Overview of Medicare Shared Savings Program (MSSP) and Quality Payment Program (QPP) Interactions for Year 2 (Performance Year 2018) Webinar
December 11, 2018

Hello, everyone. Thank you for joining today's Overview of Medicare Shared Savings Program and Quality Payment Program Interactions for Year 2, Performance Year 2018 Webinar. The purpose of this webinar is to review the interactions between the Medicare Shared Savings Program and the year 2, 2018, of the Quality Payment Program. Now, I will turn it over to Adam Richards the Health Insurance Specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead, sir.

Okay, well, thank you, and welcome, everyone, to today's webinar. I do want to start by thanking each of you for being here today and also for your flexibility, as I know this is a rescheduled date. We appreciate you all bearing with us, and I personally believe that you are in store for an excellent discussion on how the Medicare Shared Savings Program interacts with the Quality Payment Program, especially for year 2, which is 2018. Now, we've heard from many of you and maybe even all of you on the line that this is a much needed area of focus. And while we have an excellent interactions guide, which I encourage you all to review, we believe that today's webinar is a great opportunity to learn some of the nuance that may not be reflected in our current resources, as well as post questions to our subject-matter experts. I do want to note, before we get started, and I'll say this again a little later on, so apologies up front, but we are not going to cover anything related to the Shared Savings Program Pathways Final Rule. So please just table those questions for the time being, and let's just focus on the Shared Savings Program in year 2. Okay? Charging forward to slide 3. Okay, so, very quickly, our topics for discussion today. We -- again, as I mentioned, we have a number of subject matter experts here with us from different areas of the agency. We'll start with Dr. Corey Henderson from our Center for Medicare/Medicaid Innovation who will discuss the Advanced APM side of the Quality Payment Program. Rabia Khan from our Center for Medicare will cover the general SSP interactions within the Quality Payment Program. We also have Brittany LaCouture, also from our Center for Medicare and Medicaid Innovation, who will discuss the APM scoring standard for Shared Savings participants -- Shared Savings Program participants. And then we'll wrap up, just to discuss some important upcoming calendar reminders as well as some of the resources for you all as you work through the remainder of 2018 and certainly start to prepare for the 2019 performance year. So, again, we have a lot of ground to cover, so I'm going to move us on to the next slide and introduce Dr. Corey Henderson to discuss the advanced APM side of the Quality Payment Program. Corey?

Good afternoon, everyone. So that we can move as quickly as possible, I will talk in a fashion that you can understand but move a little quicker through the slides so that we can get to the meat of this conversation. Many of you already are familiar with the Quality Payment Program, so I'm going to just do a cursory overview for you. We go to the next slide, that's slide 5, where we currently are. We're going to talk a little bit about the Quality Payment Program from the perspective of the Alternative Payment Models. What you see here is an overview that kind of shows you that there are two pathways for the Quality Payment Program. That's going to be MIPS and Advanced APMs. Go to the next slide, please. So, here, to get down to the legal of how we got to Alternative Payment Models, and this is just a quick overview so that when you see the slides later, you'll have an understanding of the true definition in policy behind Alternative Payment

