Overview of MIPS Webinar
January 22, 2020

Hello, everyone. Thank you for joining today's Overview of MIPS for the 2020 Performance Period of Quality Payment Program webinar. The purpose of this webinar is to provide an opportunity for current and new participants, support staff, and other stakeholders to learn the basics of the Merit-based Incentive Payment System, MIPS, program. The presentation will be followed by a Q&A session, where attendees will have the opportunity to ask their questions. Now I'll turn it over to Molly MacHarris, MIPS program lead at CMS. Please go ahead.

Thank you, and thank you, everyone, for being here with us today. We have a lot of information that we want to cover, and we want to make sure that we have time at the end to go over your questions. So I'm going to go ahead and jump right in and move us along to slide 3 just to quickly go over the topics that we're going to cover today.

First, we're going to start with a bit of background on MACRA and QPP and briefly touch on our new MVP framework. Then we will be going into a lot of detail into our finalized policies that we finalized in last year's Physician Fee Schedule rule that outlined the requirements for participation in MIPS program for performance period 2020. So for performance that is happening this year. Again, since there's a lot we want to cover, I'm just going to go ahead and jump right in. Let's move on to slide 4 and then on to slide 5.

So, a lot of this initial information that I'm going to cover is background in nature, and most of it, I hope, is already familiar to all of you. But just in case it isn't, let me just briefly go over this. So, first of all, what is MACRA? MACRA is a law that passed back in 2015 that stands for the Medicare Access and CHIP Reauthorization Act. And the MACRA did a number of things. First, it repealed the Sustainable Growth Rate methodology, which many of you all know there were some flaws within that methodology, which required an annual "doc fix" that Congress had to pass, really, every year for many years over a decade because if they didn't do that, there would have been significant reductions to clinicians' reimbursements. MACRA ended the SGR formula and instead set forward flat fee-schedule updates with additional payment updates that come over time for participation in APMs.

It also ended a number of our legacy quality programs that you all may have been familiar with, such as the Physician Quality Reporting System, or PQRS program that focuses on quality. It also ended the Medicare EHR Incentive Program for Eligible Professionals, which focused on the usage of Certified EHR Technology for clinicians. And it also sunsetted the Physician Value Modifier program, which looked at quality and cost.

Again, those three programs have ended, and it authorized a new set of programs called the Quality Payment Program, which has the MIPS program as well as APM. So, let's go ahead and move on to slide 6, which just has some of that additional information I was just covering on what was the SGR formula and how that ended.

And then moving on to slide 7, this reflects the new quality reporting programs that we have available, which again, MACRA authorized the Quality Payment Program. There are the two tracks under the Quality Payment Program -- MIPS, which is what we'll be focusing on here today. There also is the

ability for clinicians to participate in Alternative Payment Models. We won't be getting into too much detail on Alternative Payment Models here today. If that is something that you all have interest in, we would recommend that you ensure you're signed up for QPP Listserv for additional engagement opportunities to learn about Alternative Payment Models. So, let's move on to the next slide, slide 8.

Just to highlight some of the key considerations we thought about when we initially introduced the Quality Payment Program. Some of the things that we've really been focusing on since the start of the program, and these continue to be relevant today, is we really want to improve beneficiaries, so patient outcomes. We want to have healthier patients. We also recognize that under the legacy program, there was a lot of burden involved, particularly a lot of administrative burden on having to comply with multiple programs at once. So, one of our other key goals, as we move to the Quality Payment Program forward is really to ensure we can reduce burden on clinicians.

We also want to make sure we keep a key focus on the other side of the Quality Payment Program, which is APMs. So we really want to increase the adoption of advanced APMs, as well as maximizing participation and a number of the other items that we have on this slide here. So, this was just a bit of brief background on what MACRA is. So let's go ahead and move on to slide 9, and then slide 10, to highlight what MIPS does.

So, as I've already mentioned, on slide 10, MIPS combines an end to the three legacy programs that you all may have participated under in the past. Again, the PQRS program, the Physician Value Modifier program, and the Medicare EHR incentive program. Those programs have concluded.

