Overview of the Proposed Rule for the Quality Payment Program 2020 Performance Period Webinar
August 13, 3019

Hello, everyone. Thank you for joining the Overview of the Proposed Rule for the Quality Payment Program 2020 Performance Period webinar. During this webinar, CMS will provide an overview on what is included in the proposed rule for the 2020 performance period of the Quality Payment Program, as well as how to submit formal comments to CMS. After the webinar, CMS will take as many questions as time allows. Now I will turn it over to Kati Moore, Health Insurance Specialist for CMS's Center for Clinical Standards and Quality. Please go ahead.

Great. Thanks so much, and good afternoon, everybody on the call, and thank you all so much for joining us here today. We're really excited to be here with you to talk about the Quality Payment Program and our proposals for the 2020 performance period of the program. You'll hear it referred to as 2020 performance year and as Year 4 of the program interchangeably. So, the same year. We do intend to cover both tracks of the program -- so, the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Model. So, we have a lot of information to get through today. We won't spend too much time up front. I do just want to quickly jump forward to slide 3.

Great. Thank you. There's just some important information here for you all to get started on today. A reminder -- this is the proposed rule, so that means we're in rulemaking. So, there is an open comment period right now. So, we do encourage everybody, after you hear us go through some of our proposals today, certainly take some time to read through the rule, get more information, and then we really want to hear back from you all feedback and comments through this formal process. We really tried to develop a program. We really want to go to the front lines to hear from clinicians and stakeholders, many of whom these policies are going to impact. So, this is a reminder that it's a formal process, so you do need to follow these certain procedures to submit a formal comment to CMS. And the big thing on this page to look at is -- on this slide is September 27th, which is the deadline to file -- to submit your comments to CMS. So, please keep that in mind. And then quickly, just to go over the run of show, we'll hop to the next slide.

There we go. So, we're just going to go over a quick overview of the Quality Payment Program. Then we'll go through an overview of MIPS and then our policies for MIPS for Year 4. Then we'll turn it over to Corey Henderson for our Advanced Alternative Payment Models overview. And then he'll go through some of our proposed policies for Advanced APMs. And then we'll go through just a couple more slides on public reporting, Physician Compare overview. And then we'll go over where you guys can get more help and support. And then we will open it up for Q&A at the end. And before we go ahead and get started, I would like to turn it over to Jean Moody-Williams, our Deputy Director for the Center for Clinical Standards and Quality, to get us started today.

Thanks much, Kati. And thanks to everyone for joining this call, really on behalf of our Administrator, Seema Verma, and, really, all the leaders here at CMS, Kate Goodrich, myself, and others. We welcome you and thank you for joining us this afternoon. So, I think most of us on the call are aware that the Quality Payment Program continually moves us from a payment model built on billing codes for a fee-for-service program to a program that adds consideration of quality using evidence-based measures and, fortunately,

measures that were primarily developed by clinicians in the field. And so, we are working to implement policies within the Quality Payment Program that reward high-quality care of patients and continues to shift us toward value-based care and Advanced Alternative Payment Models, and we'll hear a little bit more about the Advanced Alternative Payment Models at the end of the call. The goal really is to foster competition, choice, quality, affordability, and local innovation. It continues to be important that we don't want to stifle innovation.

Clinicians are engaging in these value-based reforms in new and different ways all over the country and are participating in the Quality Payment Program. We recently shared exciting participation results for our pay-for-performance program for the Merit-based Incentive Payment System, or MIPS, for our 2018 performance. And in all categories, we saw the average scores for individuals and groups increase compared to 2017. 98% of all of the clinicians that were eligible to participate in 2018 did participate. And that's pretty remarkable. It is an increase from 2017 across all practices. And just as exciting is that the average performance score increased from 74 to 86. And that includes a dramatic increase for small practices, where nearly 85% of small practices will receive a positive payment adjustment due to their high-performance scores. So, by all accounts, we can see that clinicians are hearing about the program, participating, and doing well.

But while these results are promising, additional improvement is needed, really, as we want to make sure that the program is meaningful for those clinicians that participate, as well as for consumers who are looking for more transparency and information about their healthcare. We continue to hear that MIPS reporting requirements cause confusion. While we want to create choice, we hear there's too much choice, which leads to complexity when it comes to selecting and reporting measures. And we hear from our consumer groups that patient experience of care, patient-reported outcome measures, and other areas need to be aligned more closely with how we work with our clinicians in the practice of medicine. On the bright side, it is a great example of how feedback is used in government policy to continuously evolve and benefit. And we use this input from clinicians and stakeholders as we develop our policies. And so, I think that with this proposed rule you can see that we have incorporated much of the input we've received.

One example of this is that we've proposed a new participation framework from MIPS beginning in 2021. This new participation framework, which we'll go into a little bit more detail about, is called MIPS Value Pathways, or MVPs. And it really looks to connect the various reporting categories so that you don't have four separate, independent categories, but begins to connect measures and activities across the MIPS performance categories, really looking to streamline reporting, reduce burden, and enhance the cohesiveness of the programs. So, the MVPs will also create kind of a trajectory into Advanced Alternative Payment Models as we begin to integrate thinking about all of the care processes that go into the reporting program. And it also, we hope, creates a more practical approach to the Quality measurement, including how we look at cost and how we look at interoperability. This is a significant shift from the way that we started the program, and we always said that it would be a program in evolution. And we always anticipated that we would continue to move toward one in which we would look at how we can promote and encourage integrated care. And that's what this does represent. It is very important, though, in order to shape the future program that we begin to get your input. We do have a request for information out, and we'll look for that. But as we move toward 2021, we

have some proposals that we'll discuss that are related to performance year 2020, as well. So, together with each of you, we encourage you to submit your comments on the future rule, as well as the 2020 performance year. We want to make sure that your voice is heard. And just as we've done in the past, we'll be sure to incorporate that as we move forward. So, with that, I want to get into a little bit more of the details, and I will turn it back to Kati.

Great. Thanks so much, Jean. Alright, we'll keep rolling today so we can get through all our slides and get to your questions. Next slide, please.

Alright, for most of us on this call, this is probably a very big refresher, but for people that are new to the program, just a quick overview. The Medicare Access and CHIP Reauthorization Act of 2015 that we refer to as MACRA requires CMS by law to implement an incentive program, which we refer to as the Quality Payment Program. There are two participation tracks in the program, as I mentioned before -- so, MIPS, the Merit-based Incentive Payment System, and then also our Advanced APMs, the Advanced Alternative Payment Models track. Next slide, please.

