MIPS 101 for the 2019 Performance Year of the Quality Payment Program Webinar
January 24, 2019

Hello, everyone. Thank you for joining today's "MIPS 101 for the 2019 Performance Year of the Quality Payment Program" webinar. The purpose of this webinar is to provide an opportunity for current participants, new clinicians, support staff, and other stakeholders to learn the basics of the Merit-based Incentive Payment System. The presentation will be followed by a Q&A session where attendees will have the opportunity to ask questions. Now I will turn it over to Adam Richards, Health Insurance Specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead.

Hi. Great. Thank you. Greetings, everyone, and thank you all for joining us today. We're excited to kick off our educational webinar series for the 2019 performance year, and we hope that you find this initial topic both interesting and valuable as you all prepare for the upcoming year. Our goal today is really to break down the Merit-based Incentive Payment System -- which we'll call MIPS for the rest of the event today -- which I'm sure the majority of you on the line have heard of in some form, and are eager to learn a little bit more. Full disclosure here, this is a 101-level webinar. Our job today is to really explain some of the key requirements of MIPS in a way that's both palatable and will help you get started. We're not going to deep-dive by any means, because we know that, for many of you, this may be your first experience with MIPS, and we want to be responsive to your needs and expectations. However, with all of that said, we will be hosting some of our more advanced webinars on many of the topics we will cover today in the coming weeks and months, and we'll talk about how you can keep an eye out for those events in just a few minutes.

So, charging along. I'm going to slide three just to talk a little bit about the topics for today's presentation. We're going to start, again, with the very basics. Talk a little bit about the Medicare Access and CHIP Reauthorization Act -- we call MACRA. A little bit of a 101 there, then we'll do a very quick overview of the Quality Payment Program to really set the context for our discussion. Then we'll drive into the Merit-based Incentive Payment System for year three, going through some of the eligibility criteria, reporting options, little bit of discussion on our performance-category requirements, and then talk about payments. We'll wrap up with options for help and support, and then, of course, if our time allows at the end, we'll have an opportunity for questions and answers. Okay. So, moving on to the next slide, and then on to slide five.

We're just going to get started, again, with basics and a little bit of history. So, as you've been researching MIPS and Quality Payment Program, you may have come across the acronym MACRA. Again, that stands for Medicare Access and CHIP Reauthorization Act. And, of course, you may be wondering, "What's the linkage, and why should I really care?" Both of these are excellent questions. So, as you can see on the screen, basically, what you need to know about MACRA is that it repealed the Sustainable Growth Rate formula, which we'll discuss in just a minute. It creates a pathway toward a value-based system of care. And it requires us, as in CMS, to implement an incentive program that helps all of us get to that ultimate goal of a value-based system. So, let's peel the onion back a little bit more on the next slide.

So, prior to MACRA, payment was primarily based on the volume of services provided and not necessarily the value, all of which occurred under what many of you are used to, a fee-for-service system. So, additionally, doctors and clinicians, for years, had to navigate the challenging nuances of the Sustainable Growth Rate formula, where Congress each year had to pass temporary fixes to prevent significant payment cuts. And as you can see on this slide, without a fix in 2015, clinicians would have faced a relatively steep cut of 21% in payments. So, putting this all together, the Medicare Access and CHIP Reauthorization Act eliminates the Sustainable Growth Rate formula. In its place, we now have the Quality Payment Program, which provides for a more predictable and stable payment structure, and really drives the very fundamental and meaningful movement toward a value-based system of care.

As you'll see on the next slide, slide seven, the Quality Payment Program really consists of two avenues, if you will, for participation. So, we have the Merit-based Incentive Payment System, which we're discussing today. We also have Advanced Alternative Payment Models. So, we really look at both pathways as foundational elements to help drive value. And we know that many of you initially will fall into MIPS, which will ultimately help you kind of build that strong infrastructure to meaningfully participate in the value-based system. We're not going to spend any time on advanced APMs today, but at a high level, this is the pathway clinicians could pursue if they're interested in taking on additional risk related to their patient outcomes with the opportunity to receive greater incentives. Again, we won't talk about this too much today, but we are planning to have an APMs 101 webinar within the next several weeks, so please be on the lookout for that, and we'll communicate that when we're ready to have it.

On the next slide, just to kind of round out just our general background and discussion about MACRA and the Quality Payment Program, this slide really consists of a number of our strategic objectives that help guide the program and the development our policies in the program. I won't step through each one of these. Two that I just want to make sure that you're all very focused on, and that we are certainly focused on as we develop policies for the program, are the top two. One -- improving beneficiary outcomes. At the end of the day, we are all here for our beneficiaries, so we take that into consideration with all of the policies that we are developing for Quality Payment Program. The other is reducing burden on clinicians, and really enhancing the clinician experience by building a flexible and very transparent program and interacting with our clinician community, and allowing them to help us shape this program. So, with that, I'm going to pass it over to our Merit-based Incentive Payment System lead, Molly MacHarris, to take us through MIPS 101.