And instead, what we have is the MIPS program, which, as reflected on slide 11 -- what we do under MIPS is we assess clinicians' performance on four separate performance categories. They include Quality, Cost, Improvement Activities, and Promoting Interoperability. So, Quality -- dealing with quality measures, Cost -- so, dealing with the measurement of costs or resource use, clinician spend. Improvement Activities deal with fostering improvement within a clinical organization, and Promoting Interoperability deals with the usage of certified EHR technology. So, as you can see with these four performance categories, there's a score or weight associated with each of those, and each of them sum up to a total of 100 points.

That is important because what we are ultimately doing here under MIPS is we are assessing your, the clinician's, performance on these four performance categories, and how you perform on each of these categories will ultimately derive in something called a final score.

That final score can range anywhere between zero and 100 points. And that final score will have, depending upon where that final score is in relation to a performance threshold, will determine your reimbursement that you would get in calendar year 2022. So, if your final score is above the performance threshold, you could get more money, so, a higher reimbursement. If it falls below that performance threshold, you would get less money. So your claims would get reduced. And if your final score is at the performance threshold, you would get no update to your claims.

We'll be talking through this in much more detail later on, but just to say it up front, the number that ideally all clinicians want to have their final

score at or above for 2020 is 45 points. That is where we've set the performance threshold, so again, anyone whose scores fall below that would be getting a negative adjustment. Let's move on to slide 12, with just a few other key terms I want to touch on.

The first is you will hear myself and some of my colleagues talk through the usage of a TIN, a Tax Identification Number, or an NPI, National Provider Identifier, and the unique term TIN/NPI. These are billing identifiers, and this is how we identify who the clinician is. So it is possible that if you are a clinician and if you, as a clinician, have one NPI, but if you practice medicine under multiple different clinics or facilities, you could have multiple TIN/NPIs. When we go to talk about eligibility, and in a few coming slides, I'll outline how that comes into play and what the implications are for you.

Also, just to briefly touch on some of our time frames here -- So, the performance period we're focusing on here today is 2020. You may hear me or my colleagues refer to it as Year 4. And again, the payment year that claims would be updated based off of your performance will be in 2022. And then moving on to the next slide, slide 13, just want to highlight at a high level our timelines here.

So, this performance period began January 1st. It closes December 31st. The majority of data submission will occur at the following calendar quarter, up until March 31st. We will then issue feedback, and then your claims would begin being adjusted in 2022. Okay, so, those are the basics. So, let's go ahead and move on to slide 14 and then slide 15.

So, on slide 15, how do we actually determine if you are included in MIPS for the 2020 performance period? Does this program apply to you? So, the first thing that we do is we look to determine if you are a MIPS-eligible clinician type. Then we look to see if you have exceeded -- we look to see if you are excluded. There's three main ways you can be excluded, which I'll talk about in a coming slide. And then we also look for one exclusion, the low-volume threshold, with more detail. So, let's go ahead and move on to slide 16.

So, again, first we look to see are you eligible, then, as reflected on slide 16, we look to see whether or not you could be excluded. So, you can be excluded for a given performance period if you are newly enrolled in Medicare during this performance period. So, if someone within your organization, for the first time, becomes enrolled in Medicare, they would be excluded from participation in this first year. The second exclusion, the low-volume threshold, I'm going to talk through in a lot more detail in some coming slides. So I won't get to too much there right now. So stay tuned. And then the last exclusion that we have is there are certain thresholds if you significantly participate in an Advanced APM, again, that other track of QPP. If so, you would be excluded from MIPS. Let's move on to slide 17.

Those are our high-level exclusions, but who could be eligible? So, MIPS-eligible clinicians consist of both physicians and non-physician clinicians who are eligible to participate. We define these annually through our rule-making process through the Physician Fee Schedule. And this is important because if you are identified as a MIPS-eligible clinician type, that is the first step in determining whether or not you would be required to participate.

The eligible clinicians that we have for 2020 are reflected on slide 18. And as you can see here, there's no change in who was eligible from 2019 to 2020. So, if you are a physician, and just as a brief reminder, when we talk about physicians here at Medicare, we mean not only MDs and DOs, but we also include chiropractors, optometrists, and podiatrists. And then we also have the rest of the list of clinicians that are on slide 18 here. So, PAs, NPs, physical therapists, occupational therapists, audiologists, et cetera. So, if you are one of these clinicians, you could be eligible. Then we would look to see if you are excluded.