Models. And since this is the Shared Savings Program, we do want to acknowledge that the Medicare Shared Savings Program was established in the Affordable Care Act to promote accountability for a patient population, improve care coordination, and encourage investment in infrastructure and redesigned care processes. And you'll find, under this policy here in MACRA, that APMs include CMS Innovation Center models under section 1115A of the Social Security Act other than a Health Care Innovation Award, the Shared Savings Program, demonstrations under the Health Care Quality Demonstration Program, and also demonstrations required by federal law. Next slide, please. Also, just wanted to touch on the fact that Alternative Payment Models are a different approach. They are a payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care. They can apply to specific conditions, care episodes, or populations, and specifically, MIPS APMs may offer significant opportunities for eligible clinicians who are not ready to participate in advanced APMs. Next slide, please. So, as I said before, I just wanted to touch on some of the key things here. And the Advanced APMs, it's good just to take a look at this graphic here, because you get to see how APMs is one category and under that are subset of Advanced APMs and MIPS APMs. When we look at Advanced APMs, clinicians and practices can receive greater rewards for taking on some risk related to patient outcomes. Advanced APMs specifically require participants to use Certified EHR Technology, they base payment on covered professional services on Quality measures comparable to those in MIPS, their entities bear more than nominal financial risk or an APM is a Medical Home Model expanded under Innovation Center authority. In addition to that, these model examples are the Shared Savings Program Tracks 2 and 3 and also the Medicare ACO Track 1+ model. Next slide, please. Under Advanced APMs, you'll find that there is a qualification that we call the Qualifying APM Participant, or the QP, you'll find. If you see the terminology or the abbreviation "QP," that is nothing more than the Qualifying APM Participant. That is an eligible clinician who achieved threshold values or levels of participation in advanced APMs. That level and threshold for 2018 performance period was 25% of Part B payments for covered professional services or they did 20% of patients through an Advanced APM. Next slide, please. This slide here goes to the QP Performance Period. It's good to note that there are three key snapshot dates that we're looking at between January 1st and August 31st, and those key snapshot dates are March 31st, June 30th, and August 31st, and we're taking a snapshot of your participation and looking for that threshold to be met or exceeded. If you meet QP status, you get the 5% incentive payment, which is determined using your Part B payments for covered professional services in the year prior to the payment year. And you'll see here with the graph, you have the QP Performance Period, the Incentive Payment Base Period, and then the payment year. So, for instance, in this graphic, you have 2018 QP Performance Period, 2019 Incentive Payment Base Period, and then 2020 payment year. Next slide. As we touched on briefly in the previous slide, some of the benefits of being a QP, which means you participate in an Advanced APM and exceed the thresholds, are one, you are excluded from the MIPS program and specific MIPS reporting -- there may be some, but specifically you are excluded from the overall program -- receive a 5% incentive payment, and that is per payment year through 2024. And then we also receive a higher Physician Fee Schedule update starting 2026 for those who are determined to be QPs. Next slide, please. So, moving right along, we have two more slides before we get to the meat. Just wanted to give you a background. The MIPS APMs are streamlined MIPS reporting and scoring for eligible clinicians in certain APMs. As the graphic shows, again, there's a subset under the APM. The APM scoring standard offers a special, minimally burdensome way of participating in MIPS for eligible

clinicians in certain APMs. The APM Entity, also known as the ACO or the APM Entity level, offers a Quality performance attribute delivered down to the MIPS eligible clinicians in that APM Entity. So, what we're talking about here is, all eligible clinicians in an APM Entity receive the same MIPS final score. One example of that is the Shared Savings Program Track 1, which is a MIPS APM. And then the final slide in the overview, and this is -- waiting for the graphic to come up. And as this graphic comes up, you'll note that this is the overview that kind of shows you how the ACO structure is laid out for you. You have the ACO -- or the APM Entity, as we just defined -- you have the Group TIN or the participant TIN, as we call it, and that participant TIN may have NPIs under it, and those NPIs will be the eligible clinicians. Under those participant TINs, there could be a TIN that has only one NPI in it, so that's the other variation in this graph is that the TIN does not always have to have many or multiple NPIs. It could be one. And I will now pass it over to Rabia Khan who will go into the presentation on the overview of Medicare Shared Savings Program.

All right. Thanks, Corey. Slide 15, please. All right. So, the Shared Savings Program is a type of APM that offers providers and suppliers the opportunity to work together through a new type of healthcare entity -- through Accountable Care Organization or ACO. It aims to promote accountability for patient population, coordinate items and services for Medicare fee-for-service beneficiaries, encourage investment in high-quality and efficient services delivery. Under the program, ACOs agree to be held accountable for the quality, cost, and overall care for an assigned population of Medicare fee-for-service beneficiaries. In order to share in savings, ACOs must meet the Shared Savings Program quality performance standard. For the 2018 performance year, we have 561 ACOs in the Shared Savings Pro-- Shared Savings Program who are providing care to 10.5 million Medicare beneficiaries. Slide 16. So, there are several participation tracks under the Shared Savings Program and the Medicare ACO Track 1+ model that allows ACOs to select an arrangement that makes the most sense to their organization. Participation in the Quality Payment Program depends on the track in which the ACO is participating. The ACOs participating in Track 1 meet the criteria of a MIPS APM. The MIPS eligible clinicians who are participating in the ACO are subject to MIPS and are scored under the APM Scoring Standard, while ACOs in the Track 1+ model, Track 2, and Track 3 of the Shared Savings Program meet the Advanced APM criteria. Therefore, participating eligible clinicians who are determined to be QPs are exempt from MIPS and will receive the Advanced APM incentive payment. MIPS eligible clinicians who do not attain the QP status will be scored under the APM Scoring Standard. This also includes clinicians who are participating in the ACO and joined after the third snapshot. And we'll review more of that in the next slide. Slide 17, please. To be considered as part of the ACO track for purposes of the APM Scoring Standard, an eligible clinician must be on the APM Participation List on at least one of the below four snapshot dates of the performance period. Otherwise, an eligible clinician is subject to the generally applicable MIPS standards. As shown on this slide, the four snapshots are March 31st, June 30th, August 31st, and December 31st. The December 31st snapshot was added for the 2018 performance year and subsequent years. It's an opportunity to allow eligible clinicians who join an ACO between September 1st and December 31st to benefit from the APM Scoring Standard. When it comes to QP determination for advanced APM tracks -- which again are Tracks 2, 3, and the 1+ model -- eligible clinicians must be on the APM Participation List on at least one of the three QP determination snapshot dates during the QP performance period. The three snapshots are March 31st, June 30th, and August 31st. There are no QP

