care for that population. The schematic on this slide has two circles, advanced payment models, and embedded with that an advanced alternate payment model.

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What are the benefits of participating in an advanced payment model? For payment years 2019 through 2024 clinicians who meet these requirements will be excluded from MIPS adjustment, and that is, again, the advanced alternate payment models, another acronym, an AAPM. Those clinicians would receive a 5% lump sum incentive payment for their Part B professional services furnished during the calendar year prior to the payment year for payment years 2019 through 2024.

Keep in mind we always have the two-year look-back, so even though we're talking about payment in 2019, it wouldn't be fair to the clinician to look back two years at the Part B professional services rendered two years prior to the payment year, so we would look back the previous year for your Part B professional services, and your lump sum bonus would reflect that previous year.

In 2025 there's not an explicit incentive, but the qualifying APM participants would be excluded from MIPS reporting in 2025 and, as always, have the potential for rewards under the advanced APMs in which they participate.

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In sum, the benefits of participating in an AAPM, the qualifying participants are excluded from MIPS. They receive the 5% lump sum bonus through 2024, for five years, 2019 through 2024, and beginning in 2026, they would receive a higher physician fee schedule update.

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The quality payment program provides additional rewards for participating in APMs. This slide actually has three columns. If the qualified participant is not in the APM, they would be subject to MIPS participation, including the adjustments, and when we say adjustments, it's not necessarily a negative. It could be the financial bonus and additionally the added bonuses that Annese referenced already in her discussion.

In the second column, if the qualified participant is in an advanced APM, they can participate in MIPS and receive some bonuses through MIPS as well as the APM rewards, but in the third column, if the participant is in the AAPM, they're not eligible to participate in MIPS. They receive the award and the 5% lump sum bonus. A clinician can fall in any of these three categories, depending on whether they're in an APM or not.

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To be an advanced APM, the participant must meet certain criteria. One is they must use certified EHR. The second is the participant must report measures that are similar to the quality measures or comparable to the quality measures that

are reported through MIPS and either be in a medical home expanded under CMS Innovation Center, and to date we do not have a specific medical home expanded under CMS Innovation Center, per se. We have a few models that are very similar to what we would say, or specialty medical homes, but to date we don't have medical homes for participants to join, or, additionally, requires participants to bear more than a nominal amount of financial risk.

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Again, the participant must use certified EHR technology. At least 50% of the clinicians in the ATM entity must use the technology to document and communicate clinical care information. The Shared Savings Program requires a clinician's report at the Group 10 level according to MIPS rules.

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Secondly, the reporting of quality measures that are comparable ties payment to quality measures that are evidence-based, reliable and valid. At least one of these measures must be an outcome measure. If the individual is in an APM, and I'll just stop to mention this, and not a qualified participant in an AAPM, reporting the quality measures through the APM would satisfy MIPS. We receive a tremendous amount of questions referable to, "Well, I'm not in an AAPM. Do I also have to report the MIPS quality measure?" Reporting the quality measures that are required through the APM would satisfy that portion of MIPS.

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Thirdly, or the third criterion, is either a medical home or a medical home model financial risk. Again, while no medical home model have yet been expanded, medical homes can still be advance APM if they include financial risks for participants. The medical home financial risk standard acknowledges that risk under the terms of an APM can be structured uniquely for smaller entities in a way that offers the potential of losses without threatening their financial liability.

The financial liability would be 8% of the average estimated total Medicare Parts A and B revenues of participating APM entities or 3% of the expected expenditures. This was changed from the proposed rule based on a great deal of feedback we received from APM, current APM participants, and clinicians that are considering engaging in participating in an APM model.

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For the 2017, for this performance year, the following models are considered advanced APMs. This is in the statute. Comprehensive end-stage renal disease care models, and there are several models within those arrangements, but it must be a two-sided risk arrangement, and that can include the large and the

small groups, comprehensive care, primary care plus, CPC plus, Shared savingS program, Track 2, Shared Savings Program Track 3, next gen ACO models and the oncology care models but only those groups that have assumed the two-sided risk.

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Future advanced APM opportunities include the Comprehensive Care for Joint Replacement, or the CJR, New Voluntary Bundle Payment Model, the Advancing Care Coordination Through Episode Payment Model Track 1, and I believe the comment period for that has closed, as well as the Voluntary Payment Model payment. The comment period has closed. The Vermont Medicare ACO Initiative as part of the Vermont All-Payer ACO Model, and ACO Track 1 Plus, which has still not been completely finalized.