So, moving on to slide 19, let me talk through the low-volume threshold exclusion. This is the one that typically excludes the majority of clinicians. So, as reflected on slide 19, the low-volume threshold is the second step that we would determine in whether or not you are eligible for a specific performance period. Based off of your billing patterns, you could be eligible for one performance period, and then in a subsequent year, you could be excluded, or vice versa.

So, moving on to slide 20, the low-volume threshold values that we have for 2020 -- again, this is no change from 2019 -- is that you would be eligible if you bill more than $90,000 annually, you provide services to more than 200 beneficiaries, and you provide 200 services.

If you exceed all three of those, and you also are an eligible clinician type, you would be considered a MIPS-eligible clinician. So, some of the common questions we get related to the low-volume threshold are, "What are the time frames we look at this?"

So, moving on to slide 21, the determination period we use to make this determination -- one is a historical period, which runs from -- for the 2020 year, runs from October 1st through September 30th of 2019. And then we also have another determination period from October 1st through September 30th. We use these determination periods -- we use these two different determination periods because, as you'll see in some coming slides, we actually build all of this information into our QPP website, and there is the ability for you to go there, enter your NPI, and see whether or not you are eligible.

So, let me just continue to go over some of the additional details on the low-volume threshold, so moving on to slide 22. So, there are different ways that you can participate in MIPS, either as an individual or as part of a group. So, does the low-volume threshold apply to groups? Yes, it does. We apply the low-volume threshold based off of the level that you report at. So, when you go to the Look-up Tool, which, again, I'll talk about in a few upcoming slides, you can see information on there that you may be excluded as an individual, but you could be eligible as a group. So, organizations will need to make these business decisions on whether or not they will want to participate in MIPS as a group or if they would want to participate as individuals. There are a number of considerations that organizations will need to think through as they make these decisions. Moving on to slide 23.

So, what happens if you are excluded under the low-volume threshold but you still want to participate? If that is your scenario, there are two options. The first is that you could volunteer to participate. What that looks like is you would not be considered an eligible clinician. So, the scenario that this may happen is maybe you've fallen under the volumes of the threshold, but you think your billing patterns may change in the future. You could

volunteer to participate, meaning you would send us in your data, and we would provide feedback on that. You would not, however, be eligible to receive any additional money, a payment adjustment, or you would not be able to receive a negative payment adjustment.

The second option, opt-in, is that you could decide to become a MIPS-eligible clinician if you meet or exceed at least one of the low-volume threshold criteria. So, what that looks like is on slide 24.

So, MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS. So, as you can see on this chart, looking at the top row first, so, if you bill less than $90,000 annually, see less than 200 beneficiaries, and render less than 200 services, you are completely excluded under the low-volume threshold. Then, looking at the bottom row -- so, this is you exceed $90,000, you see more than 200 beneficiaries, more than 200 services, you are required to participate, meaning you are a MIPS eligible clinician. However, you can see in that middle area, if one of those elements or two of those elements is true, you have the ability to opt in and finish your data. So, let's move on to the next slide -- slide 25.

So, this is where you can go to enter your NPI to determine whether or not you are a MIPS eligible clinician, if you would otherwise be excluded. We also have information within our participation status tool that touches on special statuses. Special statuses can include instances where you may be considered to be part of a small practice, if so you could have some additional scoring flexibility. The participation status tool also tells us what organization you're associated with, and it also tells you whether or not we see that you are identified as part of an APM. So, again, this is available on our website at qpp.cms.gov. Highly encourage all of you to go there and take a look at that. Let's go ahead and move on to slide 26.

And I touched on this briefly earlier, but what may happen when you go and enter your NPI into the tool -- if you could see that if you had practiced medicine under any of those two determination periods that I talked about, you could be eligible under one TIN/NPI or excluded under another. Or you could be eligible under both. Since we define clinicians based off of the unique TIN/NPI combination, we will look at you to determine whether or not you meet our eligibility criteria, as well as our performance criteria uniquely. So, let's move on to the next slide, slide 27, and then 28 to start working through some of our reporting options.

So, if you are required to participate, what are the reporting options available? So, the first is participating as an individual, which is based off of your unique TIN/NPI. The second is participating as a group. A group is defined as one TIN with two or more NPIs that have reassigned their billing rights over to the TIN.