determinations based on the fourth snapshot. Eligible clinicians who do not meet QP standards or join an ACO between September 1st and December 31st will still benefit from the APM Scoring Standard. Next slide, please. And now, we'll take a look at how ACO participation is determined for the eligible clinicians. As a part of the Shared Savings Program, ACOs must certify their ACO participant list before the performance year begins. At each of the snapshot dates, we identify eligible clinicians participating in each ACO using the certified ACO participant list and the data available in the Medicare Provider Enrollment, Chain, and Ownership System, otherwise known as PECOS. Additional clinicians are identified using Medicare claims, but it is important to note that clinicians should maintain that their information is current in PECOS because that is a source for identifying the clinicians who are part of the ACO for purposes of the APM Scoring Standard and QP determination. The QPP Participation Look Up Tool on the QPP website is where you can go to check your QPP participation status for clinicians. Please note that it is updated approximately four months after each snapshot date to reflect the APM participation and QP status. And again, the QP determinations are made only using the first three snapshot dates. Next slide, please. All right. So, another key I have to cover is the low-volume threshold. So, clinicians or groups who bill less than $90,000 in covered professional services under the Medicare Physician Fee Schedule or furnishing covered professional services to less than or equal to 200 beneficiaries are exempt from MIPS because they are below the low-volume threshold. However, for clinicians in an ACO, the low-volume threshold is determined at the ACO level. This means that even if clinicians or physician groups are at or below the low-volume threshold, if they bill through the TIN of an ACO participant or if the physician group is an ACO participant, they will be subject to MIPS if the ACO exceeds the low-volume threshold. And it is rare than an ACO does not exceed the low-volume threshold. All right. Next slide. All right, now I'll be handing it over to Britany LaCouture.

Thanks, Rabia. So, I will be presenting on the APM Scoring Standard, particularly on the payment adjustment calculations and applicable bonus points. Next slide. In 2018, under the APM Scoring Standard, MIPS eligible clinicians in SSP ACOs who report Quality — so these are participants in SSP Track 1 or those who did not receive QP status -- they will be scored on the four MIPS performance categories according to the following weights. Quality will be 50%, the Improvement Activities category will be 20%, Promoting Interoperability will be set at 30%, and Cost will remain at 0%. The Quality performance category will be based on your reporting to SSP on your SSP Web Interface measures, and beginning in 2018, we will also be scoring you on your CAHPS for ACO Quality measures that you or that your ACO will have reported to SSP. Next slide. For MIPS eligible clinicians and SSP ACOs where the ACO does not successfully report on their Quality performance category, the participant TIN in that SSP ACO may report Quality instead, and in that case, scoring for the TIN under the APM Scoring Standard will fall to the TIN level. Rather than being scored as an ACO, you will be scored at the participant TIN level. And those participant TINs may report only at the participant TIN level using any MIPS group scoring method that's available. So, that means that you may report using QCDR, EHR, CAHPS for MIPS, Web Interface -- if your TIN has registered for the Web Interface -- and solo practitioners where the TIN is comprised of only one NPI may report using claims measures as well. The IA, PI, and cost performance categories will not have any changes. Next slide, please. So, in the case where the ACO's agreement with SSP is terminated on or after March 31st, which is the first snapshot date for the 2018 performance year, the eligible clinicians in that