And here we just have listed out some of our strategic objectives for the program -- improve beneficiary outcomes, reduce burden on clinicians, increase adoption of Advanced Alternative Payment Models, maximize participation, improve data and information sharing, ensure operational excellence in program implementation, and deliver IT systems capabilities that meet the needs of our users -- so, all of you on this call today. And then just real quick, we have here at the bottom. I'm sure you guys have all seen our website, but if you haven't, please feel free to visit qpp.cms.gov. We have a lot of really great resources on there, just an overview of the Quality Payment Program and then some more specific information into the two different participation tracks. We also have a Resource Library that houses all of our fact sheets, user guides. Anything you need to get started in the program or to help you participate successfully is there and available, as well as our webinar library, which -- if any of you are wondering, these slides will be available along with the recording and transcript. Usually about a week or two after the presentation, we have those available in the webinar library so you can reference anything we talk about here today. And with that, I'm going to turn it over to my colleague Molly MacHarris to talk about our new participation framework that Jean mentioned.

Thanks, Kati, and thanks, everyone, for being here today. So, I am on slide 8. Okay, great. So, as Jean mentioned, we've been listening to all of you as we have been developing the Quality Payment Program. And what we've been hearing is that the current structure of the MIPS program and the reporting requirements have created some confusion. Generally, what we've been hearing is that there is too much choice and complexity when it comes to selecting and reporting measures, that the measures aren't always relevant to a clinician's specialty, and that it's hard for patients to compare performance across clinicians. So, based off that feedback, we have come up with our new participation framework, as Jean mentioned, which we are calling MIPS Value Pathways, or MVPs. The MVPs would have different paths which are focused on specialty or diseases, and would include a smaller set of measures and activities that meet the four performance categories of Quality, Cost, Improvement Activities, and Promoting Interoperability. The MVPs would also include common measures in all sets that are focused on population health and a foundation of interoperability so that patients can compare performance across clinicians. The goal of this new framework is to

streamline reporting requirements, reduce reporting burden, and ensure that the measures are meaningful to clinicians and patients. Within the proposed rule, we have an extensive comment solicitation on the MVP framework that will help inform our proposals that we would be making in coming years. So, let's go ahead and move on to slide 9, and I can briefly walk us through our illustrated diagram of what the MVPs could look like in the future.

So, as you can see on the slide here under the most left-hand column, we have our current structure of MIPS, where we have our four distinct performance categories where we're asking folks to do separate things. There's a lot of choice. The performance across the categories are not being fully aligned, and we're hearing overall that there's a higher reporting burden. As we move to the MVP framework, which is reflected in the middle column here, we are envisioning a closer alignment of Quality, Improvement Activity, and Cost, while still having the foundation of the Promoting Interoperability performance category and a foundation of population health measures, or folks may be familiar with them as they function currently within the program -- administrative claims measures, which are generally applicable to all clinicians. We envision when we get to this future state the participation experience will be much more cohesive. There will be reduced reporting burdens. And we will really be focusing both participation on selections that are meaningful to a clinician's practice and specialty. Then as we get to the most right-hand side of the diagram here, the future state of MIPS, we see an even higher linkage and cohesion across the Quality and Improvement Activities performance category and Cost. We envision the program will be much more simplified and there will be an increased voice of the patient as well as an increased amount of data that we, CMS, are able to provide. So, let's go ahead and move to the next slide to just walk us through an example we've created for a surgeon.

So, what we anticipate for the scenario here would be that currently a surgeon would have to choose from the measures that are available for the four separate performance categories, and they can really pick and choose whatever they feel is appropriate to their scope of practice. When we move to the MVP framework, we anticipate that a surgeon would be able to report on the same foundation of Promoting Interoperability and population health, but there would be specialty-specific measures and activities that would align to a surgical MVP. So, as you can see in the call-out box in the middle there, we have identified a few Quality measures, a few Improvement Activities, and a few Cost measures that we envision could apply to surgeons under the MVP framework. As a reminder, all of this is what we want feedback on. So, I am not saying that the example here, this is what the MVP would be for surgeons. We very much want folks' thoughts and feedback on how we construct the MVPs, as well as there's a number of items in our comment solicitation that we really are interested in folks' feedback on. Let's go ahead and jump to the next example, which is a diabetes example.

So, this outlines what it could look like for a public-health condition. So, in this example, we have an endocrinologist who is treating diabetes patients. And so, as you can see, again, looking at our call-out box here, we've created a pathway for participation that has a high focus on treating diabetes. Again, these are all examples, illustrative in nature. We really are interested in folks' thoughts and feedback on this new approach. We do believe that the MVP framework will be able to address a number of concerns that we've heard from stakeholders within the MIPS track of the Quality Payment Program. But, again, we feel it's really critical to receive all of your feedback as we move the program forward to ensure that the program

continues to have meaning as we continue to grow and evolve over time. Okay, so, let's go ahead and jump into our proposal that we have made for the 2020 year. So, let's go ahead and jump to the next slide and then the next slide again.

Okay, so, just as a quick overview, there were three legacy programs that clinicians had to deal with in the past that are now over with. That included the Physician Quality Reporting System, or PQRS program, which dealt with Quality, the Value-Based Payment Modifier program, which dealt with Quality and Cost, and the Medicare EHR Incentive Program for Eligible Professionals, which dealt with the usage of certified EHR technology. All three of those programs, again, have ended, and elements of those exist today under MIPS, which is reflected on the following slide, where we have our four performance categories, Quality, Cost, Improvement Activities, and Promoting Interoperability.

Promoting Interoperability deals with the usage of certified EHR technology, and Improvement Activities deal with improvements that clinicians and groups make within their practice. So, what is it we actually do here under MIPS? So, we assess clinicians' performance on these four performance categories, and we assign them something which is called a final score. And that final score can range anywhere between zero and 100 points. Where that final score rates in relation to a performance threshold will determine whether or not clinicians will be getting more or less money on their claim. So, what is reflected on this slide here, the performance category rates Quality at 40 points, Cost at 20 points. That is reflective of our proposals for this year. The proposed performance threshold for Year 4 is at 45 points. So, again, for clinicians to avoid a negative adjustment, where we would be taking money away from them, a clinician would need to achieve a final score at or above 45 points. I'll be talking through this in much more detail in the coming slides, and if you have questions on this, happy to talk through them. Okay, let's move on to the next slide, another brief refresher, some of our key terms that you'll hear me talking about today.

When I talk about clinicians under MIPS, we refer to clinicians based off their unique TIN/NPI combination. The TIN deals with the Taxpayer Identification Number, the NPI the National Provider Identifier. So, what this means is that if you are a clinician and you practice at multiple locations or sites, you could very well have a different TIN/NPI. So, for example, if you work or are located in Baltimore -- so, if you work the majority of your time at Hopkins and then one day out of the week you work at University of Maryland, you would in all instances have two different TINs/NPIs. So, we would look to determine your eligibility based off of each of those TIN/NPI combinations, as well as any exclusions, special statuses, et cetera. Also, as reflected on this slide here, I'll be talking about performance periods and the corresponding payment year. So, for this upcoming year, I'll be talking about our Year 4 policies, which would impact performance beginning in 2020. And the payment would begin being adjusted in 2022. And whoever's controlling the slide, if you could move ahead, please.

