Overview of the 2025 Quality Payment Program Policy Updates
November 14, 2024

>>Ketchum: Hello everyone. Thank you for joining today's public webinar providing an overview of the Quality Payment Program policies from the Calendar Year 2025 Physician Fee Schedule Final Rule. During the session, CMS will provide an overview of the finalized policies for the 2025 Performance Year of the Quality Payment Program and offer resources for helping to understand the Final Rule.

Today's presentation will be followed by a Q&A session where attendees will have the opportunity to ask questions. You can submit written questions via the Q&A box or you can raise your hand to ask a question via the webinar audio. CMS subject matter experts will address as many questions as time allows.

A recording of the webinar and slides will be shared on the Quality Payment Program Webinar Library in the coming weeks.

Now I'll turn it over to Kati Moore from CMS to begin. Kati?

>>Kati Moore, CMS: Awesome. Thanks, Hallie. And good afternoon, good morning, everybody. Thanks so much for joining us today.

We're really excited to finally been able to get this rule out and have this opportunity to run through our policies with you all, and hopefully, we'll be able to get to a number of your questions at the end. But as always, feel free to put them in the Q&A session as we go through. We'll try and answer some real time as we're able to, and then we'll try and get to some, as many as we can at the end. But as Hallie said, we'll have slides, recording, everything available in the next couple of weeks. So definitely be on the lookout for that information and as always, we have our QPP Service Center available to answer any questions or get you connected with the right information.

So thank you so much for joining us today and more importantly, thank you all so much for what you do every day to take care of Medicare beneficiaries throughout the country and in your practices, or if you're the specialty society or other form of support for clinicians and our beneficiaries, we really appreciate all that you do in your work every day. So we'll go ahead.

Next slide, please. Do one more.

Great, thanks. Real quick, just high-level what we're going to touch on today. I will just run through some reminder deadline information and where you can go to get more information through our resources, and then I'll just do a real quick recap of a Quality Payment Program overview, and then a high-level touch on our major policies that were finalized through this rule. And then I'll try and quickly turn it over to our subject matter experts so they can dive into the specific areas and get to all the information you are looking for. And then we'll end with our usual help and support information and then open it up for some Q&A.

Next slide.

Okay. Really quickly here, just some upcoming deadlines since we had this opportunity to talk with you all today, I wanted to flag. So upcoming December 2, that's our MVPs, our MIPS Value Pathways registration deadline. So December 2, if you'd like to participate for the 2024 performance year, if you want to submit your data report to us through an MVP, we need you to register and let us know that you are intending to do that. So I encourage you to check out our MVP section of our website and get more information on how to register.

And then December 31, the end of the year, coming up here faster than we're anticipating, but it's our last day to submit if you have a Promoting Interoperability Hardship, and like to submit an Exception, submit that application, or our MIPS Extreme and Uncontrollable Circumstances or EUC Application, both those deadlines are December 31. And then also virtual group election period ends on that day as well.

And then as we're closing out 2024 and looking ahead to 2025, January 2 is the start of data submission. So all of that important work you've been doing this year and collecting all of your data throughout the year can begin submitting January 2. And I'm going to start now with encouraging folks to submit earlier rather than later so that you have time to make sure that the data in the system is what you intended to be submitted to CMS and is accurate and what you want to submit. So I encourage you to get in there early and make sure we get the right information from you.

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And then just flagging some rule resources that we've put out. I know everybody was eagerly anticipating reading thousands of pages of reg. text from us. We encourage you to do that as well. So we have a link here for that. But if you need some help in a little more plain language version of what we finalized this year, I encourage you to look at our federal fact sheet, and then also we have our MVPs Guide that lays out specifically what is included in each of the MVPs that are available for the 2025 performance year.

And thank you, Hannah, for putting in links. As we're talking throughout the presentation, I just want folks to keep an eye on the chat. As we're talking and probably mentioning resources or webpages to go and look out for more information. Hannah is so nicely adding them to the chat. So just keep an eye on those.

Next slide, please.

And then I know we just mentioned our MIPS EUC Application deadline coming up, but we also wanted to let you know about our Automatic EUC policy has been applied to a number of new counties and states that have been impacted over the recent months, specifically for Hurricanes Milton, Helene, and Francine, but I encourage you to review our Automatic EUC Policy Fact Sheet that lists all the information you need to know and help figure out if you live in an area that was impacted by one of the natural disasters that have triggered our Automatic EUC policy. And what that means is that you will be automatically reweighted off all four

performance categories, will be automatically reweighted to zero percent, and effectively receive a neutral payment adjustment as long as no data is submitted to CMS by you or on your behalf. So, please look for more information on that.

And I know also by the end of this year we'll have our lookup tool updated. So our NPI lookup tool participation status will also have that information available in there soon.

Next slide. One more, please.

Okay, So, for folks that are new here today, I'm just going to cover just a level set with everybody and just cover a few here quick slides on just an overview of the Quality Payment Program and for folks that have been with us a long time, we use this as a refresher, or feel free to get up and get a drink. So, the Medicare Access and CHIP Reauthorization Act of 2015, so MACRA, is what created the Quality Payment Program. And so, there are two participation tracks in the Quality Payment Program. There's MIPS, the Merit-based Incentive Payment System, and then there is the Advanced Alternative Payment Models track of the program.

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And then so this slide, we started using a little while ago, it really helps to show where there's overlap. So, there are two tracks of the program, however, we like to point out that there are some Advanced Alternative Payment Models that participate through MIPS. So, the way we determine who participates in MIPS from the APM world if you do not have Qualifying APM Participant status and you do not achieve Partial QP status, then you are required to participate through MIPS. If you do achieve that Partial QP status, then you have the option, you can choose to participate through MIPS or not. And then if you achieve full Qualifying Participant status, you are not required to participate through MIPS.