ACO are still subject to the APM Scoring Standard. The rules for MIPS Quality reporting, PI reporting, will remain the same. If your ACO still reports to SSP, we will still score you at the ACO level. If the ACO fails to successfully report Quality, then scoring will fall to the participant TIN level, as discussed in the previous slide, and you'll be scored at that level but still under the APM Scoring Standard. If the agreement is terminated before our first snapshot date of March 31st of the performance year, the eligible clinicians will not be considered participants in an APM, they will not be scored with the ACO, they will not receive the APM Scoring Standard, and they will just be treated as regular MIPS-eligible clinicians. Oh, next slide. In an Advanced APM, if -- which is going to be Track 1+, Track 2, and Track 3 of SSP -- if the agreement is terminated after March 31st but before August 31st of the performance year, the eligible clinicians will lose their QP status and become MIPS eligible clinicians, but they will still be scored under the APM Scoring Standard, meaning that they will still have the Cost performance category weighted to 0% and they will receive all the other benefits of being scored under the APM Scoring Standard. If the agreement is terminated after August 31st of the performance year, however, the eligible clinicians will maintain their QP status, and they will not need to report to MIPS. They won't be MIPS eligible clinicians unless there are any eligible clinicians in that ACO who have not achieved QP status, in which case they will still be scored under the APM Scoring Standard. Next slide. So, the Quality performance category. Next slide. Under the APM Scoring Standard, we will score the Quality measures that are required to be reported under the terms of the Shared Savings Program for purposes of MIPS. That means that the ACOs in SSP must report the CMS Web Interface measures and the CAHPS for ACO Quality measures required by that program. The performance on these measures will be used -- will be determined using Shared Savings Program benchmarks, and we will assign MIPS point values to those measures according to the requirements of the APM Scoring Standard, which you should have a link in front of you. You can click on that, and it will go into much, much more detail on how those point values are assigned. For 2018, there will be 15 CMS Web Interface measures, however, we'll only be scoring on 11 of them, because two of the measures, are actually part of the same diabetes composite measure. And there are three Web Interface measures in 2018 that don't have benchmarks available, and so we won't be able to score those either. The measures that are eligible to be included in calculating the score will all have a benchmark available and a denominator with a case size that is equal to or greater than 20 cases. And in the CAHPS for ACO survey, we are only counting this as a single measure for the MIPS Quality performance category, meaning that the seven CAHPS Quality measures that have benchmarks will be averaged together to create a single measure score. Next slide. Bonus points. So, participants in SSP will be eligible to receive MIPS bonus points, including reporting on high-priority measures, end-to-end CEHRT use, and bonus points for participating in a small practice, which, under the APM Scoring Standard is determined at the APM entity or the ACO level, meaning that the small practice is the ACO, not your TIN or other practice level numbers. Bonus points are capped at 10% of the total Quality score denominator, and as you can see, in the chart provided, it shows the maximum number of bonus points that are available for Quality performance category. Next slide. Beginning in 2018, ACOs can also earn, a Quality improvement score, and this is awarded based on the percent increase from the previous year's performance score. So, if the ACO did not report in the 2017 performance year or if you're new to the Shared Savings Program, then the ACO Level Quality Improvement percent score will be calculated by averaging the 2017 performance year individual and group Quality performance scores for all the ACO participants in the new ACO. The