Thank you. Okay. And then the last thing I just wanted to touch on here is -- and I'll cover this in later slides -- it's important to remember, in the fourth year of the program, the total amount of payments at risk is 9%. So, that means that under the MIPS program, again, we must distribute our payments in a budget-neutral manner. So, the total number of folks that are getting a positive adjustment will offset those that are receiving a negative adjustment. The amount that we can distribute up to is 9%, but that

is subject to a scaling factor. As we've seen for the past couple of years, we got really high participation rates and relatively high final scores, which is great, but what that means is that the overall amount of money that we can distribute has been lower than what we may have anticipated. So, let's go ahead and move onto the next slide to just wrap up our background of our timeline, which is that the performance period is typically the calendar year. Data submission follows for the calendar quarter after that. We then issue feedback, and then payments would begin being adjusted in 2022 for that performance in 2020. Okay, let's move on to the next slide and then the next slide again to start talking through eligibility.

So, there were very few changes that were made to eligibility, so I think I can make up some time here so we can leave ample time at the end for questions. So, no changes were proposed to those who were eligible in this fourth year. So, all of the same clinician types that were eligible in Year 3 -- and, remember, we did have an expansion in Year 3. So, all of the same clinician types that were available in Year 3 are still available in Year 4. So, that includes physicians, PAs, NPs, CNSs, et cetera. Also as a reminder, when we talk about physicians under Medicare, we mean not only MDs and DOs, but also dentists, podiatrists, optometrists, and chiropractors. Moving on to the next slide.

No changes were made to our exclusions, either. So, our low-volume threshold exclusion, which is the one we talk about the most -- those values have remained as is, so they're still at $90,000 in billing, 200 patients, and 200 services. As a reminder, we do still have the ability for clinicians to be excluded from MIPS if they become newly enrolled to Medicare during the performance period or if they have significant participations in an Advanced APM.

Moving on to the next slide, to talk through in more detail, the low-volume threshold opt-in policy -- again, no changes were made here, so there will still be the ability for clinicians to opt into the MIPS program if they meet or exceed one but not all of the three low-volume threshold criteria. And then moving on to the next slide.

Again, no changes are made here to the MIPS determination period. We will still be looking at two 12-month segments, which run on the fiscal year, to determine both whether or not clinicians...under the low-volume threshold. But then also for the MIPS eligible clinicians to achieve a special status, those are the time frames we will be keeping. As a reminder, if you are a clinician that has a special status, that does not mean that you are excluded from the program. Instead, that means that you have a special designation. And typically, that means that you have to do a little bit less in some of our performance categories. Typically, that would occur in the Improvement Activities or Promoting Interoperability performance categories. But it can differ...by special status. Okay, let's move on to our next slide for the one change we've made in eligibility for this year, and that is our definition of hospital-based clinicians within a group.

So, our current definition of hospital-based clinicians for groups is that 100% of the group must be considered to be hospital-based. Based off of our experiences to date and feedback from stakeholders, we've proposed to lower that definition from 100% of the group to 75% or more of the group would need to be hospital-based. We also clarified our policy for non-patient facing groups and how that applies in the Promoting Interoperability performance category, as well. Okay, that's it for eligibility -- so, not

too many changes. Let's go ahead move on to the next slide and then the next slide again to start talking through the performance categories.

Okay. Folks that are following along, apologies if there's a slight delay in the slide. I'm talking a bit faster than they are, so I will try to slow down a bit. Okay, we're talking about performance category weights now. So, for Year 3, as folks know, our finalized weights are Quality at 45 points, Cost at 15 points, and Improvement Activities and Promoting Interoperability are both at 15 and 25 points, respectively. For folks who have attended our webinars in the past, you will have heard me or my other colleagues mention that by Year 6, both Quality and Cost must be set at 30 points. That is required by law. So, what we have done within this year's rules is we have started to make our gradual and incremental changes on where Quality and Cost will be set over the next few years to ultimately land at 30 points. So, as folks can see on the slide here, what we have proposed for Year 4 is Quality at 40 points and Cost at 20 points. And then moving on to the next slide.

Folks can see that we have made proposals to assess Quality at 35 points in Year 5, Cost at 25 points, and then, as required by law, in Year 6, Quality and Cost must both be set at 30 points. Okay, let's go ahead and move on to start digging into each of the performance categories in more detail.

So, I am on slide 27 for the Quality performance category. For our measures for this upcoming year, we have made significant reductions in the number of measures. And this is really based off of further implementation of our Meaningful Measures framework. Folks will recall we began implementing the Meaningful Measures framework in last year's rulemaking process, but this year we continue to apply the principles that the Meaningful Measures framework has set forward, and we have made the largest reduction in measures for many years that we've been able to do. We've proposed to remove close to 20% of the measures that are currently available in the MIPS measures set, and those are really of a standard removal to remove measures that are low-bar, standard of care, or process measures. We have modified the MIPS measurement set to have a higher focus on high-priority outcome measures, and we proposed to add seven new specialty sets. And those specialties are reflected on the slides here. Moving on to the next slide, a few other changes we've made to the Quality performance category.

The first is a modification to our data completeness requirement. As a reminder, data completeness deals with the reporting of a measure. So, just the simple act of, did a clinician see a patient and did the patient fall into the denominator of the measure and could a Quality action have occurred? We're not asking for our data-completeness threshold for the Quality action necessarily to have occurred, but just that a patient came in, met the denominator, and an understanding of why the Quality action occurred or whether an exclusion was granted. We've proposed to increase those thresholds from 50% to 70% based off of our couple of years of experience under the MIPS program. Clinicians and practices are far exceeding the 70% threshold for measures to date. Moving on to the next slide.

The last change I want to talk about for the Quality performance category is we also have made proposals to address in very unique instances where, for a given measure, the aspect of achieving 100% performance on that measure could result in inappropriate care for that patient. So, we have identified two measures where there is the potential for that to occur. That includes

our Hemoglobin A1c Diabetes Poor Control and control of high blood pressure. So, what we have proposed to do in this instance is that for these two measures for all collection types, we would revert the measure to a flat percentage, where the top decile is higher than 90%. So, what that means is in flat percentage benchmark, any performance rate at or above 90% would be in the top decile, whereas any performance rate between 80% to 89.99% would be the second highest decile, and so on. So, this approach really removes the incentive to achieve that 100% performance, again, in the unique instances where achieving 100% performance could result in inappropriate treatment for a patient. Okay, that's everything we have for Quality -- so, not too many changes here. Let's go ahead and move on to the next slide and then the next slide again to talk through the Cost performance category.