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And this just lays out similar information just kind of in a different way. So QPs are eligible clinicians who have either met or exceeded the payment amount and the patient count threshold based on their participation in their specific Advanced APM. And then Partial QPs, again, can choose whether or not they want to participate through MIPS.

Next slide. And one more.

So, I'm just going to cover the next few slides. Just hit the high points for policies that you're going to hear more in detail from our subject matter experts here today. And I just want to point out, we have a lot of really, really great team members on the call today. So I look forward to hearing the questions you have because you have the right folks on the call today. So first, just a key highlight, we're really looking to maintain stability within traditional MIPS. So I know we heard a lot from folks about the performance threshold and we did finalize to keep the 75-point threshold for 2025. And additionally, we're maintaining that 75% data completeness threshold through 2028.

And then as always, we're continuing, as we're moving forward with the program to focus on MVP development and maintenance. This year, we did finalize six new MVPs that would be available beginning in 2025. So, they're related to ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care. And again, we have that MVP Guide available where we just -- if you really just want to know specifically about MVPs, we pulled out all of the information on each of those so you have them all, all in one place. And then again, I just want to flag, we do have a really -- well, our website in general is a really great resource to go to for more information. We have our Resource Library as well as Webinar Library, but we also have a lot of other important pages and tools that really help people participate in the program and understand our policy requirements that get finalized. And we do have a very specific page that is all about MVPs, including how we develop them and how we continuously take feedback and update them periodically through rulemaking. So, if you're interested in participating in that way, again, or just learning more about that reporting option right now, I encourage you to go to the website. And then additionally, with MVPs, we did finalize some modifications to the existing MVPs in our inventory. And most notably, we

consolidated, we had two neurological MVPs and we combined them into one neurological MVP.

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And then you'll hear a lot more about this from Danielle later, but I just want to flag that we did finalize with modification and additional quality measure set under the APP, so the Alternative Payment Models Performance Pathway, called the APP Plus Quality Measure Set.
And then again, with our measures and improvement activities, inventories, we made some updates there, adding seven new quality measures, we removed ten and had substantive changes to 66 measures. And again, a helpful tool that is on our website. We have all of our measures and activities that are in the program. We have a really great interactive tool that helps you kind of look and see what measures you might want to select in the program and get more information there through our website. And we have the same information available. If you really love PDFs, the plots of information, we have them in that form as well. And then just we added six new episode-based cost measures and we revised two existing. Again, we're continuously working towards developing and adding more of those cost measures to our inventory. So, we know folks are looking for more of those. And then we revised our cost measure scoring methodology. So, you'll hear more about that in a little bit.

Next slide, please. Okay.

And with that, I am going to turn it over to Michelle Peterman to walk you through some more in-depth information about MIPS Value Pathways. Thanks.

>>Michelle Peterman, CMS: Thank you, Kati. Hi, everyone. I'm Michelle Peterman.

So, on this slide, we are going to go through our six new MVPs. They are noted here, and Kati went through them just now, but these are the official titles here, all related to these points of care. So ophthalmology, dermatology, gastroenterology, urology, pulmonology, and surgical care. We did finalize a few modifications, but as Kati noted also, we wanted to specifically call

out the one for neurology. We combined or consolidated “Optimal Care for Patients with Episodic Neurological Conditions,” and the “Supportive Care for Neurodegenerative Conditions” into a single MVP, and that one is titled "Quality Care for Patients with Neurological Conditions.” The reason for that consolidation is because the QCDR measures that were previously included in both of these MVPs are no longer available for use in MIPS, so we felt this consolidation would ensure the availability of a robust and meaningful MVP that could capture a broad scope of care provided by neurology. So, these finalized policies bring our total number of MVPs available for 2025 to 21. So, we're getting more and more. And then finally, at the bottom of this page, there's some reference links for you all. If you're interested, it will provide you more information on MVPs in general and I think she just also added it to the chat.

Next page, please.

And okay, now we're going to just take a brief view of our MIPS Final Rule policy to start.

So, this slide is going to provide us an overview of the performance category weights, as you can see. It's divided into columns by traditional MIPS and MVPs, APMs, and the APP. And it notes the specific weightings for each of the four performance categories. So what happens is the points from each of these performance categories are added together and it gives you your MIPS final score. Then the MIPS final score is compared to the MIPS performance threshold and that determines if you receive a positive, negative, or neutral payment. And that kind of sums that part up. I'm not going to pass the presentation over to Lisa Marie.

>>Lisa Marie Gomez, CMS: Thank you, Michelle. Now I'm going to go over the policies relating to the quality performance category.

Next slide, please.

The first item that I'm going to discuss relates to the quality measures. So, for the upcoming performance period, we added seven new MIPS quality measures, removed ten quality

measures, and we also made substantive changes to 66 existing quality measures. So, for the 2025 performance period, there will be a total of 195 quality measures in the inventory. I just want to note that the 195 MIPS quality measures do not include QCDR measures.

Next slide, please.

Then I'm going to briefly discuss data completeness. So for the data completeness, we finalized our policy to maintain the data completeness threshold of 75% for the 2027 and 2028 performance period. So, this means that the data completeness threshold of 75% will be maintained at 75% for a total of five years, which will be through the 2028 performance period.

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Now I'm going to turn the presentation over to Zenobia Rasbury. Thank you.

>>Zenobia Rasbury, CMS: Thanks, Lisa Marie. So, I'm going to talk about our scoring policies in the quality performance category. We finalized our defined topped-out measure benchmark policy. These defined topped-up measure benchmarks would remove the cap and score one to ten for select measures in specialty sets that are impacted by limited measure choice. We would propose measures that this benchmark would apply to each year in rulemaking and this will begin. We propose a list of measures and finalize a list of measures for 2025. Next, for the Medicare CQM collection type, we will be scoring those according to flat benchmarks for their first two years in the program. As a reminder, Medicare CQMs are those available only to Accountable Care Organizations in the Medicare Shared Savings Program.