Quality improvement percent, however, cannot be less than 0 or greater than 10. Next slide. On to performance -- Improvement Activities performance category. Next slide. So, certain APMs, like the Shared Savings Program, assign or hold their participants accountable for the cost and quality of care. And therefore, CMS assigns, um, the Improvement Activities performance category score for these APMs by reviewing the participation agreement of the entire APM or their governing regulation, which is the case in SSP, to determine which Improvement Activities are required as part of participation in the APM rather than requiring all of our participants to report on these, activities individually. We have already looked at the Shared Savings Program and determined that, based on the requirements of participation in SSP, all of the ACOs in the program exceed the requirements for the MIPS Improvement Activities performance category and therefore will be assigned, a full score of 40 points or 100% for that quality -- or for that IA performance category. Therefore, you won't need to submit any additional information for that category to get a perfect score. Next slide. The PI -- or Promoting Interoperability category. Next slide. So, ACO participants in SSP must report on the PI performance category at the TIN level, meaning we will not accept scores at the NPI level for SSP participants. These participant TIN-level scores will then be aggregated up to the ACO entity level, they will be weighted according to the number of NPIs in the TIN, and we will use that, calculation to create an ACO-level score for the PI performance category which will then be applied to all eligible clinicians in that ACO. The available submission methods for this performance category are EHR, QCDR, Registry, or the QPP Portal. For purposes of the Shared Savings Program ACO-11 quality measure, which is required even for QPs, the ACO participant TIN must report the PI performance category regardless of whether they meet the QP threshold or not. This measure is pay-for-reporting in 2018, and to meet this complete reporting requirement, at least one eligible clinician in the ACO must meet the PI base score, which is the numerator of ACO-11. ACOs that do not meet the complete reporting requirement under SSP will not meet the quality performance standard and will be ineligible to share in savings or will be liable for the maximum percent of losses under the applicable track. Next slide. Each ACO participant TIN will receive a PI score for its submission. That score is the sum of the base score, which is 50%, their performance score, which will bring them up to 90%, and the bonus score, which could be up to 25%. So, it is actually possible to earn a score of 165%. However, we will cap it at 100%. Qualifying to have the PI performance category re-weighted, such as the hardship exception or other special status, is at the group of eligible clinician level but does not re-weight the performance category at the ACO level. If the PI performance category is re-weighted for all TINs within the ACO, then the PI performance category will be re-weighted for the entire ACO. Next slide. Each ACO participant TIN submission is aggregated and weighted according to the number of MIPS eligible clinicians in the participant TIN, and again, this is used to create the ACO-level PI score. The chart and calculation that you have in front of you provides an example that helps explain not only how we aggregate the score, but also what happens in the case -- if you look at Row "C" -- where you have a TIN that has been excepted from PI reporting for some reason. Next slide. And finally, the Cost performance category. Next slide. MIPS APMs that tie payments to performance, such as the Shared Savings Program, have the Cost performance category waived in order to better align the incentives of QPP with those of the APM. Therefore, clinicians participating in the Shared Savings Program will not be scored on the Cost performance category under the APM scoring standard. Because of this, no reporting is necessary. And next slide. Bonus points. Next slide. So, went over this a little bit, but

in more detail, the small-practice bonus, which is available for small practices of 15 or fewer clinicians that submit data for at least one performance category -- in this case, it would be quality, PI. You don't really submit anything for IA since that score is automatically assigned. These small practices will automatically receive 5 points added to their final score. For small practices in an ACO, the practice size is determined at the ACO level, not the practice level. Keep that in mind. The complex patient bonus is another bonus available up to 5 points for providing care to complex patients based on medical complexity. This is measured by the HCC risk score and a score based on the percentage of dual eligible beneficiaries treated under the ACO. And again, this bonus is also determined at the ACO level. Like the small practice bonus, data must be submitted for at least one performance category in order to earn this bonus. Next slide. Final score calculation. So, in calculating the final score, again, the Quality performance category is worth 50% of your total score, the Improvement Activities performance category is worth 20% of your final score, and the PI performance category is worth 30% of your final score. Then we add in any available bonus points which should add up to a final score of up to 100 points, keeping in mind that the final score is capped at 100. Next slide. And I will hand this off to Adam.

Okay. Well, thank you, Brittany, and thank you Corey and Rabia as well, for walking through all of that content. We are going to talk a little bit about some key dates for you and some resources, and then we'll get into -- open it up for Q&A, because I know a lot of you do have questions. You've sent us some really great questions in the Q&A chat itself, and we're trying to work through those. So, bear with us, and we'll keep working through them. I'm on the next slide. Just want to talk a little bit about some key dates, for you all to consider as we move, certainly through the end of the year and into the submission period that will be begin, next year, January 2nd. So, just a couple things to keep in mind. So, the Promoting Interoperability submission period -- this is part of the general MIPS submission period -- runs from January 2nd to April 2nd next year, 2019, where clinicians will have the opportunity to submit their performance data to us. Along that same vein, the CMS Web Interface test period opens on January 7th, and that will run until January 18, 2019, so that might be another key date that you want to mark on your calendars. As soon as we close the Web Interface test period, shortly thereafter, we will open the Web Interface submission period on January 22, 2019. We'll open that up early in the morning -- 8:00 here on East Coast time -- and that will run until March 22, 2019, and it will close at 8:00 P.M. Eastern time. So, please note those dates and times. Again, as it were last year, the Web Interface submission period is a little shorter than our normal MIPS submission period, so please just keep that in mind as you're preparing for the submission period next year. Okay, moving on to the next slide. Just talk a little bit about some of the resources that we have available. Again, earlier, I mentioned that we do have the Shared Savings Program and MIPS Interaction Guide available. All of these resources are, of course, available on our resource library on qpp.cms.gov. We have migrated that back over to the Quality Payment Program website, um, so it really is a one-stop shop for all resources related to Shared Savings Program and Quality Payment Program. So please check those out if you haven't done so already. I'll also flag for you just a couple other things that you'll find on qpp.cms.gov under the Alternative Payment Models. For MIPS APMs, we have the 2018 MIPS Participation & Overview guide available, scoring for Improvement Activities under MIPS APMs, and Quality scoring for APMs. I highly recommend checking out those resources from the MIPS APM side. And then for Advanced APMs, encourage you all to look at the QP Methodology Face