Thank you, Adam. And thank you, everyone, for being here with us today. So, let's go ahead and keep moving along. So, let's move on to slide 10 to go over some key terms and time lines that I'll be talking about here. So, some key terms that I want you all to be aware of, because I will use these throughout the presentation, and you will see these referenced throughout our educational material, which is at our website, qpp.cms.gov. I would highly encourage all of you, if you have not yet been to that website, to please go there and take a look at all of the information that we have available to you. But talking through the key terms -- so, I will be talking about clinicians within the context of a unique TIN and a unique NPI. So, when we say TIN, that means the Taxpayer Identification Number, which is the number used by the IRS to identify an entity, such as a group or medical

practice. The NPI is the National Provider Identifier, which is the 10-digit identifier that you receive when you enroll within our NPPES system, and it's used to identify individual clinicians. When we talk about clinicians under the MIPS program, we identify you based off of the unique combination of the TIN -- the Tax Identification Number -- and the NPI -- your National Provider Identifier. So, this is how we identify you and/or your practice, and how you bill services to CMS. So those are some of the basic terms. And then to talk through some of our years and time lines. One thing that we deal with under the Quality Payment Program is, we deal with multiple years at once. So, you may hear me talk about the first year, or the transition year, which was calendar year 2017. That was the performance period. But that impacted payments during calendar year 2019. And the corresponding adjustment, this is the amount of money that we can distribute by law. You'll note that it says "up to" a certain amount. The MIPS program by law must be implemented in a budget-neutral manner. And what that means is that, when we assess clinicians' performance under the MIPS program, and we go to apply these payment adjustments, the total amount of positive adjustments that we would distribute would be based off of the estimate that we would have for the negative adjustments. I'll be talking about this in a lot more detail throughout this presentation, because I understand that it can be a bit of a difficult concept to understand. Also, still focusing on our years, I will be talking about our policies that are effective for our third year, which is calendar year '19. So, I may be talking about it as our third year, the 2019 performance year, or 2019 performance period. Your performance during this year will impact your payments in calendar year 2021. And as required by law, the total amount of payment adjustments that we can distribute are up to 7%, subject to a scaling factor. And, again, that scaling factor deals with maintaining our budget-neutrality requirements. Okay. So, let's go ahead and move on to the following slide, slide 11.

So, as Adam mentioned, prior to the passage of the law MACRA, there were many programs that clinicians had to focus on and understand the requirements of and participate in. So, prior to the Quality Payment Program and the passage of the law MACRA, the three programs that clinicians had to deal with were the Physician Quality Reporting System, or PQRS program, the Physician Value Modifier, or VM program, and the Medicare EHR Incentive Program for Eligible Professionals, which dealt with meaningful use of certified EHR technology. Those three programs have since ended, and now the program that clinicians participate under is the Quality Payment Program. And as we talked about, we're focusing our conversations here today on the MIPS side of the Quality Payment Program. So, let's move on to the next slide.

So, what do we do here under MIPS? So, what we do under MIPS is, we assess clinicians' performance on four performance categories. Those four performance categories are Quality, Cost, Improvement Activities, and Promoting Interoperability. Promoting Interoperability deals with the usage of certified EHR technology. And so, what we do is, we assess your performance on these four categories, and we assign to each clinician something called a final score based off of your performance on those four categories. The number to remember in this third year of the program is the number 30. That is where we have set the performance threshold for this third year. And that's important, because if your final score is below the performance threshold, that means that, by law, you would be receiving a negative adjustment, which could go up to -7%. And when I say a negative adjustment, that means a reduction of 7% on your claims that would happen in 2021. If your final score is at 30 points, that means you would get a

neutral payment adjustment -- so no update to your claims in 2021. And if it's above 30 points, that means you could get a positive adjustment. Again, it could go up to 7%, subject to a scaling factor, and we also have an Exceptional Performer bonus. I'll be talking through this in more detail in the coming slides. And then, just moving on to the next slide for our high-level timeline, just for some additional starting context before we dive into the details.

So, again, as I've mentioned a couple times here, the third year of the program, 2019 calendar year, is our performance period. Then the majority of the data submission for those four performance categories will happen following the first calendar quarter after the performance period, so by March 31st of 2020. We would then issue feedback in the summer of 2020, and then your claims would begin being adjusted beginning January 1, 2021, based off of your performance in this third year. Okay. Let's go ahead and move on to the next slide for some key resources.

So, there's a lot of information that we have on our website, the qpp.cms.gov site. We have a number of tools that many of you have worked with us on developing those tools to make sure that the information that is available there is useful and meaningful. The first tool is the QPP Participation Status Lookup Tool. This is where you can enter your NPI, that 10-digit identifier I talked about earlier, and we will share back to you all the information that we have on file, such as whether or not you are eligible for the programs, the practices we have you associated with, and any of your special statuses. That tool will be updated with the 2019 information in the next few weeks. We also have our MIPS Explore Measures tool. This is the ability where you can go to our website, go to this tool, and it works as a bit of a shopping cart, where you can go by performance category or by other search criteria, and you can select your measures and activities for the four performance categories. And the measure shopping cart should be updated in the next few days for the 2019 information. I won't go over the rest of the links on this slide here, but, again, I would highly encourage all of you to go to the qpp.cms.gov site, because we have a lot of information on there.

I'm just going to jump in, Molly, for one second.

Yeah.