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You may want to check back with CMS on or before January 28th to see what other models have been added. Now that the final rule is out and we're in the beginning of the performance year, we expect to receive a great deal of input from the advisory council on models that have been proposed by clinicians, and I will get into that later as well.

Now that we've talked about models, let's talk about participants within the model. Qualifying APM participants, or QPs, are clinicians who have a certain percentage of their Part B payments for professional services for patients furnished Part B professional services through an advanced APM entity. In other words, the clinician may not be seeing 100% of their patients through that APM.

Keep in mind that if you are within an APM model or considering joining an APM model beginning in 2021, the threshold may be reached through a combination of Medicare and other non-Medicare payer arrangements such as private payers and Medicaid. If you're working with private payers, the Blues, for example, the Aetnas, they have their own innovation centers. You might want to while you're working with CMS also consider working early on with the private payers as well.

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We look at whether a qualifying participant is qualified by going through a few steps. The determinations are made at the APM entity level with certain exceptions. Individuals participating in multiple advanced APM entities, none of which meets the QP threshold as a group and eligible clinicians on an affiliated practitioner list when that list is used for the QP determination because there are no eligible clinicians on a list for the APM entity. For example, gain sharers in a Comprehensive Care for Joint Replacement Model will be assessed individually.

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We use two methods of calculation. I will tell you that we always choose the calculation that favors the professional. On the left we look at the payment amount method, and that includes payment for Part B professional services to attributed beneficiaries over the Part B professional services to attribution eligible beneficiaries, and we get a threshold score. We do the same for the patient count.

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In statute, there's a grid that lists the threshold requirements. This is in law. The percentage of payments through an advanced APM for this performance year, 2017, must be 25%, and the percentage of payments through an advanced APM must be 20%, but if you look over into 2019 you see that that number jumps up to 50% for payments and 35% for patients. Again, that reflects including the patient's end or the payments from the private payers and Medicaid.

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This is a schematic that goes through what I've just covered. All of the eligible clinicians in the advanced APM become qualified participants for the payment year.

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Let's look at the performance period for qualified professionals or participants. The QP for performance period is the period during which CMS will assess the eligible clinician's participation in advanced APMs to determine if they will be what we have termed QPs for the payment year, and the QP performance period for each payment year will be from January 1st through August 31st.

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We use three key dates for the APM scoring standard. We look at the participants in the APM at three points in time, March 31st, June 30th and August 31st. If a participant is participating in the AAPM March 31st, they are considered a participant for the entire year as well as in June. Now, if the participant comes in prior to August 31st ... Let's say they come in August 15th and they are a participant for that AAPM on August 31st, yes, they are considered a QP for that entire year.

If the qualified participant is deemed participating March 31st and they leave the entity in April or May, they are still considered a qualified participant for that entire year. Once they're deemed a qualified participant, they don't lose that status if they move to another area of practice.

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When will clinicians learn of their status? This schematic basically lists the time-frame. For example, if a QP is determined to be a QP in March, March 31st, they will know by the end of July, and subsequent determinations, July 1st, or the June 30th, rather, they learn the end of October, and if a QP is deemed later in the year, the August 31st, then they will be informed by the end of December of this year.

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Let's say a QP is determined to not quite meet the threshold but they're still participating. In statute there's also a grid where that participant can meet certain criteria for the program, not all criteria. They're not immune from MIPS, but I will get into what they would have to do to be completely successful in participating, but we would call them MIPS APM. The patient threshold would be 10% as opposed to the 20, and percentage of payment is 20% as opposed to 25. That would be for 2019, and I'm not sure where the 2017 grid is at this point.

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It would be the same number.

What are the MIPS APMs? MIPS APMs, again, are an entity within the APM where the goal is to reduce clinician burden, maintain focus on the goals and objectives of the APMs. In other words, these are individuals that may be in a Track 1 and they're moving towards assuming more financial risk, but if they don't want to fully participate in the MIPS program, so what we've done is streamlined the MIPS reporting and scoring for eligible clinicians in certain APMs. It also aggregates eligible clinician MIPS scores to the APM entity level. All eligible clinicians in an APM entity receive the same MIPS final score, and it uses APM related performance to the extent that is practical.