Sheet, which is also available. Of course, if you do have questions, and we are seeing a couple questions come in on the Promoting Interoperability performance category, also highly recommend checking out that specific fact sheet on qpp.cms.gov as well. So, that's everything under the qpp.cms.gov, the Quality Payment Program website. I'll also note, and we recently launched these in the last few days, I believe, we have new APM -- Alternative Payment Model -- pages on qpp.cms.gov, specifically for MIPS APMs, advanced APMs, and the All-Payer Combination Options. So, if you haven't been on the site lately, a lot of new and exciting things are going on there. Aside from the Quality Payment Program resource, I'll also note the very top resource, first on the page, the Shared Savings Program 2018 and 2019 Quality measure benchmarks are available on cms.gov on that following link. I won't read it out to you, but when the slides do become available, you'll be able to click through to all of these resources. And then, finally moving on to the next slide just to talk a little bit about technical assistance. I know we do have some of our technical assistance folks on the line with us today, which is really fantastic. But again, for those of you who are included in Quality Payment Program, MIPS eligible clinicians, and need some assistance, highly recommend reaching out to one of our technical assistance networks. This is free support for anyone who is included in the program, and we have a number of different networks that are available to help you based on practice size, need, so on and so forth. I anticipate many will probably be either be working with our large practices, the Quality Innovation Networks, or maybe even our Small, Underserved, and Rural Support Initiative. You can get some really great, resources, feedback, help in preparing for the, well, at least finishing out 2018 strong, preparing for submission, and certainly preparing for the 2019 performance period. And of course, we always provide assistance through our Quality Payment Program website, qpp.cms.gov, that we've talked a little bit about earlier as well as our Quality Payment Program service center, and both the phone number and e-mail address for our service center are available on that infographic. Okay. So, charging forward, I think we are going to enter into our open question and answer session. Before I turn it over to the moderator to help us get connected and to give you information on how to call in, I do just want to re-emphasize that, we are not going to address questions related to the Pathways rule, so please table those questions for us. We're going to answer as many questions as we can, so as it relates to the Shared Savings Program and its interaction with the Quality Payment Program in 2018. Please do us a favor and try to limit your question to one per person so we can get through as many questions as possible. And at this point, I'm going to turn it over to the moderator to explain how you can get into the phone queue.

We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via the phone, please dial 1-866-452-7887. Again, the number to dial is 1-866-452-7887. When prompted, please enter the I.D. 3976865. The I.D. again -- 3976965. Once you have joined the conference, please press *1 on your telephone keypad to ask a question. Again, that is *1 on your telephone keypad to ask a question.

Okay, so, while folks are dialing in, just wanted to take the opportunity, we saw a lot of questions in the chat just around the availability of the slides and this recording. So, if you'll all give us about a week or two, we will make sure -- we'll get both the slides, the transcript, and the recording posted to our Quality Payment Program website under our new webinar page, actually. So that'll be available. We'll also make sure that we send that information out to folks just to let you know that this is

available, because I know we covered a lot of good information today. I'm sure a lot of you will most likely want to kind of read through the slides or read -- or view the recording again. So that'll be available in about a week or two. Okay, so, let's take our first caller if we could, please.

Once again, to ask a question, please press * then the number 1 on your telephone keypad. Our first question is from Randi Terry.

Hi, Randi.

Hi. I have a question. When we submit our PI for a MIPS APM, we submit it at a TIN level. How do you know how many NPIs or individual providers that represents? And the reason we ask that is we have providers that have left, we have providers that are PEDs that obviously aren't registered in PECOS. We have providers that are on non-certified EHRs. We have hospital-based, and we have real healthcare providers that, you know, aren't going to show up. And so, whereas you may think we're submitting 100, we may be submitting for 50 or we may be submitting for 150.