Just to pause for a second, because we are experiencing a bit of technical delay. So, we are trying to get the slides advanced forward. Just going to take a pause for a second. So, I'll just talk for a little bit. Hopefully we can get the slides back up to speed. Working through that right now. So, apologies to all of you. Thank you for flagging this for us. So, as Molly was mentioning, those are excellent resources to really start with Quality Payment Program. Again, highly encourage you all to start with qpp.cms.gov, as all of the sources will be listed there -- everything from the Resource Library to the Explore Measures, the NPI Lookup like Molly was discussing. Also, on that website is our Quality Payment Program webinar page, so if you are interested in participating in any future webinars, those will be listed on that page, as well. So, as I mentioned earlier, we will be having an APM 101 event that will be coming very soon, as well as a few other additional events on the Merit-based Incentive Payment System, so you can definitely find that information there. Also want to highlight for you all, one key point that Molly made was the listserv. This is a very important piece of communication, or a very important thing to sign up for. It is our way of

communicating with all of you about the Quality Payment Program. That is available, again, by going to qpp.cms.gov, scrolling down to the bottom of the page, and just entering your e-mail address. So, it's pretty simple, pretty straightforward. So, if you haven't done so already, definitely check that out. Again, we will communicate all of our program updates, our new resources that are available. We'll talk about dates for important milestones, but also our webinars, a number of our other events that are happening, and so on and so forth. So, it really is a great method of communication. And I think we are still working through to get the slides back up to where we were, so just bear with us for one more minute, folks. Having a bit of technical delay here. Okay, folks. Apologies again. We are experiencing something very unusual for us. The slides are not progressing. But in the interest of time, and to be responsive to everyone's schedules and for being here with us today, we are going to try to charge forward as best we can. We'll try to get you all caught up. Again, we will send these slides out after the fact, along with the recording. So, we're going to try to get these slides up to speed. I think we're moving now, which is good.

Are we?

I think so. So, we're going to start on slide 15. We're going to jump into the actually MIPS pieces of this now, starting with eligibility. So, if we can start back up, and we'll keep charging forward.

Okay, great. And this is Molly again. As Adam said, apologies for the technical difficulties. I don't think this has happened to us before, so thank you for bearing with us. I will continue to move along as I am talking through this, but my colleagues here will just keep me posted if we need to pause and redirect. But, so, the next piece of information I wanted to go over with all of you is the eligibility basics. And so that starts on slide 16. So, the basics for eligibility. One of the things you may be asking yourself is, "Okay, there's a MIPS program. Am I eligible? And if so, what do I have to do?" So, as reflected on slide 16, the question is, how do we determine if you are included in MIPS for this third year? So, the first thing that we do is, we start by identifying if you are a MIPS eligible clinician type -- and I will be going over what those eligible clinician types are -- then we look to see if you exceeded all three elements of the low-volume threshold criteria exclusion or our two other exclusions. And if you meet those elements, then you are required to participate in the program. What it means to be required to participate in the program is that you are potentially eligible to receive a positive MIPS adjustment -- again, if your final score is above that 30-point threshold. Or, if you do not participate with a final score of 30 points, you could get a negative adjustment. So that means that you are in the MIPS program, and you can earn the benefit of more money, but if you don't meet that performance threshold, you could have money removed from your claims in the 2021 year. Let's move on to slide 17 to talk through those basic exclusions I mentioned.

So, you could be excluded from MIPS based off of three ways. The first is if you are newly-enrolled to Medicare. So, if you become initially enrolled in the Medicare program during this calendar year, you are not required to participate for this year. You would, however, be required to participate in a future year. That's just a one-year-only exclusion. Then I'm going to skip the middle one for just a second and talk about the Advanced APM exclusion. So, as Adam mentioned earlier, there's two tracks to the Quality Payment Program -- the MIPS track and the Advanced APM track. If you significantly participate in the Advanced APM, you can be excluded from MIPS. And then the

middle exclusion, which I will be talking about in more detail, is the low-volume threshold exclusion. And this is where you can be excluded from the program based off of a certain amount of billings that you do, the number of patients that you see, and the number of services that you render. Let's move on to the next slide to talk about who is an eligible clinician.

So, eligible clinicians are both physicians and non-physician clinicians who are eligible to participate in MIPS. We define this annually through rulemaking. And why this is important is because being identified as a MIPS eligible clinician is the first step in determining whether you're required to participate. So, moving on to the next slide, the MIPS eligible clinician types include physicians. And just as a reminder, under Medicare, the definition of physicians includes not only MDs and DOs, it also includes dentists, podiatrists, optometrists, and chiropractors. In addition to physicians, those that are eligible also include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and then newly in this third year, clinical psychologists, physical therapists, occupational therapists, audiologists, registered dieticians or nutritional professionals. So, if you are one of those clinician types, you could be eligible for the MIPS program. Let's move on to the next slide, though, to talk about those exclusions I mentioned in more detail.

So, again, if you are one of those clinician types -- so, if you are an MD, you could be eligible for the MIPS program if you're not otherwise excluded because of being newly enrolled to Medicare or significant participation in an Advanced APM. The other way that you could be excluded from MIPS is through the low-volume threshold. And what this does is, it helps us determine if you as a MIPS eligible clinician bill a sufficient amount of allowed charges, see an appropriate number of patients, and an adequate number of services to be included in MIPS. So, let's move on to the next slide for what those thresholds are.

So, as reflected on slide 21, we look to determine if you met the low-volume threshold based off of three criteria. The first is, did you bill more than $90,000 annually in allowed charges? Did you see more than 200 patients? And did you render more than 200 services? If those three items are all true, then you are considered to be MIPS eligible. If all three of those are not true, then you are excluded from the program. But if only one or two of those are true, we have a choice that you can make in this third year, which I'll talk about in just a minute. Let's move on to the next slide.

So, you may ask, "Okay, I understand that my billings would have to be $90,000. 200 patients. 200 services. What time frames do we look at?" We look at your claims data for two segments. They both run on the fiscal year. So, our historical period runs from October 1st through September 30th of 2018, and this provides your initial eligibility in the MIPS program. And, again, that information will be updated within our Participation Lookup Tool in the next few weeks. And then we also will do a second determination period or a second look, which runs from the current fiscal year up until the end of September. Moving on to the next slide.