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The requirements to be considered a MIPS APM, the entities participate in the APM under an agreement with CMS. APM entities include one or more MIPS-eligible clinicians on a participation list, and the payment incentives are based on performance either at the APM entity or eligible clinician level on cost utilization and quality.

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To which APM does the APM scoring standard apply in 20-20-17 ... or 2017? The ESRD care, all models, the CPC plus, the next gen, the Shared Savings Program

Track 1, 2 and 3 and the Oncology Care Model, all arrangement, whether it's the one- or the two-sided risk.

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We have thought a lot about small rural and health profession shortage areas, the HPSAs. Basically, because of all of the feedback and the discussions we've had with clinicians in those areas, we do not want to drive clinicians out of practice in those rural areas. In fact, we would like to give them more support than ever simply because of all the challenges that they meet everyday. What we have done is increase the availability of advanced APMs to small practices. We've increased the ability for clinicians practicing at critical access hospitals, rural health clinics and federally qualified health centers to qualify as advanced, as qualifying APM participants. We're providing funding for direct technical assistance.

Again, we have heard these concerns. We've received a great deal of feedback during the comment period on MACRA. We re-looked at some of the requirements that were going into effect this year. We've reduced the time and cost to participate in the program. We've excluded more practices through the low-volume threshold. The pick-your-pace is in effect for this year. We are also going to be working directly with small rural practices in a pilot to determine burden reduction. You'll be hearing a great deal about that coming up soon.

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The independent physician focus payment model, otherwise known as the Advisory Committee, is the group that will be receiving model proposals by participants, clinicians and other stakeholders that know what model of care would work for their patient population. The committee is comprised of care delivery experts. They'll review the proposals and submit the recommendations to the secretary. The secretary will comment, and CMS, through the CMMI, will consider testing those models.

Do not think that your ideas would not be considered. We have all different types of models that we expect will come into CMS through the committee for consideration. There are several types of medical home for specialty groups. There's several types of transitional care models that we would like to see, so don't think that your ideas aren't, that we're not interested in your ideas. We cannot achieve what we would like to achieve here without the clinician's input.

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For those clinicians that feel that they need some assistance to be successful here, there are several avenues you can take. One is working within transforming clinical practice initiatives, working with the PTNs to actually come into your practice, do an assessment, tell you whether you're ready, help you

develop practices and different areas within the practice that may need some workaround. They can help you with that as well. It is free. Monies for the TCPI was appropriated by Congress, and this money has been set aside to assist clinicians to be successful.

The QIN QIOs are also working with clinicians as well as the Innovation Learning Center has regular work groups for those models that are already in the CMMI Center.

Next slide, please.

I can turn this back over now to Laurie.

Laurie Fink: Yes. Thanks, Dr. Connors.

We're going to now move into the Q&A portion of the session. If you have any questions for either of our speakers, please type them in the chat or the Q&A box on the right of your screen. If you have already submitted a question during the presentation and it wasn't already answered, it will be addressed now as time permits.

I know we have had a bunch of questions submitted. Kathy Wild, who is our Quality Insight Network Task Lead for the MACRA MIPS Initiative, has been answering some of those questions.

Kathy, are there any additional questions that were submitted that you want to address to Dr. Connors or Annese?

Kathy Wild: Yes. Thank you, Laurie. Can you hear me okay?

Laurie Fink: Yep, we can hear you.

Kathy Wild: Okay. Sorry, everyone. I have a touch of bronchitis here. Yeah, I'm going to start with some of them at the beginning. "For the quality portion of MIPS will reporting be similar to the way the current PQRS reporting is done?" I don't know who want to take that.

Okay. Thank you, Dr. Connors.

Patrick Hamilton: This is Patrick Hamilton from the CMS regional office. The reporting mechanisms have not been finalized in that the portals or the actual mechanics that you're going to report haven't been finished, for lack of a better word. However, there are different data submission mechanisms that have been finalized in the role, so for quality, if you're reporting as an individual you'll have the same options as you do under PQRS. You continue to report. You can continue to report some claims. You can use a qualified registry. You can use a qualified clinical data registry, or you can use your EHR system.