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Next, the complex organization adjustment was finalized as well. The complex organization adjustment adds one measure achievement point for each Medicare eCQM submitted by an APM Entity or virtual group that meets the data completeness in case minimum requirements.

This adjustment may not exceed 10% of the total available measure achievement points in the quality performance category.

Next slide, please.

Next, I will be discussing our revised data submission policies, beginning with the data submission criteria. We finalized that a submission in the quality performance category must include a numerator and denominator for at least one measure. A data submission requirement without any scorable data, meaning no numerator and denominator, would not satisfy the data submission criteria.

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We also codified -- finalized our proposals to codify existing processes for scoring multiple data submissions. For quality submissions for an individual group or subgroup, or a virtual group from different organizations, meaning a submission from a qualified registry and a practice administrator for the same individual clinician, for example, we would score each submission and assign the highest of all scores, meaning we would calculate and score all measures received and pick the highest scoring. As a note, we wouldn't combine data submitted for different reporting options, meaning we wouldn't combine a submission for traditional MIPS with an MVP submission.

Next slide, please.

Now, for multiple submissions, for the same organization submitted the same way, meaning for the same way, for the same reporting option and the same performing category, we would score the most recent submission and the new submission will override a previous submission. So to distinguish this from the previous policy we just discussed, this is multiple data submissions via the same reporting mechanism. So these submissions would override each other.

Next slide, please.

>>Allie Newsom, Acumen: So through this rule, we finalized to add six new episode-based cost measures beginning with the 2025 performance period. So that's the Respiratory Infection Hospitalization, Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis measures. Again, those were newly added for 2025. And then also finalized substantive changes to two existing episode-based cost measures. That's the Cataract Removal with Intraocular Lens Implantation and the Inpatient Percutaneous Coronary Intervention Measures. And for those of you who are interested in seeing more information about those measures, you can review the Measure Information Forms on the CMS website. And I believe there's now a link to those Measure Information Forms in the webinar chat for your reference.

Next slide.

Thanks. We also finalized the following criteria to serve as guidance when considering whether to remove a cost measure. So number one, it isn't feasible to implement the measure specifications. Number two, the measure steward is no longer able to maintain the cost measure. Number three, the implementation costs or negative unintended consequences associated with a cost measure outweigh the benefits of its continued use in the MIPS performance category. Number four, the measure specifications don't reflect the current clinical practice or guidelines, and number five, a more applicable measure is available including a measure that applies across settings, across populations, or is more proximal in time to desired patient outcomes for the particular topic.

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Shirley I'll be passing over to you now.

>>Shirley Fung, CMS: Thank you, Allie. Can you all hear me? Can you all hear me?

>>Chris Ferrante, CMS: Oh, we can hear you well.

>>Shirley Fung, CMS: Thank you. Good afternoon. Good morning. I am going to finish off the cost performance category. We finalized our proposal to update the cost measure exclusion policy, beginning with the 2024 performance period and 2026 payment year. This updated cost measure exclusion policy aims to provide CMS with greater flexibility to be responsive to any "errors" or "significant changes" outside of the control of MIPS-eligible clinicians that negatively impact the ability of specific cost measures to assess clinician performance. And under this finalized exclusion policy for cost measures, significant changes or errors would include, but not limited to, rapid or unprecedented changes to service utilization, the inadvertent omission of codes, or inclusion of codes, or changes to clinician guidelines or measure specifications. CMS will determine whether there is a negative impact from the change or error that would affect cost measure scoring. This policy also allows us to exclude cost measures when such changes and errors occur in or outside of the performance period.

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We also finalized to revise the cost-scoring benchmark methodology, beginning with the 2024 performance period, 2026 payment year. In the new benchmark methodology, the national median cost for a measure will be set at a measure score equivalent to the performance threshold established for that MIPS payment year. Then the cutoffs for the benchmark ranges would be calculated based on standard deviations expressed in dollars from the national median. The following example demonstrates that the finalized benchmark methodology can more appropriately incentivize or penalize clinicians.

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So, in this example, the national median cost for the Screening Surveillance Colonoscopy measure is $969.72 Dr. Clark, her average cost per episode for this measure is $1104, which is about $135 above the national median. Under the current methodology, her $1104 average cost per episode would give her 2 to 2.9 measure achievement points. Under the finalized benchmark methodology, she receives 6 to 6.9 achievement points instead, which is appropriate

for her slightly above national median cost performance on this measure, and it brings her closer to the performance threshold equivalent of 7.5.

Now I'm going to turn it over to Chris Ferrante to go over the improvement activities performance category.

>> Chris Ferrante, CMS: Thank you, Shirley. Hello, everybody. I will now go over the Final Rule policies related to improvement activities, as Shirley said.

So for the improvement activities performance category for the 2025 MIPS Final Rule policy, we finalized adding two new activities, modifying one already existing activity, and removed four activities. This resulted in 104 total improvement activities for the 2025 performance year. We also finalized the removing of four activities for the 2026 performance period.

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We also finalized to remove activity weighting in order to simplify scoring which we believe will refine and improve the inventory moving forward. Requirements for attestation were also simplified. In traditional MIPS reporting, clinicians, groups, and virtual groups that have a special status of small practice, rural, non-patient facing, or health professional shortage area only need to attest to one activity, while all other clinicians, groups, and virtual groups must attest to two activities. And MVPs, clinicians, groups, and subgroups must attest to at least one activity.

Next slide, please.

We also finalized that a submission for improvement activities must include a "yes" designation for at least one improvement activity to be considered a data submission and subsequently scored. Please note that a submission with only a date and a practice ID would not be considered a data submission and would result in a null score.