So, how does the low-volume threshold apply to groups? So, we will look to apply the low-volume threshold at the level that clinicians participate under. I'll talk about this in a little bit more detail coming up, but you can participate in MIPS either as an individual, as part of a group, or as part of a virtual group. So, we apply the low-volume threshold based off of

how you participate. So, if you participate as an individual, we would look to see if you exceeded that low-volume threshold all on your own, based off of your unique TIN/NPI combination. But if you participate as a group, we would look to see for all the clinicians that are associated with that TIN of that group, whether or not the group met the low-volume threshold. Let's move on to the next slide.

So, I mentioned a few minutes earlier that, in this third year of the program, we've added in some additional flexibility for those three criteria -- the $90,000 in billing, the 200 patients, and the 200 services. If you want to participate in the program but you, again, are excluded only under one of those criteria, there's a couple options that you have. So, if, for example, you are a clinician, and you billed $100,000 in billing annually, you rendered 250 services, but you only saw 100 patients, what that means is that you've met two of the criteria, but not all three. And one just quick aside of a common question we've received of, what is the difference between a patient and a service? So, as I'm sure you all can imagine, you could see a given patient five times during the year. That one patient would count as a one toward your patient count of 200 patients, but the fact that you saw that patient five times, that would count as five services. So that would count as a five towards your services count. But, so, again, going back to my example, if you're a clinician, you billed $100,000 annually, you had 250 services, but you only had 100 patients, you have two options available to you. You can either choose to become MIPS eligible and opt-in to the program, or you can choose to be excluded and volunteer to participate. The advantages of opting-in to the program is that you would be considered a MIPS eligible clinician, and you would have the ability to potentially earn, again, that positive adjustment that could go up to 7% -- again, subject to a scaling factor. Some of the risks that you all should be considering is that, also, if you are a MIPS eligible clinician, if your final score is not at or above the 30-point threshold, you could get a negative adjustment. So, let's move on to the next slide.

And I've touched on it a couple times here today, but I do just want to re-emphasize this, because it's a really great tool. We've worked with a number of clinicians and societies and stakeholders to build this out, to make sure that it provides meaningful information to you. So, you can check your participation status at qpp.cms.gov. Just as a reminder, this tool still has our year one and year two information. Our 2019 information, which is the year three program, that will be updated within the tool in the next few weeks. And, again, as Adam mentioned earlier, if you have not yet signed up for our listserv, I would highly encourage you to do so, because that is where we will be providing the communications on when that tool is live. And moving on to the next slide.

So, what happens if you are associated with multiple practices in the Lookup Tool? So, I mentioned that this could happen earlier. So, again, when you think about MIPS and how we identify a clinician based off of your unique TIN/NPI combination, you as a provider could be associated with multiple practices. So, for example, for us located over here at CMS headquarter ins Baltimore, Maryland, you could be a clinician who works at Hopkins, and you also could be a clinician that works at University of Maryland. In that circumstance, you would have two separate TIN/NPI combinations, because in all likelihood there would be two separate Tax IDs for University of Maryland and for Hopkins. And so, we would provide that information that we have available to you based off of data within PECOS and within Claims in that Participation Lookup Tool. Okay. So those are the eligibility basics.

Let's keep moving along. There's still a lot of information I want to cover, and I do want to try to leave some room at the end for questions. So, let's go ahead and jump to our reporting options, starting on slide 28.

So, I've touched on this a couple times already, but just to re-emphasize it -- there are three main ways that you can participate in the MIPS program. The first is as an individual, which, again, we identify that based off of your unique TIN/NPI combination. The second is as part of a group, and a group is defined as where two or more clinicians -- so two or more NPIs -- have reassigned their billing rights to the TIN. And then the third main way that you can participate in MIPS is as a virtual group. A virtual group is defined as by law "a composition of solo practitioners and groups of 10 or fewer clinicians who virtually come together to participate in MIPS." The virtual-group elections, there are some additional requirements that we have to follow, again, by law. By law, the virtual group elections have to be made prior to the beginning of the performance period, so unfortunately this option is no longer available in the third year if you did not send us your election by December 31st. But if it is something that you're interested in, I would encourage you to take a look at the information, again, that we have on our website, qpp.cms.gov, on what this looks like in case it's something you would be interested in in our fourth year, because, again, we would need those elections by no later than December 31st. Let's move on to the next slide to start talking about ways that you can get your data in to us.

So, there's some key terms that I want to go over. These are relatively new. So, we talk about, under the four performance categories, different things. So, the term “collection type” deals with, under the Quality performance category, a set of comparable measure specifications and data completement criteria. The collection types that we have available include electronic clinical quality measures, eCQMs, MIPS CQMs, which used to be referred to as registry measures, QCDR measures, Part B claims measures, Web Interface measures, the CAHPS for MIPS Survey, and administrative claims measures. In the next two slides, I have information on what of these options is available if you participate as an individual versus a group. So, those deal with a set of Quality measure specifications. Then, the submitter type deals with how the data can come in to us. So, the submitter type could include the MIPS eligible clinician, the group, the virtual group, or the third party. And then our submission type deals with how the submitter -- so, for example, a third party, would send data in to us. And that includes options of direct, log in and upload, log in and attest, Part B claims, and CMS Web Interface. So, moving on to the next slide, slide 30, which has the chart of options available for individuals.

A couple terms which may be unfamiliar to you because these are new. So, our direct submission type, that deals with the ability for many third parties and many larger practices, as well as some smaller practices, where they can send data to us directly using an automated programming interface, an API, which is a computer-to-computer exchange. Our log-in-and-upload submission type deals with going to our website, logging in using a set of secure credentials, and uploading your data to us. And then, moving to slide 31, on the group options.