Under Cost, we have made some revisions to this category. We've made revisions both to the two global measures, the Total Per Capita Cost measure and the Medicare Spending for Beneficiary clinician measure. For those two measures, we have updated the attribution methodology to more accurately address stakeholders' concerns. And we also have proposed our 10 new episode-based measures. We do still have in place the 8 episodes that we had in prior years. Moving on to the next slide, just to briefly touch on some of the attribution changes.

For the Total Per Capita Cost, the attribution would require E&M services to have an associated primary care service or a follow-up E&M service from the same clinician or group. It also would exclude certain clinicians who primarily deliver certain non-primary care services. For the Medicare Spending for Beneficiary clinician measure, the attribution changes would have a different methodology for surgical and medical patients. And those are all the changes to Cost, so let's go ahead and move on to the next slide and then the next slide again to briefly talk through the proposed changes to Improvement Activities.

Again, not too many changes here, either. As folks can see on the slide, we have made a few changes to the inventory. We've proposed to add 2 new improvement activities, modify 7, and remove 15. And then moving on to the next slide.

We have proposed to modify the way that groups and virtual groups are able to attest completion of their improvement activities. So, the way it works today is that one clinician that's part of a group would need to confirm that they have completed an improvement activity for the entire group. We don't believe that's quite appropriate for global performance, so we are proposing to increase that threshold from one clinician to 50% of the clinicians within the group. They would need to complete and perform the activity and then they attest that 50% of the group's clinicians completed that activity. And that's it for Improvement Activities, so let's go ahead and move on to the next slide and then the next slide again just to briefly talk through the Promoting Interoperability performance category changes.

Again, since we had our overhaul last year of the Promoting Interoperability performance category, not too many changes are being made here. But reflected on this slide here, slide 37, I've already gone through this earlier on in the presentation, so I won't go through this again. It essentially just addresses the changes we've made to our hospital-based clinician and clarifying how non-patient-facing groups work in Promoting Interoperability. Let's move on to the next slide.

We have made a couple of proposals of changes to objectives and measures both for the 2019 performance period and for the 2020 performance period. All of these proposals are to maintain alignment with the Promoting Interoperability hospital program. So, as folks can see, for the 2019 performance period, the Query of PDMP measure would require a yes/no response instead of numerator/denominator. We also have made proposals on how to redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure. And then in the 2020 performance period, we've proposed to remove the Verify Opioid Treatment Agreement measure. And those are all of the changes we've proposed to the performance category for this fourth year. Before I go ahead and move on to the next set of policies to propose, I want to turn it back to Kati so we can do a quick break question for you all.

Yeah. Thanks, Molly. So, on your screen, everybody, there is a quick polling question just so we can break the slides up a little bit and pause for a quick knowledge check to see if everybody's staying with us and following through on what we're talking about today. So, the first question you'll see on your screen, it says "Which performance category weight?" So, percentages towards your final score in the column went through. Which are proposed to change next year? So, everybody can go ahead real quick and select your answer and hit "Submit." Give it about 10 seconds, and then we'll see how, as a group, we all are following along. Alright. So, Ketchum team on the phone. If we have results for that, we want to -- Oh, I think we're going to do our second question right away. So, the second question real quick, and then we'll see how we did on both of these. So, "which of the following MIPS policies is proposed to change in 2020 -- the types of eligible clinicians, the low-volume threshold, our opt-in policy, or definition of hospital-based clinicians?" Which one is changing or proposed to change? Alright. I think -- I think that one might be closing. Oh, there we go. Alright. So, I think on the first question we asked, 83% had that correct. So, we're proposing to change the Cost and Quality category scores. Yeah, so almost 84%. So, we're doing pretty good. And then we'll wait one second. We'll see how we did on the second question. Ketchum team, if you can jump in and help me out with the -- yeah, results there, that'd be great.

Sure. So it looks like for the question, "Which of the following MIPS policies is proposed to change in 2020?," 73% got the correct answer, which is "Definition of hospital-based clinician." "Opting in" was a close second at 13%, but most people did get the correct answer, "Definition of hospital-based clinicians."

Alright. Great. Thanks. And then we'll go back to Molly, and we'll start talking about Third Party Intermediary policies.

Okay, thanks, Kati, and thank you, everyone, for your feedback on the polling question. That really helps us as we develop our material to make sure that we are hitting the right things. And just to clarify that last question, the proposal that we actually made is for the hospital-based definition for groups. So, if anyone was a top performer, reader of the rule, and that's why you didn't select that answer, we'll give you an excuse for that one. Okay. So, let's go ahead and jump back into the slides -- only a few more, and then I'll turn it over to Corey to talk through the Alternative Payment Models.

So, if people are following along, they should be on Slide 40. So, for our Third Party Intermediary changes. As folks can see from what I've covered

today, not too many changes have been made to eligibility performance category requirements. We had made a number of changes, however, to our Third Party Intermediaries. When we're looking to the future -- again, folks, please remember the MVP framework that I touched on earlier and that Jean talked about in her opening remark - as we're looking to the future of the program, we really envision that our Third Party Intermediaries, which can include our Qualified Registries and our Qualified Clinical Data Registries, or QCDRs, that we really want to have improved partnerships with these third parties to really help reduce the reporting burden that clinicians face. So, our vision for Third Party Intermediaries as we move to the future state, that these third parties will really become a one-stop shop to really ease the burden of participating under the Quality Payment Program. I also should note health I.T. vendors are also considered to be Third Party Intermediaries, as well. But what I'll be talking about here today is really focus on the Registry and QCDR based off of our experiences with them to date. So, overall, our proposals touch on that both of these, the Registries and the QCDRs, would be required to support the Quality, Improvement Activity, and Promoting Interoperability performance category, providing enhanced performance feedback, and deliver quality improvement services. So let's go ahead and move on to the next slide, Slide 42, where I'll talk through this in more detail.

So, the current requirement is that Registries and QCDRs are only required for Quality. It's optional to support the other performance categories. Based on our analyses and experience to date, we're seeing that the overwhelming majority of registries and QCDRs do have the ability to support the three performance categories. So that's why we've made this proposal here -- again, keeping with our concept of our one-stop shop. I did want to note that we do recognize that some Registries and QCDRs are specialty-specific and that a given specialty may not be currently required to participate under the Promoting Interoperability performance category. So, in that unique circumstance, if you are a solo specialty-specific Registry or QCDR, and your specialty is not required to do Promoting Interoperability - so, for example, if you are a QCDR that only focuses on occupational therapists - we have proposed an exception for those solo-specialty QCDRs and Registry. Okay, let's go ahead and move to the next slide to talk through the Enhanced Performance Feedback Requirement.