Next slide, please.

We also finalize the codifying of our existing processes for scoring multiple data submissions. When there are multiple data submissions for an individual clinician group, subgroup, or virtual group from different organizations such as a qualified registry and the practice administrator from the same reporting option -- for the same reporting option, excuse me, we will codify our existing process and score each submission received and assign the highest scores. In practice, this means we score all activities but not to exceed the maximum points available in the performance category. Please note that we won't combine activities submitted for different reporting options.

Next slide, please.

Now, in a situation where there are multiple data submissions for an individual clinician group, subgroup, or virtual group from the same organization, different from before where it was different organizations, now it's the same organization, such as by two practice administrators, for the same reporting option, we finalized to codify our existing process. This means we will score the most recent submission and that the new submission will override the previous submission of the same submission type from the same organization. Please note that this policy won't apply to different submission types for the same organization. Activities submitted via file upload won't override the activities submitted via attestation. These are distinct submission types. This concludes the improvement activity section and I will now pass it along to Chelsea.

>>Chelsea Mackiewicz, CMS: All right, so let's get started on the final policies for the PI performance category.

So starting in the performance year 2025, automatic reweighting will only apply to MIPS eligible clinicians, groups, and virtual groups that have the designated special statuses of Ambulatory Surgical Center-based, or ASC-based, hospital-based, non-patient facing, and small

practice. Now this isn't on the slide, but to add to this, beginning in the 2025 performance year and 2027 payment year, clinical social workers will no longer be re-weighted.

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In 2025, we established data submission criteria for PI that must include all of the following elements: Performance data for the required measures in each objective, along with any claims of applicable exclusions, the necessary attestation statements also specified by CMS, your CEHRT ID, which can be found on the Certification Health IT Product List, and the start and end dates for the performance period, which can be defined in the section 414.1320.

It's also important to note that if your submission only includes a date and practice ID, it's not going to count as a valid submission and it will be assigned a null score. However, it will not affect the reweighting of the PI performance category. And this policy really is just intended to mitigate a negative scoring impact on clinicians due to unintentional submissions that would possibly override reweighting.

Next slide, please.

So starting with the calendar year 2024 performance period in the 2026 MIPS payment year, which means data will be submitted in 2025. We'll calculate a score for each data submission received, and then we'll assign the highest score from that submission. And then finally -- next slide, please -- we decided to continue with our policy that a subgroup must submit the data for its affiliated group for PI.

And now I will pass it over to Shirley for our final scoring policies.

>>Shirley Fung, CMS: Thanks, Chelsea. I think it's Zenobia. Please, Zenobia.

>>Zenobia Rasbury, CMS: Hi, yes. Thank you, Chelsea and Shirley. So for our score, final scoring policies. We finalized a policy to allow clinicians to request reweighting for the quality

improvement activities or Promoting Interoperability performance category, in instances where data were inaccessible or unable to be submitted due to reasons outside of the control of the clinician because they designated submission updated to a third party intermediary and that third party intermediary did not submit on behalf of the clinician, these requests would be submitted to the QPP Service Center and would be received before November 1, prior to the relevant MIPS payment year. So for the 2025 performance period, this would be -- the deadline would be November 1 in the year of 2026. These requests can be submitted beginning with the 2024 performance period, so the data submission period in 2025.

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We finalized -- for the performance threshold policies, we finalized to continue using the mean to assign the performance threshold for the 2025 performance period through to the 2027 performance period. Additionally, we also continued our performance threshold at 75 points for the 2025 performance period.

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And now I will pass to Julie Johnson to discuss our Final Rule policies for the third party intermediaries.

>>Julie Johnson, CMS: Thank you, Zenobia.

Good afternoon or good morning, depending on where you are listening from in the United States. I will now go over one change we have for the CAHPS for the MIPS survey and third party intermediaries. Starting with calendar year 2026, we are requiring that CAHPS for MIPS survey vendors submit the best estimate of the cost of their services to CMS. We will publish these vendor costs on the QPP website to increase transparency on the cost of participation in the program and to improve consistency across requirements for third party intermediaries. Based on comments received on the proposed rule, we are working on how this pricing

information will be displayed for our participants and how updates to pricing information will be handled.

This is all I have for today. I will now turn this over to my colleague, Trevey Davis, to go over Final Rule changes for Advanced Alternative Payment Models.

>>Trevey Davis, CMS: Thanks, Julie. All right. We can go to the next slide. Okay.

So today I'll be summarizing the changes to the Advanced APM category and the changes as part of the PFS rule. Before I do so, I would like to plug our 2024 learning resources for QP status and APM incentive payment. This is a zip file that we place on the Resource Library. And if you want to learn more about how QP status is determined or how APM incentive payments are calculated and made to QPs, this is your place to start.

Now that I'm done with that plug, we had two primary changes in the proposed rule that related to QP determinations. The first change, which we finalized, was an update to the QP thresholds, which reflect those thresholds stipulated by the Consolidated Appropriations Act of 2024. For everyone's awareness, the thresholds that were updated for the performance year 2024, they are 50% for the payment amount method and 35% for the patient count method. Now the second item which we proposed, but did not finalize, was a change that we put forward which would have calculated QP determinations using covered professional services as a means to identify attribution-eligible beneficiaries. While we received generally supportive comments, we did not finalize this change. If you would like more detail around the current method for calculating threshold scores, I would encourage you to refer to the document that I mentioned earlier, the set of documents that I mentioned earlier. And that wraps it up for me.

So I will hand you off to my wonderful colleague, Danielle.

>>Danielle Drayer, CMS: Thanks, Trevey.

I'm going to talk to you about the APM Performance Pathway and specifically the new APP Plus quality measure set.