The main distinction here that's available for groups that's not available for individuals is the usage of our Web Interface. This is a distinct set of Quality measure specifications and patient samples that groups of 25 or greater can report on for their clinicians. Okay. So, those are the basics on how you can participate and how you can send data in. So, let's go ahead

and move on to slide 32 and then 33 to start going over the performance requirements and what you have to do.

So, on slide 33, I've talked about the performance period in the past. So, the performance period is the length of time for each performance category that you or your group are required to report data for a specific MIPS performance category. So, as I talked about earlier, calendar year '19 is the performance period for the third year. So, for the Quality and Cost performance categories, it's 12 months -- so all of calendar year 2019 -- whereas for the Improvement Activities and Promoting Interoperability performance categories, it's a continuous 90-day period that falls within calendar year '19. You can report for Improvement Activities and Promoting Interoperability longer for a 90-day period, as well. Moving on to the next slide.

So, what are the performance category weights? So, a weight is the overall value assigned to each performance category, and this impacts the total amount that those weights contribute to your final score. So, in this third year, Quality counts for 45 points, Cost for 15 points, Improvement Activities, 15 points, and Promoting Interoperability, 25 points. One piece I do want to highlight is that you will continue to see us modifying the Quality and Cost performance categories, because by the 2022 performance year, which is year six of the program, Quality and Cost, by law, must both count for 30 points. Okay. Let's start talking through each of the four performance categories.

So, Quality -- the basics. Quality, again, counts for 45 points towards your final score. The performance criteria is that you would need to select six measures. One of those measures would need to be an outcome measure. If an outcome measure is not available, please select from a high-priority measure. And the high-priority measures include Outcome, Patient Experience, Patient Safety, Appropriate Use, Efficiency, Care Coordination, and newly, for the third year, Opioid-Related measures. You can select those six measures from a broad set of 257 measures, which, again, is part of that measures shopping cart, which I mentioned will be updated with the 2019 information in the next few days. Or you can select a specialty-specific set of measures. We work with a number of specialties to ensure that those specialty sets are meaningful and applicable to your specialty. Moving on to the next slide. Some additional basics. We do offer bonus points in this performance category. You can receive bonus points for reporting on more than the required outcome or high-priority measure. So, you can earn two points for outcome or patient experience measures, and one point for other high-priority measures. You also can earn points for submitting your data in an end-to-end manner using your certified EHR technology. We also have a small practice bonus available within in the Quality performance category. Some other basics for the Quality category deals with data completeness. So, our data completeness thresholds are 60%. And what this means is, we check to see if you or your practice has submitted data on a minimum percentage -- so the minimum percentage of 60% of your patients that meet a Quality measures denominator criteria. If you do not meet that 60% data completeness for each of the measures -- again, thinking about those six measures. So, if you fail data completeness for one of those measures, the maximum number of points that you can earn for that measure is one point or, if you're a small practice, three points. Typically, for each measure, you can earn up to 10 points. Okay. Those are the basics for quality. I'm going to go ahead and jump to the next slide for cost.

For Cost, it contributes 15 points for your final score. There's no separate reporting requirement. We are able to calculate all of these measures based off of administrative claims -- so the Part B claims data we have in-house. We will assess your performance on Cost on a handful of measures, including the Medicare Spending Per Beneficiary measure, the Total Per Capita Cost measure, and newly in this year, we have eight episode-based measures. What we will do for Cost is we will look to attribute each of these measures to you to see if you meet or exceed the case minimum. We will attempt to calculate your performance on all of these measures. In instances where we can't calculate your performance on all of these measures, we will calculate them for as many as we can. If a scenario exists where we cannot calculate your performance on Cost for any of the measures -- and moving on to slide 38, you can see what those eight episode-based measures are. So, if we can't calculate your performance on any of these eight measures or the Medicare Spending Per Beneficiary measure or the Total Per Capita Cost measure, then the 15 points that are allocated for Cost will get redistributed to the Quality performance category. Okay. Let's move on to the next slide, slide 39, to talk about Improvement Activities.

Improvement Activities, this deals with clinical practice improvements that you or your practice make within your organization. The performance criteria is that you will want to hit the number of Improvement Activities that will get you to 40 points. Medium activities count for 10 points. High-weighted activities count for 20 points. So, clinicians can reach that 40-point threshold through any combination of medium or high activity. There's 118 activities available for 2019. Again, that information will get updated within our measure shopping cart in the next few days. Another thing to note is that, if you are a clinician that has a special status, I didn't really talk too much about special statuses, but happy to take questions on this. Special statuses apply to certain types of eligible clinicians. For example, if you're part of a small practice, if you're organization has 15 or fewer clinicians, if you are in a rural area, a HPSA area, or if you're a non-patient-facing clinician, your activities receive double points. So that means that one high activity for you would count for 40 points, one medium activity would count for 20 points. Okay. Let's move on to the last performance category, Promoting Interoperability.

So, for Promoting Interoperability, this contributes 25 points toward your final score in this third year. You must be using 2015 edition certified EHR technology. And this performance category deals with performance-based scoring at the individual measure level. There are four objectives that we will be looking at your performance on in this third year. That includes e-prescribing, health information exchange, provider-to-patient exchange, and public health and clinical data exchange. And on the next slide, slide 41, you can see these objectives, as well as the measures associated with them and the maximum points. Okay. So, moving on to slide 42.