So, currently Registries and QCDRs are required to provide feedback up to four times a year. What we've heard from clinicians and stakeholders today is, generally, they find the feedback from Registries and QCDRs really helpful, but we have heard that the type of feedback that is provided across the Registries and QCDRs can be really different. So, some QCDRs are able to provide really top-notch feedback that they can give to your clinician throughout the year, whereas others are really just providing the bare minimum of the four times a year and not as valuable as clinicians would like it to be. So, our proposed enhancement is to require Registries and QCDRs to include information on how their participants compared to other clinicians that use a Registry or QCDR on a given measure, and that could include a Quality measure or a QCDR measure. Moving on to the next slide.

Oh, another piece I just wanted to touch on for the enhanced feedback -- we see this as, again, trying to level the playing field of the enhanced feedback. We do recognize that there is a lot of other great pieces and elements of feedback that clinicians would like to have and do currently receive from their Registry, the QCDR. We are not in any way saying to discontinue that. Again, this is a gradual approach to starting to ensure

that clinicians are receiving the same type of feedback regardless of which entity they're working with. Let's go ahead and move on to the next slide and start talking through some of the QCDR measure Requirements.

So, we have made a number of proposed changes here. QCDR measures, as a reminder, are those measures that we do not propose through notice and comment rulemaking. They extend outside of our measures. And QCDRs can have the ability to offer up to 30 non-MIPS measures with 30 QCDR measures to their clients, to their clinicians. What we've seen, however, as the QCDR option has really evolved and developed over time is that we are seeing numerous instances of very similar, but not 100% exact QCDR measures coming from different QCDRs. So, for example, we are seeing for some measures where the denominator age range differs from the 18 to 80 versus 20 to 80 versus 16 to 85, and while the slight differences on the surface may seem like it's not too big of a deal, it does mean that we can't meaningfully look at the differences. So, what our proposal is getting at here is in instances in which multiple similar QCDR measures exist that warrant approval, we would provisionally approve the individual QCDR measure for one year with the condition that the QCDR works with the other QCDRs that we would identify for further harmonization, adjudication of those QCDR measures. We anticipate that after that one year is complete, the QCDRs and our measures that we have identified need to be harmonized. We would only approve the one measure that we had previously identified with the approved measure. So, again, we're trying to get to a state where we have a more cohesive set of measures that are more meaningful to clinicians. Let's go ahead and move on to the next slide, slide 44, to talk through just a few more QCDR measure requirements.

So what I just went over, those are things that we see in place, starting with the 2020 year. We also have made a number of proposals on items that we would like to see, beginning in the 2021 year. Since many of these may require additional time, we felt it was appropriate to delay this proposal by one year. So, there's a number of proposals we've made. I won't go through every single one of these that are on the slide, but I do want to call out that one of the most important ones, we believe, is that QCDR measures will be required to be fully developed with completed testing results at the clinician level and must be ready for implementation at the time of self-nomination. What we've experienced to date is a number of QCDR measures have come to us that are really still in a test-bed type fashion. We strongly believe that the QCDR measures should be at the same measurement standard of all of our other MIPS Quality measures. We follow the CMS measure blueprint. So, what our proposals are getting at here is to really ensure that the QCDR measures will be at those same measurement standards as all of our other QCDR measures. And then moving on to slide 45.

We also have made another proposal for QCDR measures that would be removed beginning in the 2020 year. These include instances where there's a measure that's duplicative of any existing measure or one that has been removed if the measures have unintended consequences, if the measures don't address a priority area in the Measure Development Plan, or if they are process-based or have no actionable Quality action. Okay. So those are our proposals for Third Party Intermediaries. Let's go ahead and move on to the next slide, and then the next slide again to start talking through the performance threshold and payment adjustments.

So, as I mentioned previously, our proposed performance threshold for Year 4 is at 45 points, and we propose to increase the exceptional performer bonus

at 80 points, and the payment adjustment, as required by law, could go up to 9% in Year 4. Let's move on to slide 48 and talk through our table here.

So, looking at the right-hand side, our Year 4 2020 Proposal, our green ribbon in the middle, that is the neutral payment adjustment. That's our proposed performance threshold. That means clinicians whose final scores are at that level would see no impact to their claim. Moving up the table -- so, for clinicians whose final scores are greater than 45 points, but lower than 80 points, would receive a positive adjustment. Those whose final scores are at 80 or above would be able to receive the exceptional performer bonus. Again, as folks will recall, the exceptional performer bonus is a separate bucket of $500 million that we can allocate annually that exists outside of our budget requirement. Going back to the green ribbon in the middle, and then going down, for the negative payment adjustment -- and, actually, we can update this. There's an updated version. Apologies folks, I'm seeing that the lowest quartile isn't reflected accurately here. So what it should be is that the lowest from 45 points, which, apologies for my non-mathematician skills. I think that may be at 13 points below, but I could be wrong on that -- would get a maximum negative adjustment of negative 9%. Then whatever that lowest quartile is from 45 points, again, apologies for my non-math skills, it would be a sliding linear scale into that 45-point range, again, on the negative end. And you really want folks to avoid that negative payment adjustment. So, let's go ahead and move on to the next slide. And then the next slide again.

To slide 50, the final score calculation. Just a few other items I want to touch on, and then you guys won't have to hear from me anymore. We have introduced a new policy in this year that deals with reweighting due to data integrity concerns. So, as folks may recall, we do have the flexibility under the MIPS program to reweight, again, a performance category due to certain circumstances. So, we have circumstances that currently exist if you are impacted by something that is an extreme, an uncontrollable circumstance, such as a natural disaster. As folks remember, there's been a number of hurricanes and fires over the past few years, which has resulted in reweighting some performance categories. I know the Promoting Interoperability performance category, there is a number of exceptions to deal with reweighting. We also recognize that there may be some very rare instances where the data that we receive is not completely true, accurate, and complete to a clinician's knowledge, and it is outside of their control. In those instances when we do make that determination, we would have the ability to reweight the impacted performance category.

And then moving on to slide 51, the last slide for me, we also have made clarification on what our targeted review timeframe is. We clarified at 60 days following the release of performance feedback. So, at this point, I'm going to go ahead and turn the rest of the presentation over to Dr. Corey Henderson. Corey?

Hello! Good afternoon, everyone. How are you today? So, we wanted to go straight to the next slide -- Alternative Payment Models. Thank you. And you can go to the next slide.