Next slide, please.

We finalized with modification the APP Plus quality measure set, a new quality measure set under the APM Performance Pathway that is separate and distinct from the original six-measure APP quality measure set. Quality measures will be incorporated more gradually into the APP Plus quality measure set than originally proposed. When fully expanded, the APP Plus quality measure set will be comprised of 11 measures.

The APP is an optional MIPS reporting and scoring pathway specifically for APM Entities, groups, and MIPS eligible clinicians that participate in MIPS APM. When reporting the APP with respect to the quality performance category, MIPS reporters will generally be able to choose between the original APP Quality Measure Set and the new APP Plus quality measure set. However, beginning with the 2025 performance period, Shared Savings Program ACOs will be required to report the new APP Plus quality measure set. This means that the original APP quality measure set will no longer be available to them.

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This slide lists the six quality measures that will be part of the APP Plus Quality Measure Set in the 2025 performance period. The six quality measures are Diabetes: Glycemic Status Assessment Greater than 9%; Screening for Depression and Follow-Up; Controlling High Blood Pressure; the CAHPS MIPS Survey measure; Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate; and Breast Cancer Screening.

This isn't on the slide, but I want to note that the APP and APP Plus quality measure set will both have six measures in the 2025 performance period. The measures overlap with each other but are not identical. Specifically, the APP Plus quality measure set will not include in 2025 the Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with

Multiple Chronic Conditions measure, but will include the Breast Cancer quality measure, Breast Cancer Screening measure.

Next slide, please.

This slide shows the remaining quality measures that will be phased into the APP Quality Measure Set over time. As you can see, in 2026, we will incorporate the Colorectal Cancer Screening measure and the Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure.

Then in 2027, we will incorporate the Initiation and Engagement of Substance Use Disorder Treatment measure. And finally, we will incorporate the Screening for Social Drivers of Health measure and the Adult Immunization Status measure in 2028, or the performance period that is one year after the eCQM specification becomes available for each respective measure, whichever is later. This means that the Screening for Social Drivers of Health measure and the Adult Immunization Status measure may be incorporated in the same year or in different years, depending on the availability of the eCQM specification for each measure.

And now I'm going to turn it over to Sabrina Ahmed to discuss new Medicare Shared Savings Program policies.

>>Sabrina Ahmed, CMS: Thanks, Danielle. I'll be presenting the next three slides on Shared Savings Program policies.

Next slide, please.

So we finalized that, for the performance year 2025 and subsequent performance years, Shared Savings Program ACOs will be required to report the APP Plus Measures Set and that the existing APP quality measure set will no longer be available for reporting by Shared Savings Program ACOs beginning in performance year 2025.

We finalized with modification the collection types available for Shared Savings Program ACOs supporting the APP Plus quality measure set, specifically we finalized that the eCQM and Medicare CQM collection types will be available for the calendar year 2025 performance period and subsequent performance period. And here we note that the Shared Savings Program ACOs that report eCQMs will be eligible to receive the newly finalized complex organization adjustment that was described in Slide 22.

And we also finalized that the MIPS CQM collection type will be available for two additional years. That's the calendar year 2025 and 2026 performance period, and the MIPS CQMs won't be available to Shared Savings Program ACOs reporting the APP Plus quality measures that beginning in the calendar year 2027 performance period.

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As described earlier in Slide 22, we finalized that beginning with the calendar year 2025 performance period measures newly incorporated into the APP Plus quality measure set and reported using the Medicare CQM collection type, which is available only to Shared Savings Program ACOs, will be scored using flat benchmarks for the measures first two performance periods in MIPS. We also finalized our proposal to extend the Shared Savings Program, eCQM reporting incentive to performance year 2025 and subsequent performance years, and also in order to align the reporting incentive with our policy to make MIPS CQMs available as a collection type for Shared Savings Program ACOs reporting the APP Plus Quality Measure Set for two additional performance years, we also finalized the policy to extend the reporting incentive to ACOs reporting MIPS CQMs in performance years 2025 and 2026.

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Slide 58 provides an overview of the existing Shared Savings Programs quality EUC policy. This is meant to serve as a reminder of the existing quality EUC policy under the Shared Savings Program. So if an ACO is determined to be affected by an EUC during the performance year or the reporting period, then the ACO's health equity adjusted quality performance score is

set to the higher of the ACO's health equity adjusted quality performance score or the 30th -- or the 40th percentile MIPS quality performance category score in order to meet the Shared Savings Program quality performance standard. ACOs that are impacted during the performance year or the reporting period and are unable to report the quality data via the APP will have their health equity adjusted quality performance score set equal to the 40th percentile MIPS quality performance category score.

So this is the end of the Shared Savings Program portion of the presentation. Now I would like to hand it off to Kati Moore.

>>Kati Moore, CMS: Awesome. Thanks, Sabrina. Next slide, please.

Okay. I know we -- wow, we moved pretty quickly. I know that was a lot, a lot of information, but again, I just want to reiterate that we have some resources available on the Resource Library for you to take a look at. I also want to flag, I think I missed this earlier to say, but we also -- the Shared Savings Program team has a really great fact sheet if you're looking for information specific to that program as well as it relates to QPP. So I encourage you to check out that resource as well and then we'll have these slides and the recording posted to our Webinar Library soon. And then we just include here always our Quality Payment Program Service Center. There are some really great agents available to answer questions or get you connected with the right teams to get the help you need.

So with that, I am going to turn it over to our support team to let us know how we're going to do Q&A. We have a good bit of time so if we run out of questions, we might go ahead and let everybody go early, but we'll get to as many as we can.

>>Ketchum: Thanks, Kati. So we're now going to start the Q&A portion of the webinar. As a reminder, you can ask questions using the Q&A box or you can raise your hand to ask a question via the webinar audio and we'll unmute your line. As a reminder, in order to ask a question through the webinar audio, you must have a working microphone.