As with PQRS you need to make sure ... Either look at the measure specifications for the measures that you are going to choose, because not all measures are able to report it using all of the reporting mechanisms. You want to make sure that if, for example, that you are going to use your claims to submit your quality data, that the measures you're choosing, the specifications allow for the claims reporting option.

Also, what you should know is that if you choose one submission mechanism for one of the categories, for example, if you're going to select claims for quality, you can use other mechanisms to report the other categories, the data for the other categories. For example, you could use claims for your quality. You can use a qualified registry for your improvement activities, and you can report your advance in care information directly from your EHR system, so we do allow multiple submission method across the quality ... or, I'm sorry ... the performance categories.

Kathy Wild: Great. Thank you, Patrick. I think that definitely answers the question.

The 271 quality measures are available on the QPP website if anyone wants to see them there. Measure sets for specialties are also available.

Another question we got refers to the choose your test method for 2017. They want to know exactly what is the minimum amount of data that has to be submitted so that you don't have that 4% penalty. If you pick the quality category, can it be the quality measure for just one patient for one day, or would that not suffice and you would have to do something for 90 days?

Patrick Hamilton: It depends on the actual quality measure that you are choosing. It's again important to look at the specification, how we are defining a minimal amount of data. If you're looking for the absolute minimum amount of reporting that you need to do in 2017, it would be submitting just one quality measure. The absolute lowest score that you can get, so long as you meet the minimum data submission requirements, is a score of 3. You can get as high of a score as 10, depending on how well you fared in that measure.

You have to look at the specification. It can be just for one patient, but some measures require 90 days of data. Some require just one visit. Some may require a visit and a followup. I don't want to say you just have to do one patient for one day or for one visit. You have to look at the specification. You can do it just for one patient, but it's not a blanket statement that you can do it just for one day.

Kathy Wild: Okay. Great. Thank you very much.

Another question, "Can a nonparticipating provider which bills the limiting charge participate in MIPS?

Patrick Hamilton: This is actually, it's funny that you mention this, because before I jumped on this webinar I was on an internal call, and we were having this very discussion. We are in the process of finalizing an FAQ, and hopefully some applies that we can include in this presentation that actually address this issue.

The responses I got was that we are still going through and putting together what the exact policy is under MIPS, because right now what we have on the CMS website are material or information as to how nonparticipating providers participate in PQRS. I'm not exactly sure that it's going to be exactly the same policy, so I don't want to give a definitive answer today on the phone, but I'll make sure that we follow up with Laurie and Kathy once we get the finalized non-par information, and we'll share it and make sure that that gets out to the audience.

Kathy Wild: Okay, great. Thank you.

Another question, "We have several physicians that work at multiple locations under different TINS. In order to avoid the penalty, are they required to report under each PTAN, or will participation and reporting under the individual NPI suffice for all locations?"

Patrick Hamilton: I'll try to give this one an answer, Barbara. You can add or correct me if I speak out of line.

The identifier for the MIPS program is a combination of NPI and TIN. If an eligible clinician, as we identify them by his or her NPI number, works under different tax identification numbers. Then each NPI TIN combination would have to meet satisfactory reporting requirements so that each NPI TIN combination would not be subject to payment adjustments.

Barbara, is that how you understand it?

Barbara Connors: Yes.

Patrick Hamilton: Okay.

Barbara Connors: Yes.

Patrick Hamilton: Again, that is if they are reporting as individuals. It gets into a little bit, a little differently if they are reporting as a group, but if they're reporting as an individual, then each NPI TIN combination would have to meet the criteria. That is not unlike the current requirements for PQRS and the value modifier.

Kathy Wild: Okay. Very good. All right.

"If we are currently meeting the 10% threshold ..." and I believe this one is referring to the advanced care information category. Specifically, they're looking

at the health information exchange objective when a provider has to send a summary care document, and the question is, "If we currently meet the 10% threshold, will we get more points than the base score since we already have this measure implemented and working?"

Patrick Hamilton: Under advancing care information there's technically no longer a threshold. Under meaningful use, up until, well, last week actually, for Medicare providers, certain of the objectives had thresholds, which meant that if an eligible provider did not surpass the threshold, then they basically failed the program and they got hit with the penalty.