Oh, are you on mute?

Nope, we're good.

Just wanted to make sure you could hear me. So, this is Corey Henderson. The concern is that -- just want to repeat back the question. You're submitting for clinicians in your entity and you want to make sure that you're submitting for the correct amount. Is that correct?

Well, we're going to submit as a TIN.

Correct.

And we're going to submit the providers that, you know, are on certified EHRs that are not hospital-based. It includes PEDs. We're not going to submit those that have left during that timeframe. But you will never from anything.

So, just making sure you reconcile your list with our list, is that what you're saying? Reconciling what you know with what we know?

Yeah. It will never match.

Okay. So, the concern is that we do an analysis on each NPI and TIN, and what we're working on is, we're looking at other solutions so that, going into the future, you'll have a way to identify who's under your organization. So that's a tool we're actually working on developing now looking at the specifics around how to do that, so we can make sure on the front end you see that. Because on the back end, we are able to see what was submitted and who's under that organization, and we have that. I see affiliated practitioner and also the, eligible clinician list under that APM entity. But we reconcile those, too. But we will have a system that we're working on -- fingers crossed -- that we're working on trying to be able to show each of the individual clinicians under an organization so that those that have permission to log in can reconcile those lists. So, for now, that's pretty much all I can share. But we do have a system that does check each clinician to see what their status is.

Will that be ready for the 2018 submission? Do you have any idea?

We're not sure yet. That's something that we have in our sandbox of ideas, because we want to make sure we can give you as much visibility as possible. So, I just wanted to kind of put that out there just to say it's something we're working on in trying to meet the needs of the users.

Thank you much.

Again, to ask a question please press * then the number 1 on your telephone keypad. That's * then the number 1.

And folks, just want to make something -- just wanted to call to your attention, we do have a number of our subject matter experts with us in the room and online. If at any point you hear some silence, it's not because we've lost you, so just hang on for a minute. We're just talking over our answers so we want to make sure that we give you the best information possible. So, just bear with us. Okay. Do we have another caller?

Your next question comes from Joanna Lucia.

Hi, Joanna.

Good afternoon. My question is about ACO members when they log on to the QPP website. So, we are a Track 1 ACO, and if the members, log in and they see individual MIPS eligibility and then group MIPS eligibility, did I understand that for exceptions, if the provider is -- has an exception like they're hospital-based, and then they show that they are MIPS excepted, they do not have to report PI? Does that -- Is that true?

I can take that question. That is very close to being accurate. So, the low-volume threshold is calculated under the APM Scoring Standard at the ACO level only. So, if you have a participant TIN or individual eligible clinician who are below the low-volume threshold and are therefore considered not MIPS eligible or otherwise excepted from PI because of that low-volume threshold, we don't look at that. They're still required to report PI because their ACO is above the low-volume threshold. If we're looking at other exceptions from PI reporting, such as extreme or uncontrollable circumstances or other hardships or, a TIN that's non-patient facing, if the entire TIN is excepted from the ACI -- or, I'm sorry, from PI reporting, then that TIN does not need to report that performance category. But that does not mean that the entire ACO will be excepted, only that the TIN is not included in the ACO level calculation.

Right, thank you.

Your next question is from Randi Terry.

I'm sorry. I have another one, and I put it in. We have a question. At the time we signed up for an ACO, we had two TINs that existed, and that was October 1st. On January 1st, those two TINs ceased to exist because they were purchased out by a larger hospital. Should we file for an exemption from submitting the PI because there's nothing to submit because those TINs didn't exist the entire year?

Sorry. This is Rabia. Could you repeat that? I was just trying to follow along to make sure I had that.

Okay, so, October 1st of 2017, we had to tell the ACO whether we were in or out, and at that time, we told them we were in because we didn't know when we would be purchased by a larger hospital. Between October 1st and December 31st, those two TINs were purchased by a larger hospital and then ceased to exist because they were purchased out. So, the ACO was saying we have to submit data for PI, but there's no data to submit because that TIN didn't exist in 2018. And so, our question is, do we just try to apply for an exemption so we don't have to submit PI data for those TINs that don't exist?