So we'll get started by taking a look at our written Q&A box. And the first question that we have is for Elizabeth Holland. And the question reads, "Regarding slide 45 reweighting, can you please elaborate on this, the timeline of submission for reweighting needs to be submitted basically by November 1 in the year between the program year and payment year, correct?"

Christian, can you please go to slide 45? And, Elizabeth, I'll let you take the floor.

>>Kati Moore, CMS: Hallie, I think that's -- and I think, Zenobia, I think that was your slide, I think.

>>Elizabeth Holland, CMS: Yeah, I was one who flagged it to answer on live. Though Zenobia is welcome to answer if she would like.

>>Zenobia Rasbury, CMS: Sure. Can you repeat the question?

>>Ketchum: Sure. "Regarding slide 45, reweighting, can you please elaborate on this? The timeline of submission for reweighting needs to be submitted basically by November 1 in the year between the program year and payment year, correct?"

>>Zenobia Rasbury, CMS: Yes, that is correct.

>>Elizabeth Holland, CMS: But also I would add that it's in a very, very limited situation. So this is when your data are not accepted. You delegated your data submission to your third party intermediary, but they didn't submit for you and therefore, you're in a predicament because no data got submitted, so you would be able to apply for this special reweighting after the data submission closes but before the actual MIPS payment year.

>>Ketchum: Thank you both. Our next question is for Kati and it reads, "When will clinicians see if the Automatic EUC policy applied to their eligibility status if they were in one of the FEMA-designated areas?"

>>Kati Moore, CMS: Sure, thanks, Hallie. Yeah, I saw a couple of questions asking this and I know our product team is working on it now, but we'll definitely have it up within the next month, so definitely before the end of the performance year so that people know, going into data submission, what your final eligibility status is.

And then to answer a couple of other questions that I saw people asking. When the measure specification and benchmark information will be available for 2025? So for the measure specifications, for all of our measures will be up by the end of the year. So before the start of the performance year, and then our benchmarks will be available by the end of January 2025. And if folks are wondering the reasoning behind the delay, we've been doing it this way for a couple of years now, and it was really because just the timing between when the measures have finalized and all the specifications and everything that needs to be done with all the different measures to make sure that the benchmarks are accurate. We were, in the years past, we had gotten everything out by the 31, prior to the start of the performance year and then we'd have to, just because of the timing, we'd end up finding different mistakes or things we needed to update in the benchmark files. So it just makes more sense to be able to go out with a little bit more time and have them fully accurate.

>>Lisa Marie Gomez, CMS: And this is Lisa Marie. I just want to elaborate with regard to measure specification. So with regard to eCQM measure specifications, those are actually, for 2025, they're actually available currently right now on the eCQI Resource Center, so you can access those specifications right now. Thank you.

>>Kati Moore, CMS: Yes. Thank you so much, Lisa Marie, for flagging that, yep.

>>Ketchum: Thank you, both. We're now going to turn it over to the phone line. The first question we have is from Anita. Anita, we have unmuted your mic if you'd like to unmute yourself.

>>Attendee: Hi, thank you. I'm actually trying to understand the data completeness percentage. And because we have several different AMRs, but 80% -- I say about 80% of our population are

on *Epic*. Are we still needing to somehow ingest that 20% that are on other EMR in order to comply with that data completeness?

>>Lisa Marie Gomez, CMS: Hi, this is Lisa Marie. I'm actually going to ask Jamie to answer this question, so I'm going to defer the question to Jamie.

>>Jamie Welch, PIMMS: Thanks, Lisa Marie. Hey, Anita, I did respond to you in the chat, and data completeness would be over all available data to your organization. And that's what you would want to take a look at to determine whether -- you know, I'm going to try to say this again. So it's all that data that you have available to you. And maybe we should talk, if you submit a Service Now ticket, we can walk through that as well too. And we can—

>>Attendee: Perfect.

>>Jamie Welch, PIMMS: Yeah. You can request to talk to Jamie Welch, send it over to the PIMMS team.

>>Attendee: Okay. Thank you. Appreciate that.

>>Jamie Welch, PIMMS: No problem. Thanks.

>>Ketchum: All right. Great. Turning back to our Q&A box. Our next question is for Michelle. And the question reads, "Who can opt in for an MVP? Any practice, a certain size practice, do registries such as AAO, IRIS, work with MVPs, or only MIPS?"

>>Michelle Peterman, CMS: Yeah, sure. For that one, any MIPS-eligible clinician group can choose to report an MVP that includes measures applicable to the clinician or group. So reporting of MVPs require four quality measures, one of which must be a high priority or outcome measure. If you are a small practice, you're only required to report the claims-based measures included in the MVP. And we do work with QCDRs and can select to support MVPs

that are reflective of the scope of care for the clinicians they support. So we're always happy to work with QCDRs and get as many of those measures in that we can. So, thank you.

>>Ketchum: Thank you. Back to the phone line. Our next question is from Jeanie. Jeanie, we have unmuted your line if you'd like to unmute yourself. Jeanie, are you on the line? All right. In the interest of time, we'll move along. The next question on the line is from Alexandra. Alexandra, we have unmuted your line if you'd like to unmute yourselves.

>>Attendee: Hi, can you hear me?

>>Ketchum: Yes.

>>Attendee: I had a question specifically about the tobacco measure screening for tobacco and, well, doing that cessation intervention, are you able to answer that question?

>>Ketchum: We can certainly try.

>>Attendee: Okay. It's mostly about vaping use, so the measure specification doesn't have any guidance or like the workflow of like vaping, is vaping included in that?

>>Kati Moore, CMS: What measure number you're referring to?