Okay, great. So, here we want to talk about the Alternative Payment Models, and, really, what they mean is the payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care. As we speak to what Alternative Payment Models are, I think it's important that we speak to what the whole focus of the Alternative Payment Models are, and

that is really to apply specific conditions, care episodes, or populations to understanding how we get the cost-efficient care, and they may offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs to prepare. Next slide, please.

Here we're going to go through the slides. I'm actually going to move this a little bit to see if we can get a better refresh on my screen. So here we're going to talk about the Advanced APMs and the benefits that Advanced APMs provide. The Advanced APMs provide you an alternative to not only participating, but two different types of rewards -- Advanced APM specific rewards and also the 5% bonus on what we call the APM incentive payment. Next slide, please.

So, understanding the Advanced APM and getting to the rewards, we must define what an Advanced APM is. The Advanced APM provides three specific requirements in order to be considered an Advanced APM. One, it requires that participants use certified EHR technology. Two, that it also provides,the alternative payment model provides payment for covered professional services based on Quality measures comparable to those used in the MIPS Quality performance category, and either is a Medical Home Model expanded under CMS Innovation Center authority, or requires participants to bear a more than nominal amount of financial risk. Next slide, please.

Here are some key terms that you'll find important for understanding Alternative Payment Models, and, specifically, Advanced APMs. The APM entity, which is an entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation. An Advanced APM, as we described earlier, is a payment approach that gives added incentive payments at high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. The Affiliated Practitioner is important, also, because an eligible clinician can be identified by a unique APM participant identifier on a CMS-maintained list, who has a contractual arrangement or relationship with the Advanced APM Entity, and this is for the purpose of supporting the work of the Advanced APM Entity, the quality or the cost goals under that Advanced APM work. And that list, again, is compiled from a CMS-maintained list and maintained at CMS. Next slide, please.

Additional terms include MIPS APMs, which are your most Advanced APMs that are also MIPS APMs. So, there are eligible clinicians participating in the Advanced APM, but they do not meet the threshold for sufficient payments or patients through an Advanced APM in order to become what we call the Qualifying APM Participant, or QP. They're further excluded from MIPS, or the MIPS eligible clinician will be scored under the MIPS APM scoring standard, and as according to the APM scoring standard. When we talk about the exclusions, that is for the QP or the Qualifying APM Participant. So, again, if you do not meet the threshold, and you're in a model that also has MIPS APM designation, then you do get the APM scoring standard, which is designed to account for activities already required by the APM. There's also the Participation List, which is a little different from the Affiliated Practitioner List. This is the list of participants in an APM Entity that is compiled from a CMS-maintained list. The Qualifying APM Participant, for definition, is an eligible clinician determined by CMS to have met or exceeded the relevant QP, Qualifying APM Participant payment amount or patient count threshold for a year based on participation in the Advanced APM Entity. Next slide, please.

So, let's talk a little bit about the proposed rule for Year 4. For the APM Scoring Standard, CMS is proposing that MIPS eligible clinicians participating in APMs are allowed the option to report for the MIPS Quality performance category to offer flexibility and improve meaningful measurement. CMS is proposing a MIPS APM Quality Reporting Credit for APM participants and other MIPS APMs, where quality scoring through the APM is not technically feasible. That includes a credit equal to 50% of the MIPS Quality performance category weight and quality reporting exceptions for participants reporting within an APM Entity similar to those available for the MIPS Promoting Interoperability performance category. Next slide, please.

Here, too, is another proposal for the Alternative Payment Model. This is specific to Partial QP. For Year 3, you'll remember that the final rule in 2019, that a Partial QP status -- a clinician who is a Partial QP is excluded from MIPS at the NPI level, which includes all TINs the clinician is associated with. The Year 4 2020 proposal is that Partial QP status will be specific. It is only excluded from MIPS in the TIN through which the clinician receives that Partial QP status. Next slide.

Finally, for the Other Payer Advanced APM proposals, Year 3 2019 final rule, under the Marginal Risk -- in order to meet the nominal amount standard for an Other Payer Advanced APM, the specific level of marginal risk must be at least 30% of losses in excess of the expected expenditures and total potential risk must be at least 4% of the expected expenditures. A payment arrangement must require APM Entities to bear financial risk for at least 3% of the expected expenditures for which an APM Entity is responsible under the payment arrangement. For Year 4, we propose in 2020 that the Marginal Risk -- when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceeds expected expenditures, we will use the average marginal risk rate across all possible levels of actual expenditures for comparison to the 30% marginal risk requirement of the generally applicable nominal amount standard. And that finalizes the proposals for the Alternative Payment Models. Next slide, please. And back to Kati Moore.

Great. Thanks, Corey. Again, I know we're throwing a lot of information at everybody, so we're going to pause here real quick and just do a knowledge check on an APM-specific question. So, on your screen, you'll see "CMS proposed to exclude Partial QP clinicians from MIPS at the TIN level instead of at the NPI level. Is this true or false?" Just make your selection and hit "Submit." Alright. We're closing the poll now. So, we'll see how we're all doing with APMs. Alright.

Kati, 70% got "True." Yes.

Alright. Corey, is everybody right?

That is correct.

Alright. So, we're doing pretty good. Okay, just a few more slides to get through here, folks, so hang in there with us, and then we'll move into our Q&A portion. So, real quick, just this slide right here talks about our public reporting that is down on Physician Compare. So, here's just one proposed change for Year 4, so for 2020. In 2019, we finalized that there was no established schedule for release of the aggregate MIPS data that's

displayed on Physician Compare. So, for 2020, we are proposing that beginning with the 2018 aggregate MIPS data will include the minimum and maximum MIPS performance category and final scores. We'll make those available on Physician Compare as is technically feasible. We're trying to have that available later this year. Next slide, please.

You can actually go ahead one more. So, real quick reminder on available technical assistance and resources to help you all out. We have two technical assistance organizations available. So, the first one is our Transforming Clinical Practice Initiative, so TCPI, for Primary Care and Specialist Physicians. And then we also have available our Small and Solo Practices. So, our SURS for Small, Underserved, and Rural Support. Those are available. We have more information on our qpp.cms.gov website on how to contact those organizations directly, or you can always, with questions about technical assistance or just any general questions you have about the Quality Payment Program, either about MIPS or APMs, you can always contact our Quality Payment Service Center. On the right, you'll see our phone number and our e-mail address to send questions to. We have really great agents available, ready to answer questions and help you participate successfully in this program. Again, here, we disclose our website with all those resources on there, and I also just want to highlight our Center for Medicare and Medicaid Innovation Learning System is also available to provide support on APM-specific information. Next slide, please.

A very important reminder that we talked about in the beginning, but I wanted to highlight it again that our proposed rule comment period ends on September 27th, and although we're going to listen and take your feedback today, we really need you to submit formal comments for consideration through this official rulemaking process, and if you go to the proposed rule, they'll have specific information on how to submit your comments officially to CMS. Next slide.