I think that -- what we'd like to do is, so that we can make sure we answer the question properly, let's get an e-mail that you can send that response to or, trying to think. Maybe you can --

Yeah, could you send that to the Quality Payment Program Service Center, and I think we'd have to take a deeper dive looking at your specific scenario to make sure we give you the appropriate recommendation.

Well, we did, and they said you had to submit data. So, I mean, I can send it again, but we've already submitted it a couple times. So...

Well, if you can reference that -- this question is from this webinar, then we can have that question pulled or it will be sent to us. But we can get the answer for you. We want to make sure we help you actually submit the right information and not be burdened.

Perfect. I will. Thank you.

Thank you.

We have another question from Dana Pittman.

Hi. Can you hear me?

Yes, we can.

Okay. Thank you for taking the question. I just wanted to know when you guys would update, uh, information around the 2019 criteria for ACOs that are subject to MIPS.

Sure. So, I can take that one. If you have anything to add, Rabia, please do. So, yeah. Since we are working on, the majority of our resources for 2019 right now. We are trying to get as many of those resources out the door by the beginning of the performance period as possible since we do know that, you know, certainly in Quality and Cost for a full year of reporting, like 2018. So, as we begin to roll those materials out in the coming weeks and months, we'll be sure to stay connected with all of you. Highly recommend, if you haven't done so already, to sign up to our listserv on qpp.cms.gov. That's the best way of us communicating all the resources coming out, and that'll kind of keep you updated when they're available.

Thank you. Thanks.

I think we have time for one more question.

We have a follow-up from Joanna.

Hi. Thank you again. This is probably a really quick question. I'm following up on my QPP question earlier. So, if a provider logs in to the QPP website and he's part of our Track 1 ACO and he's looking at his eligibility for whether or not he needs to report PI or not, he needs to look not at the individual eligibility but at the group eligibility, and then that rolls up to the TIN and then some of them roll up to the ACO. Is that correct?

This is Rabia. I can start, and Brittany, feel free to jump in, but yes. So, if they're -- If this is a clinician who is in a Track 1 ACO, would look at the group eligibility related to that, so that TIN, and the TIN would need to report Promoting Interoperability. And then, ultimately, all of the ACO participant TIN scores get aggregated, and weighted to create an ACO level Promoting Interoperability score that all clinicians will get who are participating in the ACO.

That's perfect. We just have a lot of folks who are looking at individual and looking at their exclusions and getting confused. So, I'm trying to guide them the right way, but I wanted to make sure I understood it correctly first. So, thank you.

Okay. Fantastic. Thank you. I know we're at the top of the hour. I know we got started a few minutes late, so we're going to take one more question, if we have anyone available.

Again, press *1 if you should have a question.

Last call.

We do have a question from Brian Jones.

Hi, Brian.

Hi. Thanks. I have a lot of providers in my ACO who are asking about whether the small-practice exception requires other criteria -- other hardships besides being in a small practice. Does it require a separate identifiable hardship outside of being a small practice?

Brittany --

Yeah. So, I think what you're referring to about small-practice exceptions from PI reporting?

That's correct.

Yeah. So, that is an exception that's available under MIPS. However, Rabia, please correct me if I'm wrong. The Shared Savings Program itself outside of QPP requires ACO-11 reporting, and if you don't finish -- complete reporting on that measure, which is actually considered a quality measure, you will have failed reporting under the Quality performance category. So, unless there is some extreme hardship, where you have a TIN that can't report on the PI measure, really, if you're in SSP, that you should still be reporting PI. Does that make sense?

As far as it applies to ACO-11, they have to be reporting PI?

Right. So, even if you have that exception as a small practice from regular MIPS, you're still required to report, for SSP, and it's not an applicable exception under SSP. So, you kind of still need to report it anyway, although if you don't, it won't hurt your PI score, but it will hurt your quality score.

Okay. Okay, I understand that. Thank you very much. That helps.

Okay. Great. Thank you. Well, we're at time, folks, so we are going to wrap up for today. A lot of great questions both in the chat and certainly on phones, so we thank you all for the questions. We thank you for your attendance today. We did see some questions about when we'll have a similar webinar for the 2019 requirements, so I think the content was certainly well-received, and that's great feedback. That's something we can certainly think about as we move into the next performance year. So, again, we'll try to have these slides and recording posted in the next one to two weeks. We'll make sure everyone is aware that those resources are available. Until that point, we thank you all again for joining us, and we'll talk to you again soon.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.