>>Attendee: 138 eCQM and then MIPS CQM 226.

>>Kati Moore, CMS: Okay. Lisa Marie or PIMMS team, is this one you guys can take or do we need to follow up offline?

>>Deb Kaldenberg, PIMMS: We may be able to get back to that one. I think folks are trying to just take a real quick look at the measure specification to ensure that we provide the appropriate response. So, if you want to move on and we'll let you know if we can come back to it. Thank you.

>>Attendee: Okay, thank you.

>>Kati Moore, CMS: Thanks, Deb. Yeah, Alexandra, we'll try and get back to you. And if we don't get to on the call today, we can circle back with you over email.

>>Ketchum: Great. Our next question is asking about the diabetes measure title. Danielle, I believe this question was for you if you would like to go ahead and provide an answer.

>>Danielle Drayer, CMS: Sure. I just want to thank the commenter for pointing that out. We are aware that the title was inadvertently not updated in Table 39 and we'll be issuing a technical correction. That's it.

>>Ketchum: Thank you. Our next question on the line is from Connie. Connie, we have unmuted your line if you'd like to unmute yourself.

>>Attendee: Are you able to hear me?

>>Ketchum: Yep.

>>Attendee: Perfect. We are currently a hospital who reports traditional MIPS as a group and I'm having conversations on the progression to MVPs. I know, and I saw in the questions that it was listed as, you know, the purpose and the answer is to ease the reporting burden. And I'm having a hard time wrapping my brain around that we currently report 110 with six measures and the IA, PI, and cost. And we're going to be moving to dozens of subsections where we're reporting for measures for group and their IA and I'm having a hard time understanding how that's easing the reporting burden for us. So I'm just trying to get a little bit more understanding.

>>Michelle Peterman, CMS: I can start us off a little bit on the MVP piece. So currently you're required to report six in traditional MIPS quality measures and in MVPs, it's only four. And so, that is a reduction right there in burden. Also grouping of the -- you know, for the

subgroups, grouping people in similar and like groups will make it easier to report things that are applicable to your practice rather than just reporting, you know, a measure that really is not applying to every single person in the group. So that's part of it. Also, in the MVP, we organize them and put all of the quality measures that are, you know, for like things to gather under certain conditions, which is also easy in the reporting burden so you're not looking through hundreds of measures. That's another piece of it that is easing it. I don't know if that's helpful. But I don't know if anybody else, Jamie or anyone else would like to jump in, feel free.

>>Attendee: Can you still hear me?

>>Michelle Peterman, CMS: Yes.

>>Attendee: Yes, I work in quality. So we report everyone's, and so it's more us organizing multiple groups. So it's not, you know, pulmonology submitting theirs and cardiology submitting theirs. I think that's where my confusion comes from is that it's actually now more, it might be four for that subgroup, but with all subgroups reporting, it's more than the six.

>>Michelle Peterman, CMS: Our goal and that is to try to get like people reporting like measures so that we can compare them better and have better data so that you're not being compared against another clinician that's nothing like you at all, right? Like, it's so that it would be a better, fairer comparison.

>>Attendee: Okay. I have to try to explain this and it's hard to wrap my brain around it.

>>Michelle Peterman, CMS: Yeah. I understand.

>>Ketchum: Thank you. Excuse me, thank you. I believe we have an update on the vaping question. So Amy, if you would like to unmute your line and provide that answer.

>>Amy Dushane, PIMMS: Hello, can you hear me okay?

>>Ketchum: Yes.

>>Amy Dushane, PIMMS: Yep. In the definitions for the posted measures, the 2024 measure specifications, they do have vaping as indicated as tobacco use.

>>Ketchum: Thank you, Amy.

>>Amy Dushane, PIMMS: Yep.

>>Ketchum: Our next question is for Trevey. And the question reads, "As the guide program on MIPS APM, we are on the guide new track. Do we need to continue to report on Interoperability and improvement activities?" Trevey?

>>Trevey Davis, CMS: Thanks. So to answer the first portion of this, there was sort of the first question here is guide at MIPS APM. The answer to that question is yes for 2024. We annually, we put out a comprehensive list of APMs, which indicates each APM's MIPS APM status as well as its Advanced APM status. We plan to publish the list for 2025 in the coming month. And so, expect that on the Resource Library for those who are tracking. So that answers the first portion.

The second portion with regard to PI and improvement activity reporting. So MIPS APM status wouldn't change the PI requirements. Though for those participating through the APP, you would receive full credit for the improvement activities category. So it sort of depends on where you're tracking your MIPS eligibility to. But that is to say, for that last portion, yes, the requirements of PI and improvement activities still apply.

>>Ketchum: Thank you, Trevey. Our next question on the line is from Jennifer. Jennifer, we have unmuted your line if you'd like to unmute yourself.

>>Attendee: Hi, thanks. I had a question about something I saw in the chat. It says that for MSSP purposes of complying with the new CEHRT requirements for 2025, even if you qualify

for an exception or an exemption, you still have to be on CEHRT. Is that correct? Can you confirm my understanding?

>>Kati Moore, CMS: Elizabeth, do you want to try and end on this one?

>>Elizabeth Holland, CMS: I will think. Can you clarify the question, please? You qualified for reweighting and you're asking whether you still need to --

>>Attendee: No. No. So for purposes of the MSSP CEHRT requirements that are changing in 2025, if a practice meets an exception from PI, it was my understanding that then they did not have to be on CEHRT, but in the chat, somebody answered the question saying they would still need to be on CEHRT, they are just accepted from actually reporting PI. Is that correct?

>>Elizabeth Holland, CMS: No, because the PIs -- yeah, you wouldn't have to have CEHRT. Ideally, you someday should have it, so you're interoperable. But if you don't have to report PI, you do not need CEHRT.