Advancing care information works quite differently. We've talked about the base score and the performance score. The base score, which is worth half of the total of the ACI information, it's just basically if you are submitting the CMS, the data that comes from your system for five particular measures, so that basically means reporting a yes or a no attestation for two measures and simply giving us your numerator and denominator for three other measures. I don't remember if those actual measures were listed on the slide. I think they might have been.

If you report, just give us the data for those measures under the base. You get half of a point. Now, the way that you get the other half is what we call the performance measures. You do not have to surpass a particular threshold in order to get points, but the higher your percentage is means the more points that you will get in the performance score. Annese said we weren't going to go into the technicalities of the scoring, and the advancing care information is the most complicated of the three categories that we're scoring this year to understand.

Basically, you can get a total of 10 points for each of the measures that are in the performance score, and the way that it works is let's say that you are getting 12%, 12%, you score 12% in, I think you said health information exchange. What we would do is we would convert that 12$ on a 10-point scale, so that would be 1.2, but then for ACI we round it up to the nearest 10 or to the nearest point. Instead of saying that you only had it 12%, we would convert that to a 1-to-10 scale, which would be 1.2. We round it up to 2 points. You would get 2 points on the advancing care information and for that portion of the performance if you had a 12% performance. If you had a, let's say 57% performance for that measure, you would get 6 points because we'd convert it to 5.7 and round it up to the nearest whole number.

The better you perform the more points you will receive. That's the easiest way to understand it. No more, "I fell short of hitting that 5% goal so therefore I failed," but the higher you perform the more points you receive under the performance category.

Kathy Wild: Right. Thank you. I do want to stress that I had the QPP Service Center clarify this for me, that you have to meet all of those base score measures before you can receive any points for the ACI category at all, so you have to do that.

Patrick Hamilton: That's correct. Right. There are two measures that require a yes or no response. One is doing the security analysis, and the other one is e-prescribing. If you answer no to the security, then you get a total of zero and you can't move on to the performance score. The same thing with e-prescribing. If you answer no, that you're not e-prescribing, you get a zero for the base score, so it is very important. Then for the other ones you have to submit your numerator and your denominator for the other three measures under the base score. If you fail to submit information for any one of those, then you can't get any points.

Keep in mind again, because this is a program that is now incorporating all of the categories under one umbrella, if, for whatever reason, you should get a zero with advancing care information, you can still make up points on quality and improvement activities and next year with cost, but, again, we are in no way advocating that you should just not do advancing care information, because 25 points in 2017 could be the difference between getting a pretty good payment adjustment or possibly getting into that exceptional category. In order to get the exceptional category you have to surpass a score of 70. It's much easier to do that if you have points in all three of the categories.

Kathy Wild: Right. One of the things I know, we have been looking at the improvement activities, and there are several of those, I think there's nine, it could be more than that, that if the practice uses their certified EHR technology, they are eligible for five extra bonus points for the ACI category, so we're trying to promote that also, but, once again, if they don't meet those base measures they wouldn't be eligible to get those five extra bonus points.

Patrick Hamilton: Right. There's bonus points for submitting improvement activities with your EHR technology. You can also get extra points in the advancing care information if you submit to more than one public reporting registry, and I'm not sure if we mentioned that during the presentation. There's two opportunities to get even more points under advancing care information, but you are correct, Laurie is correct, that you have to at least submit the data for the five base points, for the five base measures, in order to advance.

Kathy Wild: Just so everyone on the call knows, that, as a QIN, we are in the process of developing a lot of resources and tools that will be handy and ready to give you all of these shortcuts for each of the different categories, little handbooks and guides, and they will be available soon, and we do plan to have individual training sessions on each of the different categories so we can get into more of the nuts and bolts for each one.

All right. Moving on to another question. "We are an endocrine practice recently. We achieved the medical home specialty practice. We have two

physicians and two nurse practitioners. We want to know which model will benefit us. Should we try MIPS or APM?"

Barbara Connors: I can take this. If they're a medical home practice, they're not eligible to participate as an AAPM at this point in time. They would receive some credit towards MIPS categories as a medical home, but they would not be in that AAPM category.

Kathy Wild: Okay. Very good.

We did have a request, and I'm not sure what state Alice Hopkins is from. If she can identify that in the box, we will be sure to touch base with her. She is from a small practice and would like assistance. They want to proceed because there is a limited number of vendors providing assistance, and they would like to participate in TCPI.