So, to earn a score for the Promoting Interoperability performance category, again, you have to use your certified EHR technology for a minimum of a 90-day period. Then there are a handful of attestations that you would have to indicate that you have complied with. The first is the Prevention of Information Blocking Attestation. The second is the ONC -- Office of the National Coordinator -- Direct Review Attestation, and then also the Security Risk Analysis measure. Then you would need to report the required measures under each objective or, as applicable, claim any exclusions. If any exclusions are claimed, the points would be re-allocated to other

measures. And let's move on to the next slide, slide 43, to talk through a few exclusions.

So, under this performance category -- so, again, thinking about who's eligible under the MIPS program -- we do have some exclusions if you are a certain type of an eligible clinician or if you have a special status applied to you, or there may be circumstances that would require re-weighting. So, what happens here is that, if you are eligible for one of those, the 25 points that are allocated for Promoting Interoperability will get redistributed to the Quality performance category. So, there are some of these re-weighting items that are automatic, which means we will do these on your behalf. So, the first is if you are a non-patient-facing clinician, if you're a hospital-based clinician, or if you are a clinician that is ambulatory surgical center-based, also if you are a clinician type other than a physician, your Promoting Interoperability performance category will automatically be re-weighted. Then we have a number of application-based re-weightings. This includes if you have an extreme and uncontrollable circumstance, if you are part of a small practice, of if you're using de-certified EHR technology, you can, again, come to our website and request a hardship and re-weighting application for the Promoting Interoperability performance category. Okay. Let's move on. Just a few more slides I want to cover before we can start opening it up to Q&A. So, let's go ahead and jump to slide 45 to sum up all of this, and the implications for your performance and the payment adjustments.

So, at this point, you guys should understand whether or not you would be eligible, and where you can go if you need to find out your eligibility information. You should understand that what we do under MIPS is, we assess your performance on four categories, and we are looking, based off of that performance, whether or not you exceeded a performance threshold. In this third year, that performance threshold is 30 points. And let's move on to the next slide, slide 46, because I think this chart actually helps explain it really nicely.

So, as you can see on this chart here, looking at the green row, 30 points will get you a neutral adjustment in 2021. Again, no impact to your claims. Looking at the positive side first, so going up the chart, if your final score is anywhere above 30 points, that means you will be getting more money in 2021. Your payment adjustment could range anywhere between 0.01% positive adjustment up to 7%, subject to a scaling factor. Again, the scaling factor helps us at CMS maintain budget neutrality. If your final score is at or above 75 points, you also will be eligible for an exceptional performer bonus. For the first five years of the program, we have the ability to distribute up to $500 million annually for exceptional performers. Then, going down the bottom part of the chart -- so, the negative side. So, if your final score ranges between 0 and 7.5 points, by law we have to give you the maximum negative adjustment of -7%. We ideally would not like to do this to all of you. So, again, I would highly encourage you to participate in the program. Also, as you can see from this chart, if your final score ranges from slightly above 7.5 points but directly below 30 points, you would still be getting a negative adjustment, and it could range anywhere, from the negative side, up to that -7%, again subject to our scaling factor and budget neutrality. Okay. So, that covers all of the information for MIPS. I'm going to go ahead and turn it back to Adam to go over a few key resources before we take a couple questions. Adam.

Fantastic. Well, thank you so much, Molly. And thank you all for bearing with us as we worked through those technical difficulties. Just want to cover two last slides before we jump into an opportunity for you to kind of call in and interact with us through Q&A discussion. This is our "getting started" checklist. So, we all came together and thought about some action items to really consider as we start the 2019 performance year, and as we've been talking about throughout the majority of our presentation today, these are a couple of items that we definitely want to encourage you to pursue over the next few days and weeks as you get started with 2019. So, one is definitely -- and I know we've said this many times throughout -- to familiarize yourself with the contents and tools on the Quality Payment Program website, qpp.cms.gov. Again, you'll want to check your participation status on the QPP Participation Status Lookup Tool. Again, that information is coming within the next few weeks. We anticipate it being available in the next few weeks. For folks who are a little concerned about the delay, don't worry. As Molly mentioned, we do have different performance periods, so you still will have plenty of time to capture your data and report as we continue on throughout 2019. So, please, don't get concerned yet. Another big piece of this -- if you are included -- once eligibility information is available and you've looked it up in the Lookup Tool, if you are included or you intend to opt in to MIPS, start having those conversations about whether you want to participate as an individual or as a part of a group. Those are conversations that you definitely want to have with the other clinicians within your practice to make the best decision possible. Certainly, identify the measures and activities on which you or your group will report. For those who have been with us the last two years, you may have some Improvement Activities and measures that you've been reporting on. Definitely check to see if those are still around for 2019 and if that's an option for you. For those new to the program, start exploring some of our measures and activities. Again, we'll have our shopping cart, as Molly mentioned, updated in the coming weeks, as well. And then, of course, once you're ready to go, we'll begin capturing Quality measure data. So, remember, for Quality, it is 12 months of Quality performance data, so this is why we do encourage you to have these discussions right now. Start to think about those measures, and really get started as soon as you can. And, of course, please reach out to the various forms of support that we have. If we jump on to the next slide, what we'll show you here -- Again, this is all free support for you.