>>Attendee: Thank you. That was my understanding. So, someone might want to fix that in the chat. Thanks.

>>Ketchum: Thank you. Our next question is from Rachel. Rachel, we have unmuted your line if you'd like to unmute yourself.

>>Attendee: Hello, can you hear me?

>>Ketchum: Yes.

>>Attendee: Hi, I just had a question. I believe it was on slide number 45 where the new requirement is that you're not penalized if the company or the vendor who was supposed to submit on your behalf does not do so. We run into often the scenario where we have two systems, for example, two registries or two EHRs that are not compatible and are not able to

combine data to create a full reporting year. Does that new stipulation and flexibility also cover that scenario?

>>Julie Johnson, CMS: If you have two different EHRs you're supposed to add the data together to submit it.

>>Attendee: Correct. But if we have hired two registries in order to compile our data and they are not able to submit a full reporting year because they have run into technical difficulties, does that new leniency cover that scenario?

>>Zenobia Rasbury, CMS: I believe that would depend on the circumstances regarding this issue. If this was identified after the submission window and this was an issue that was unknown, and there would be recourse for us to reweight. However, it sounds like this is something that's standing and needs to be a system put in place.

>>Attendee: Great. Thank you.

>>Kati Moore, CMS: Yeah, and to give an example, if, you know, EHR or somebody you've been working with and then they go out of business and we'll give you the data, some kind of more extreme circumstances like that, where you have, you know, no way as a clinician or practice able to get the data from this third party.

>>Attendee: Correct. Or more commonly, we have one system that's extremely outdated and we're trying to help with it get upgraded to a compliant system that cannot interface with the previous system's data. Thanks, that's helpful.

>>Ketchum: So, as a reminder, you can go ahead and type any questions you may have into the Q&A box. Additionally, you can raise your hand to ask your question over the line and we will unmute your line and allow you to ask your question out loud. So on the line now we see Sharon with the question. Sharon, we've unmuted your line if you'd like to unmute yourself.

>>Attendee: Yes, I just want clarification on the CEHRT requirements. It's my understanding for PI, you need it for the full 180 days. Otherwise, you need to be on CEHRT for the submission of eCQMs by the last day of the performance year or before the submission begins. But for MIPS CQMs for quality, it is not required. Can you confirm that that is correct?

>>Elizabeth Holland, CMS: MIPS eCQMs need to be reported using CEHRT, but there are many CQMs that are different collection types that do not require CEHRT.

>>Attendee: So the eCQMs require CEHRT end-to-end?

>>Elizabeth Holland, CMS: Yes.

>>Attendee: Okay. I just want to -- I heard you say that other than PI, you don't need it, so I just wanted to clarify that for the eCQMs, the electronic CQMs, you do need to be on CEHRT by the last day of the performance period before submission.

>>Elizabeth Holland, CMS: Yes.

>>Attendee: Thank you.

>>Kati Moore, CMS: Hallie, do we have anybody else with their hand up?

>>Ketchum: Oh, I'm so sorry. So we -- yes, so our next question was asking how to submit a ticket if you need help. If you need help, you can submit a ticket via the QPP Service Center or you can send an email or call the number, and we will put all of those in the chat again for reference. The next question that we have is from Karen. Karen, we have unmuted your line if you'd like to unmute yourself.

>>Attendee: Hi, thank you. Just to expand on one of the earlier questions, just want to make sure we have the -- I'm going back through your questions and seeing if you edit the answer, we just want to make sure we have it correct. So with the new MIPS PI CEHRT requirement for

MSSP, for PY25, even if you're not an advanced APM, let's say you're MIPS APM, if a practice, let's say, is exempt from PI, let's say due to a small practice, are you saying that for PY25, they do not need to be on CEHRT for the purpose of that PI requirement for MIPS that goes into effect next year? So if there's a paper-based office, for instance, that's a small practice, will they need to be on CEHRT for PY25? We just want to make sure we're clear on that for any paper-based offices. Thank you.

>>Elizabeth Holland, CMS: Yes, that is my understanding.

>>Attendee: Thank you.

>>Ketchum: Great. It's questions just asking to take another look at slide 15. So, Christian, can you please go back to slide 15?

>>Zoom: This is slide 15.

>>Ketchum: Okay, thank you. And the next question.

>>Kati Moore, CMS: Is this the slide?

>>Ketchum: This is.

>>Kati Moore, CMS: Oh, there we go. Okay. Yeah, that makes more sense.

>>Ketchum: The next question we have on the line is from Lori. Lori, we have unmuted your line if you'd like to unmute yourself. Lori, are you there? Okay. In the interest time, we'll move along. Danielle, we have unmuted your line if you'd like to unmute yourself.

>>Attendee: Hi, yes. I work with an EMR that's a Qualified Registry. I'd like them to add one of the new measures that was just released in the Final Rule. Is there a deadline when they have to like nominate to do that?

>>Kati Moore, CMS: So you're looking for the self-nomination period, the deadline for 2025?

>>Attendee: Yes. Yes.

>>Trevey Davis, CMS: They should send it in as soon as they as they can.

>>Attendee: There's no hard deadline?

>>Trevey Davis, CMS: There is a hard deadline. I don't have it at my fingertips, but if they send it in between now and the middle of December, they should be fine.

>>Attendee: Okay. Thank you.

>>Trevey Davis, CMS: You're welcome.

>>Ketchum: All right. Thank you, everyone. That's going to conclude our Q&A for today. So, I'll turn it back to Kati Moore to conclude the call.

>>Kati Moore, CMS Okay, thanks, Hallie. Thanks, everybody, for joining today and for all of your great questions and discussion. Again, feel free to reach out to us if you have any additional questions or we weren't able to get to your information today. We'd be happy to answer your questions. Thank you all so much and have a great day.