Alice, we will have your email address from the registration. We will get in touch with you and definitely get you in contact with the TCPI in your state, so thank you for that.

Let's see. Okay. I don't know that this was covered today. "What is the definition of a hospital base that's eligible clinician?" We've had some questions come into our QIN about that.

Patrick Hamilton: If you give me one second, I can pull up exactly what the definition is. Basically, under the Meaningful Use Program, hospital-based clinicians were exempt if they had a certain percentage of their services occur in certain areas of a hospital. I believe it was 90% or more of services in either the inpatient setting or the hospital or the emergency room setting. We looked at specific dates of time in order to make that determination.

It's changed slightly in the final rule, and I am looking that up right now. If you just give me one second, I'll give you exactly what that ... Because I think off the top of my head, I'm just ... Okay. Here we go.

A hospital-based MIPS eligible clinician is defined as a MIPS-eligible clinician who furnishes 75%, so the threshold actually was lower ... Seventy-five percent or more of his or her covered professional services in sites of service identified by the place of service code used in HIPAA standard transaction as in-patient hospital, which is Place of Service 21, on-campus outpatient hospital, which is Place of Service 22, or emergency room setting, which is Place of Service 23. Based on claims for a period prior to the performance period specified by the amount. It's 75% or more of services either in Place of Service, 21, 22 or 23.

What's the time period that we're looking at? The rule says that we intend to use claims with the dates of service between September 1st of the calendar year two years preceding performance periods through August 31st of the

calendar year preceding performance period. Basically, that means the fiscal year prior to the performance year.

For example, for 2017 we will be looking at fiscal year 2015, which technically runs ... Actually, it's not technically the fiscal year, because our fiscal year begins on October 1st. I'm sorry. We do specifically say it would be September 31st of 2014 through August 31st of 2015. That's the period of time that we're looking at the claims to see if 75% or more of those claims took place in either Place of Service Code 21, 22 or 23.

Kathy Wild: Okay. Great. Thank you.

Patrick Hamilton: Slight change than what the definition was under "meaningful use," but it actually is to the benefit of those providers that may have had trouble hitting that 90% threshold under the old program.

Kathy Wild: Great. Okay. Here's a question that I think is going to be a little difficult to answer because it's very broad. "Can you please explain how we should determine whether to report measures individually or as a group?"

Patrick Hamilton: We get this question all the time.

Oh, Barbara, go ahead.

Barbara Connors: Go ahead, Patrick.

Patrick Hamilton: I'm sorry.

We get this question all the time, and really what it comes down to is if the group is multi-specialty, sometimes it is more difficult to find the requisite number of claims to report that would pertain to a majority of the clinicians in the practice. It also usually comes down to how the practice would like to report. We still have groups that want to report via claims, but that is not an option under the group reporting option, so we'll have a lot of groups that will continue to have their clinicians report individually because they like that option to report via claims.

If they're going to use the web interface, the group has to be more than 25 clinicians, and they have to be able to report on all of the measures that are included in the interface, so that sometimes is a challenge.

Barbara, do you want to go ahead and jump in?

Barbara Connors: No, other than to reiterate what you said. We do not really work with practices individually to help them make that determination, because it's the practice that really has to do what's best for them, and we can't proscribe what works

for them. It's a business decision. In my experience many of these decisions are not being made with the actual clinicians. The clinicians are delegating this.

What I'm trying to do is message to the clinicians that they have to be engaged. If the question is coming from a practice where, for example, the office manager or the billing manager has to make this decision, they really have to go back to the clinicians, because the clinicians are actually seeing the patients, and much of the data is really extracted from that work.

Kathy Wild: Okay, great. I think that's a good starting point as we get these requests for assistance. It's one of the things they need to look at. However, do you feel that they need to make that decision and stick to it? There isn't a set point in time during this upcoming year where they could actually change their mind. I guess if you're doing claims, you have to start that way at the beginning.

I'm sorry. Go ahead.

Patrick Hamilton: I'm sorry. In terms of group reporting, if, and I think I have this right, if they're going to use the web interface or if they are going to opt to use a CAP survey, which is a I think 12-point beneficiary, basically satisfaction, survey, that can be used in conjunction with other reporting materials, they actually have to register. They have to register using a web interface, and they have to register for the CAP survey, because they have to actually find a vendor to administer the survey on their behalf. I believe that the deadline, and I'm not sure that this has been set in stone, but I believe that the registration deadline is June 30th.