And, again, just a reminder that we have to protect the rulemaking process and comply with Administrative Procedure Act. So, we're going to take in all your comments today, but we really need you to submit through that formal process.

Alright, and then just a quick reminder about our Q&A today. We really want to keep our questions focused on our 2020 proposed rule. If you have questions about 2019 participation or any other information about the program that isn't specific to our proposed rule, please contact the Service Center with those questions, but we're happy to open up the phone lines right now for any 2020 proposed rule questions. So, I will turn it over to our team on the phone to let you all know how to dial in.

We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask questions via phone, please dial 1-866-452-7887. If prompted, please provide I.D. number 1083278. Once you join the call, press star 1 to be added to the question queue. Please note that we may not be able to answer all questions submitted via the Q&A box. Questions asked during the webinar are intended for clarification of the Proposed Rule. Only comments formally submitted through the process outlined by the Federal Register will be taken into consideration by CMS. If your question is not answered, please contact the Quality Payment Program Service Center. Please hold for your first question.

Great. Thanks. And while we're getting that question lined up, this is a tiny reminder real quick just to give some clarifying information about any MVP questions you all may have.

Yeah, thanks, Kati. And thanks, again, to everyone who's been listening to the call today, for your great questions that have been coming up on the chat. I did just want to clarify one thing since we've been seeing a lot of questions related to the MVPs in the chat, which is really great. I did just want to clarify, though, for folks. So, the MVP framework is -- we have a proposal related to the MVP framework, and then we have many questions that we are very much interested in your thoughts and feedback on. The questions span not only what is the process and how should you go about creating the MVPs, as in what are the key characteristics that we should be taking into consideration, what are the types of measures and activities we should be looking at? We also have a number of questions regarding how people could either be assigned or how people would be able to select an MVP that's related to their scope of practice. We also have a number of questions regarding how the MVPs could work for larger organizations that have multispecialties. This is a concept we have requested folks' pass some feedback on for the past couple of years, and as we move to the MVP framework, we feel it's really critical that we address that. So, again, there's a number of questions within that portion, as well.

We also have a number of questions within the MVP framework that focus on how Third Party Intermediaries or Registries for QCDRs can really function in the MVP framework, again, as the one-stop shop. We also have a number of questions that focus on ensuring that the data that we get in for the MVPs framework is meaningful and robust, and also how we can go about sharing that data back out not only to clinicians in a timely and useful manner, but also how we can share the right types of information to patients. So, I just wanted to provide a little bit more background on some of the pieces of information that we are looking for. For folks that want to verbally ask their questions here today, feel free to ask questions that you have on the MVPs, but in a number of instances, just as a heads up, I will probably refer you guys back to the RFI itself, to those many questions that we have there, and ask you to submit your comment. We really, really want to hear all of your thoughts and feedback as we approach the new framework of the MIPS program. We're not trying to be evasive by any means. We really just want to ensure that we can take into consideration everyone's thoughts and feedback as we move forward to the future state of the MVPs. So, I think I've taken up enough time, so let me stop there and turn it back to Kati to go through the Q&A.

Yeah. And I'm actually going to turn it right over to folks on the phone. Do we have any questions? And also a reminder, I know a lot of you have already been using our chat function, but we are -- we do have a lot of our subject-matter experts in the room and on the phone trying to answer those questions as we can. So, we'll try and get to as many of those, and then we're happy to take whoever is ready on the phone.

We have a question from Kim Sweet.

Yes. Hello. Thank you very much for taking my call. My question is in reference to the inappropriate treatment of those two measures that you brought up. One actually happens to be an inverse measure and the other one is not an inverse measure. So that 100% kind of has me a little boggled, but I guess could you expand on that, and do you mean to remove the benchmarks

on those reporting? I'm not quite clear what's supposed to happen to those. Thank you.

Are we on?

We're good.

Okay. Alright. Sorry about that, folks. Sure. So, you're referencing what's on slide 29, our proposed benchmarking methodology for inappropriate treatment. So, thank you for calling out that MIPS measure number one, Hemoglobin A1c Poor Control, is an inverse measure. So, yes, what we would be looking for in the inverse measure is instead of 100% performance being ideal, 0% performance being ideal. So, for that particular measure, we would be applying it in that inverse fashion. Overall, for these measures, what we are seeing is when you're trying to achieve top performance, whether it's 100% or for the A1c measure, 0% performance, we are seeing that in some rare instances that trying to achieve that 100% accuracy 100% of the time could lead to inappropriate treatment for a patient. So, what our proposal is modifying here, is instead of applying our typical approach for creating benchmark based off of historical performance, where it's broken up by deciles, or it could be within the top range, which would be to get the 10 points. Performance rates could range, let's say, between 94% to 100%. What we would do under this policy is we would create flat percentage benchmarks. So, in that top decile, that would include any performance that would go from 90% to 100%, et cetera. So, again, we believe that this approach would remove that incentive to trying to achieve 100% accuracy all the time. Again, as with everything else that we've been talking about here today for the proposal, we really welcome feedback, as well as any of our other policy through the public-comment process. But I hope that helps clarify our intent here.

Thank you.

Thank you.

Your next question is from Maggie Wisment.

Yes. My question is in regards to the hardship exemption application for small practices in 2019. Can you clarify? Is this for any practice that has fewer than 16 providers in 2019, and will the P.I. category be then reweighted to Quality?

This is Molly. Let me start with, so, I think you're asking about for the hardship exception for small practices for the Promoting Interoperability performance category? Is that right?

Yes.

Okay. So, sure. To be able to achieve that hardship exception, I recommend that you go to our Look-up Tool and confirm that you have that small-practice special status. If you do, in fact, have that, then you can go to our website and request the hardship exception. I don't know that it has been released as of yet. We have a number of items that we're trying to get out. So, let me actually see. Kati, do you have a timeline of when the hardships will be coming out?

Very soon.

Okay. Yeah.

And they'll be available through the end of December. So, we open through December 31st to submit those applications.

You'll have plenty of time.

So, all that's required is to have fewer than 16 providers, then? There's no other criteria for it?

You need to be considered a small practice, which we define as 15 or fewer clinicians. Again, please make sure that you have that designation stated with you because we will be looking for that, but, otherwise, yeah. That's the main criteria to be able to receive that hardship.

Okay, great. And then P.I. would be reweighted to Quality, then?

To another performance category, yes.

Okay. Thank you.

Thank you.

Your next question is from Jessica Peterson.