So, just really starting at the bottom righthand corner of slide 49, this is our Quality Payment Program service center, always available to take your phone calls. The number and the e-mail address are listed on-screen, so if you do have any questions following our discussion today -- and, just full transparency, we are receiving quite a few questions in the chat, so we're trying to work through them. But the few of us can't keep up with all the questions coming in. So, if you do have questions, certainly reach out to the Quality Payment Program service center. They are there to help. They're an excellent source of information. We also recommend, for those of you who are newer to the program, to reach out to our technical assistance. It is free support. We do have our technical assistance available based on your practice size, as well. So, if you are a small practice as we define -- 15 or fewer eligible clinicians -- we encourage you to reach out to the Small, Underserved, and Rural Support initiative. They are available to provide support to you. Our larger practices can certainly work with our Quality Innovation Networks and Quality Improvement Organizations. And for those of you, whether you're small or in large practices, and you're interested in potentially really starting to move in the value-based direction and

starting to work in Alternative Payment Models or Advanced Alternative Payment Models, we do encourage you to enroll with our Transforming Clinical Practice initiative. It's kind of the best of both worlds because you'll receive free MIPS support, and you'll also begin preparing to make the transition into an Alternative Payment Model. So, again, all of this support is absolutely free to you, so please take advantage of it. Okay. I think we're going to charge along to our Q&A session. I know, with the technical difficulties, we lost some time there, so I think what we'll do is extend just a little bit to make sure that we can take a few questions from you all. So, at this point, I'm going to turn it over to the operator to let you know how to get into the phone queue.

We're 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, 1-866-452-7887. If prompted, please provide the conference ID, 5782298. Again, 5782298. We'll pause for just a moment.

Okay. And as we are waiting for you to dial in, just again a reminder, because I think this is the best form of us communicating with you all -- please sign up for the QPP listserv on qpp.cms.gov. Also, I do want to answer a number of questions just around the availability of the presentation, the slides, the recording. All of that information will be posted in the webinar library that I mentioned to you early on on qpp.cms.gov. We anticipate about a week or two, so we'll communicate when that information's ready to go, and it's posted on the website, so you can go back and take a look at some of the information that we've presented today. Okay. So, I think we're going to take our first question.

We have a question from Rebecca Ball.

Hi. How are you today? Thank you so much for your presentation. I do have a question about -- I know it's not part of the Promoting Interoperability, but you must submit a yes to Prevention of Information Blocking Attestation, and submit a yes to ONC Direct Review Attestation? I think most of us are familiar with the Security Risk Analysis, but can you expound on that for me, please?

So, we do have an Information Blocking fact sheet on our website. It's actually in there for each year. So, if you went to our Resource Library, under Promoting Interoperability for 2019, you could see a copy of that fact sheet, and it sort of spells it out more for you. For the ONC Direct Review, that would mean that they have contacted you, and you are undergoing a review with them, so you would know -- For most people, this will not be applicable. But if they've contacted you, then you would need to attest to that.

So, if you aren't contacted by them, then you would say no to that? Or if you were...? So, essentially, you have to submit a yes. So, if you're not contacted by them, you would submit a no?

No, you would submit a yes.

So, either way, you need to submit a yes?

Correct. Unless you're not cooperating with them, in which case you would submit a no.

Yeah, okay. Right. You don't kind of have a simple overture of what the Prevention of Information Blocking is?

We're actually in rulemaking right now, and we're hoping a new rule will come out soon, so it would be premature of me to state it right now. So, I can only --

Okay, so, is it really better for us to wait, then, until the final rule comes out on that?

No, no, because I'm not sure when it's going to come out, and it's a proposed rule, so there's just going to be clarifications of what it is and what it isn't. And so that would be --

So, it's in the library on the QPP where?

It's in the Resource Library under Promoting Interoperability performance category.

2019.

Okay. Thank you.

Thank you.

Great. Thank you. Thank you so much.

Take our next caller.

Our next question is from Jennifer Hay.

Hi. This is Jennifer Hay with IPS out of San Diego. I have a question on the Promoting Interoperability objective of public health reporting. What would you suggest is the best way to find out whether or not you're required to report public health in your particular area or jurisdiction?

Well, it's not whether you're required in your jurisdiction, because there are many national public health registries that you could be reporting to. So, on the specification sheets, we lay out what active engagement is for public health reporting, and there are three levels of active engagement. To satisfy the public health reporting requirements for the Promoting Interoperability category, you need to submit to two different registries. They can be under the same measure, but they need to be two different registries. Or there are exclusions for many of the registries, so if you qualify for one of the exclusions, if you submit to one registry and you claim an exclusion for another, you would also earn the 10 points for that.

If you are a specialty, by chance, that would not be able to submit to -- like a syndromic, or they don't take case reporting from chiropractors because they're chronic-care providers -- then what would be your course of action? There is a possibility of excluding out of that objective entirely, correct?

If you qualify for two exclusions, yes.

I see. So, my real question would be, how would we find out if we are included or excluded? Is there a certain contact sheet for those registries?

I'm just not sure how we would go about that, or how we would direct our clients.

We are working on a database that might be available, but currently it is not yet publicly available. I would definitely check with your localities or your specialty societies, because many specialty societies have their own clinical data registries.

Okay. Perfect. That's the advice we've been giving. I appreciate your time.

Okay.

Thank you. Next caller, please.

Our next question is from Sima Alta.

Hi, Sima.

Yes, hello. I have two questions. Can you guys hear me?

Yes.

Yes. So, question number one is that, because we have added new types of providers, and most common the physical-therapist one, they don't have EMRs, and they really rely on their claims data for quality data submission. Since the 2019 eligibility is not updated, and for data completeness, as we all know, more is better, and we don't know when the eligibility will come, what would you advise to them?