In the past under PQRS if a group was going to register as a group regardless of how they were going to submit their data, they had to register as a group. Under MIPS the registration is only required for the interface and for the CAP survey, but the decision should be made sooner rather than later. Especially if you're going to be using a registry or a qualified clinical data registry, you want to start that process now to make sure that the registry that you choose is adequate for your business needs and also can report on the types of measures that pertain to your scope of practice.

We always say you never want to wait until the last minute to start this. I know that we mentioned the October 2nd date as the last date to start reporting at all. We never advocate that. We also understand that there is a lot of thought and decision-making that needs to go into this process, so time is not always on your side, but we always say, better to start thinking about that stuff now rather than doing it in September and being behind the eight ball.

Kathy Wild: Right. Okay. All right. I'm looking at the time. I'm thinking we might be able to get these two last questions in before we have to log off. "What documentation is required to prove that we have completed an improvement activity?"

Barbara Connors: At this point the only documentation is essentially maintaining records, so you should really maintain the records similar to the maintenance of records now. I believe you should maintain the records for 10 years. We could ask. I think it's going forward.

We could ask six years and three months, is it, Patrick? Maintain the records that reflect the improvement activities that the practice has performed.

Kathy Wild: Okay. Thank you.

The last one, "What clinicians will require an application to have the Advancing Care Information portion re-weighted, and when will this be available?" I'm not sure but I know for the Advancing Care Information the new clinicians that are added this year, such as the nurse practitioners and PAs that could only participate in Medicaid, meaningful use before, they have the option to report to the ACI category or not. If they choose not to, I guess the question is when will that application be available, and could you tell us a little bit about that?

Patrick Hamilton: I don't think that there is an application, and, Barbara, correct me if I'm wrong, but I think that the exemption for the non-physician clinician, so that's physician assistants, nurse practitioners, clinical nurse specialists and the certified registered nurse anesthetist, I think that we know by their enrollment data that they are a specific non-physician clinician type, and I don't think that they need to proactively apply for that exemption.

Is that how you understand it, Barbara?

Barbara Connors: Yes. Yes, but if they do voluntarily participate, they will be scored. This would be under their NPI. If they're working under the physician's NPI, they wouldn't even come up, but if they're using their own NPI and they decide to report the ACI, they will be scored. We expect in a few years they will be considered participants.

Kathy Wild: Very good. I think that is it. There might be a couple more. I will go ahead and collect those and send something out when we send the webinar recording out.

Laurie, do you want to do our closing statement?

I personally also would like to thank Dr. Connors, Patrick and Annese for educating our members in our five states. We truly appreciate all the help and guidance you've given us.

Laurie?

Barbara Connors: Could I ...?

Kathy Wild: Oh, sure.

Barbara Connors: Yeah. Some of the questions that were just asked, the answers and further information is on the QPP portal website. For example, when Patrick went into the breakdown for the performance categories for ACI, there's a nice grid where you actually see what each subsequent measure would score out as. If the attendees on the webinar haven't gone on to the QPP portal, please go on, because this is where they'll be getting all the information, the specifications for the measures, et cetera, et cetera, where we're posting everything.

Kathy Wild: Okay, thank you, Dr. Connors.

Laurie?

Laurie Fink: Yep. Thank you so much to everyone. We had a pretty lively session and a lot of good questions, so thanks so much to our speakers. Again, that was Annese St. Louis, Dr. Barbara Connors and of course Patrick Hamilton, thanks so much for jumping in during the Q&A. There's obviously a lot of questions, and you guys provided a lot of great information and details to help transition to the new quality payment program.

As you'll see on the screen right now, here is a list of the state contacts in our five states, quality, innovation, network region for our MACRA and MIPS team. If you have any questions, please reach out to the coordinator in your state, and they will be happy to help you out with whatever you need assistance with.

With that, I'd like to thank everyone for joining us today. We hope you found it to be a very informative and beneficial presentation. When you close out of the session, you will be directed to a very brief survey. Please take a minute to complete it. We greatly appreciate your feedback. Have a great rest of the day, and this now concludes the session.