Hi. I have a few questions, and they're mostly "yes" or "no," so I'm going to try to shoot them out really quick. In the Targeted Review Data Validation section of the proposed rule, on page 968 of the single-page version -- not the three-column version -- it states that a duplication of a targeted review application will result in the denial of the duplicative request. I'm just unsure, and it's a little unclear if that means that both requests -- let's say a practice accidentally submitted to you, because two different people submitted it, would be denied, and that would be the final decision, or if just the duplicative request would be denied and the other targeted review request would still be allowed?

This is Bobby Harris from CMS. The duplicative targeted review will be denied only.

Okay. Great. Other question would be, the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions proposed measure based on administrative claims -- it sounds a lot like the All-Cause Readmission measure, which is mandatory for large practices. It's just automatically calculated under Quality. Is this the same kind where it will be automatically calculated whether you want it to or not, or is this a measure that you can choose?

Hey, Jess. It's Molly. So, for the new population health measure, we are anticipating that it could be calculated similarly to the current administrative claims measure that we have within the program. However, as we move to the MVPs framework, that is something we are looking for additional feedback on.

Okay.

So, I hope that helps.

It does. And then two last questions both on the QCDR section of the proposed rule. Under the New Measures for Consideration for Approval portion of the QCDR section, two of them -- QCDR Measure Availability and QCDR Measure Addresses a Measurement Gap, two of them don't state what year they're being proposed for, and there's a lot of variability for a 2020 performance or 2021, and I was wondering if you knew that off the top of your head.

Great question. I think we have to take a closer look at that. If you want to submit a comment to us on that, that would be really helpful, as well. Thank you.

Absolutely. And then last one, again, under QCDRs, where it's talking about remedial action and termination of QCDR, it states that -- it's basically about that whole cherry-picking discussion where you're not really submitting 70% of the patient that's not representative, you could get in trouble, but there are small practices in order to get 3 out of 10 points on a measure because maybe they can't find enough and they're overburdened, then just submit on one patient with that being the only intention -- just getting that 3 points. So, I was wondering if that was kind of excluded from this proposal? It wasn't quite clear.

That's another great question. I don't know that that's something we considered or worked through, so I'd also recommend you submit a comment on that one, and we can address that in the final. Please also submit, along with that, what your opinion is, which I assume you will. Thank you.

[Laughs] I will. Thank you much for taking all my questions.

Thank you.

Your next question is from Amanda Ward.

Can you guys hear me okay?

We can, Amanda.

Go ahead.

Okay, great. Thank you. What I wanted to ask was a little bit more about the MVPs in relation to both Qualified Registries and QCDRs from the sort of software-development scoring perspective. I was just wondering if you guys had all talked about how the policy is just going to shift from policy to actual implementation and, like, maybe one question related to that would be, for example, in 2021 and beyond, would Qualified Registries and QCDRs still have the ability to, perhaps, say, use something like the CMS Submission API to submit the MVP categories? Has that been baked out yet in terms of the software? Will we still be using the HARP account and all these other layers of complexity that I know deal with other contractors that work on sort of implementing the actual policy of the program, but I'm curious to know if the proposed rule has sections in it that focus -- I know there's a lot that focus on the policy and what the MVP, what you want it to look like, but how it's going to actually be implemented and what our role as Qualified Registries or QCDRs is going to be in terms of getting that data to you? Is there more information about that? Has it been discussed yet? Is

it something that might make sense to try to add as comments into the proposed rule or where would we go about learning more about that?

Sure. So definitely recommend you submit a comment on that. For the overall kind of question of do we envision a drastically different submission process or drastically different infrastructure when we move to the MVPs framework, the answer to that is, we will still, of course, have our underlying infrastructure that we've built for the QPP project. So, for some of the items you're touching on, and the actual method of submitting data to us using our direct method, using the specific identity management account, those are really driven more based off of technology and less off of policy. So, unless there is a significant technology change in the next few years, which is always possible, we don't anticipate major changes in that area at least not that's policy-based. However, with that being said, if there are key areas of the MVP framework that you envision would require additional changes or if you have more specific questions on different areas of, for example, what the multispecialty reporting element of the MVP framework would look like from a submission standpoint, we recommend that you give us your feedback, as well as any questions that you have there so we can take those into consideration as we develop our policy for future years. I hope that helped. Thanks.

Definitely. Thanks so much.

Again, if you would like to ask a question, please press star and the number 1 on your telephone keypad. You next question is from Teresa Kegg.

Hi. Thanks for taking the call and thanks for the presentation today. It's really helpful. My question is with regard to the Third Party Intermediaries now being required to submit Improvement Activities in P.I. So, is the CMS portal still available if we want to utilize that? I really enjoy how easy that is to use and it doesn't require us to incur additional cost from those Third Party Intermediaries. I'm just curious to see if it’s CMS' goal that we're going to move away from that?

Sure. Great question. So, no. We do not anticipate moving away from the ability for clinicians to submit data directly to us without entering into a business relationship with a third party. We, overall, as folks can see with the way we've constructed the Quality Payment Program, we want to provide as much choice as we can to clinicians, but we are very much aware that sometimes when you provide so much choice, it can become overwhelming and there just becomes exhaustion there. But we are not, at this moment in time, considering eliminating the ability for clinicians to come in and attest to Improvement Activities directly through our website and same with Promoting Interoperability or, for that matter, for practices that have the technical capabilities to directly upload data to us. We do still envision that being an option for the future. We do just recognize that a number of clinicians find working with a third party really meaningful and valuable, and we really want to ensure that those third parties provide the same level of benefits across the different organizations.

Thank you.

Alright, we're getting close to our time here, so we'll probably just take one more quick question before we wrap up.

Our last question will come from Jessica Basillo.

Can you guys hear me?

Go ahead.

Yes.

Thank you. My question is in regards to how a third party vendor and a Health I.T. vendor are required to submit at least one category. Is the creation of a QRDA III file and the submission of that sufficient, or are you looking for more than that?

So, the submission format is different from the proposal that we put forth. We are proposing that health I.T. vendors support at least one of the performance categories until we get the proposal. So that's between Quality, Improvement Activities, and the Promoting Interoperability performance category, and so that's separate from the submission format of QRDA III. I want to make that clear.

Okay. Thank you.

Uh-huh. No problem.

Alright, great. Thanks, everybody, for all your questions today in the chat and on the phone, and just a reminder, as we said before, the slide, transcript, and recording will be available in the next couple of weeks on our QPP Webinar Library. So, keep checking back there, and, also, a quick plug for our QPP listserv. If you aren't already signed up, we encourage everybody to sign up for that. That's how we alert people when we have our most recent available information. So, you can go to our main website, and at the bottom of the homepage, you can enter in your e-mail address to get all of our updates on the latest and greatest with the program. So, thanks so much, and we'll talk to you all soon.

Thank you. That concludes the Q&A portion of the webinar. Thank you all for joining.