Sure. So, again, the eligibility information within our Lookup Tool will be updated within in the next few weeks, so it is coming. The fact that those PTs, OTs, they do not have access to an EHR, that's okay, because, again, as I mentioned earlier, there are exclusion for PTs and OTs from the Promoting Interoperability Performance Category. For the Quality performance category, PTs, OTs can select from any of the available collection types, submission types, submitter types I talked about earlier in the presentation. You did mention that many PTs, OTs use Part B claims. I do just want to clarify that we did make a change this year, that the usage of the Part B claims collection type is only available to small practices. So that would be practices of 15 or fewer. But we do still have our MIPS CQMs, our eCQMs if you do have access to certified EHR technology. If your PTs, OTs have access to a QCDR, they could work with those measures, et cetera.

Okay. And one more question. So, how would you differentiate between the opt-in and the volunteer submission? The next year, when they go for the submission, would that be a click somewhere, where they would say it's opt-in versus volunteer, or is there a registration process?

Sure. Great question. So, we're actually working with a number of folks who have volunteered to help us design the opt-in process. So, more details will be coming soon, once we've worked through that collaborative process. But what we do anticipate is that, if you are a clinician that is opt-in eligible -- so, again, if you don't meet all three of those low-volume thresholds, but you only meet one or two -- then you would have the ability to either opt-in to the program -- and, again, that would mean that you are MIPS-eligible, and you can either earn the positive adjustment or potentially get the negative if your final score isn't at or above 30

points. Volunteering to report, you really just get the benefit of doing the measures and activities, but you wouldn't get any of the monetary benefits. We would, however, issue to you feedback.

So, would that be a process for those who want to opt-in? Would that be a registration or application process? Or when they go for submission next year, they would just click on "Opt-in"? How would they define they are opting-in.

Sure, sure. So, we're still working through the exact details of how people will tell us that. I don't want to say that there wouldn't be any sort of separate process required. We don't, at this point, anticipate there will be. We anticipate it's something that could happen around the time of submissions, where it's as simple as just clicking a box. But since we're still working with many of you on developing and designing that, I don't want to be too prescriptive at this point. But we are envisioning something as simple as just clicking a box of "Yes, I want to opt-in."

Great. Thank you.

Do we have another call?

Your next question is from Qi Trong.

Hi. Qi Trong with Woodlands Medical Specialists. We have received a payment adjustment for the 2017 year, but it was on a laboratory billing, a urinalysis. And we were trying to determine if that falls under the definition of covered professional services. I thought that was CLFS.

Yeah, that's a great question. What I would say... I think what we may want to do in this circumstance is have you reach out to our service center, and you can provide the additional details, and the specifics of the exact service that the adjustment is being applied to. Under the MIPS program, by law, we are required to apply the payment adjustment to cover professional services only. So, again, as you're seeing, we are implementing the 2019 adjustment based off of 2017 performance now. Typically, my understanding is that those types of labs, they wouldn't be considered a covered professional service, but I think the best course is, if you can reach out to our service center and provide those details, we can work though that specific service and get that resolved for you.

Is there a phone number I could call?

Yes. It is...

So, I think what would be best, just to send an e-mail to qpp@cms.hhs.gov. That's our direct mailer to the Quality Payment Program service center. That way we have all of your information on file, and we can respond to you.

I did send it to them, and I guess they didn't understand my question. They sent me the definition of covered professional services.

Okay. If you continue to run into issues, you can feel free to reach out to me. My name's Molly McHarris. You can... And I would say, if you do continue to have issues, the pieces of information that would be helpful for us here is the case number.

Case number.

Thank you.

Okay. Thank you.

Thank you. We're going to take one more question, and then we're going to wrap up today.

Our last question will be from Sharon Glass.

Hi, Sharon.

Are you there, Sharon?

Do we have you?

Yes. Can you hear me?

Yes.

All right, awesome. First of all, let me thank the entire CMS crew for the education that you provide to the physician community. My question is largely regarding payment adjustments, and how those are reflected from year to year. If a practice were to receive either a positive or a negative adjustment, will that be reflected on the EOB in terms of how the claim was processed? For example, if there was a 3% positive adjustment, will that be reflected in some way on the explanation of benefits?

Sure. This is Molly. That's a great question. So, the payment adjustment, whether it's positive or negative, there are specific remittance-advice codes that are associated with that. So, there's associated remittance-advice codes, so the RAs. I think there's also associated cart codes with that. I do not have what those specific codes are right in front of me, but that information is, I believe, forthcoming -- Actually, wait. Hold on. I just went to our Resource Library, did some quick searching. I think I might have found it. So, for those of you on the phone, what you can do is, you can go to qpp.cms.gov, and on the top of the site, you'll see an "About" button. If you click on that "About" button, and click on "Resource Library," and then if you scroll down to about the middle of the page, there's something called the Full Resource Library. If you search for performance year 2017, it's the second document. "2019 MIPS Payment Adjustment Remittance Advice FAQs." So that should have the answers to all of your questions, and for anyone else who has questions on understanding those codes. If you do have any other questions that this set of FAQs does not address, I would again encourage you to reach out to our service center. As Adam said, you can contact them at qpp@cms.hhs.gov. There we go. I hope that helps.

Thank you.

Thank you.

Thank you. Okay, well, thank you all, everyone. We are going to adjourn for today. We appreciate you all being here and sticking with us through our technical difficulties. Again, this was our 101 webinar to really get the performance year started. We will and we are planning to have additional

deeper-dive webinars on many of the topics that you learned today. So, again, please sign up for our listserv, because we will be putting out those webinar dates in the very near future. Until then, take care, and we'll talk to you again soon. Thank you.

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