And then the third option is participating as a virtual group. The virtual group is based off of solo practitioners in groups of 10 or fewer eligible clinicians who decide to form a virtual group. Based off of our MACRA statutory requirements, those elections must be made to us prior to the beginning of the performance period. So, unfortunately, if this was something you all were considering doing for 2020, it's not an option available anymore. We would have needed to have heard about this by December 31st. However, if it is something you all may want to consider, you can certainly do so for a future year. Moving on to slide 29.

When we think about the way that our data can come into us through our four performance categories -- Remember, we have Quality, Cost, Improvement Activities, and Promoting Interoperability. So, you'll hear us talk about different collection types. Collection types refer to, under our Quality performance category, we have a number of quality measures that have different collection types. Some of those can include Electronic Clinical Quality Measures. We have MIPS CQMs, which, if you are familiar with the legacy programs, is what we previously refer to as registry measures. We've since updated that term because it's not really accurate to call them registry measures because you don't have to work with a registry to use those.

We also have our QCDR measures, which are specific to QCDRs. Our Part B claims measures, our Web Interface measures. We also have a CAHPS for MIPS survey, a patient experience survey. And we do have administrative claims measures.

When we talk about the submitter type, that is the entity that is acting on behalf of the MIPS eligible clinician, or it could be the clinician themself, to submit data on those measures and activities on all of those various collection types and all of the activities and measures and objectives across the other performance categories.

And then we have submission types, which refers to the different ways that data can come into us. They mainly include the ability for you to go to our website, qpp.cms.gov, sign in, and upload a data file for some performance categories, such as Improvement Activities and Promoting Interoperability. You can sign in and attest. We also have the ability for some organizations to submit data to us directly using an automated programming interface, which is a computer-to-computer exchange. So, let's go ahead and move on to slide 30, where we have this broken down by who is eligible to do what as an individual.

So, as you can see here, it does differ by performance categories. The methods that are consistent across all are direct in sign-in and upload. Also, individuals and third parties can submit for all of these.

And moving on to slide 31, our submission options for groups. As you can see, they're slightly different. There are a few additional submission options for groups. Namely, we also have the CMS Web Interface, which is a method of submitting data to us using a beneficiary assignment and sampling algorithm. Okay, so, those are the basics of how data can come in. Let's go ahead and briefly move on to slide 32 and 33 again to talk through some of the performance category requirements.

So, as reflected on slide 33, you've heard me touch on here a couple times here today the reference to a performance period and 2020 as the performance period. So, as you can see for Quality and Cost, our performance period is the entire calendar year, 12 months. Whereas for Improvement Activities and Promoting Interoperability, it's a continuous 90-day period. For the Improvement Activities and Promoting Interoperability performance categories, you're always welcome and encouraged to report on a longer performance period than 90 days if you so choose. There's no limitation there. And then moving on to slide 34, our performance category weight.

Again, I mentioned this earlier, at the beginning of the presentation, but again, the performance category weights are the specific weights that each of these performance categories will contribute to your overall performance score.

So, as you can see right now, the one -- there was no change in these weights from 2019 to 2020. And as you can see right now within the program, we still have a really strong emphasis on Quality with that contributing 45 points, with Cost at 15 points, Improvement Activities at 15, and Promoting Interoperability at 25. I do want to flag, however, that over time, we are required to continue to increase the amount of weight that is associated with Cost and decrease the amount of weight that is associated with Quality. So, by law, in 2022, so, two years from now, each of those must be set at 30 points. So that's something we'll be thinking a little bit more about in coming years. So, let's go ahead and move on to the next slide, slide 35.

And to talk through the Quality performance category requirements, I'm going to go ahead and turn the next part of the presentation over to my colleague Sophia Sugumar. Sophia?

Thanks, Molly. Alright, so, just a few Quality basics for the 2020 performance period. We have maintained that total Quality performance category's worth -- 45% of your MIPS final score. This is the same as it is for 2019, or was for 2019. You'll notice that there's been a reduction in the volume of quality measures we have available in the program. Our measure inventory is now down to 218 quality measures. And this is in alignment with our Meaningful Measures Initiative across the agency that we're looking to remove -- duplicative, topped-out measures, measures that are standard of care, that do not have a robust quality action. And so, this is a part of that initiative, and we've been able to make a reduction in our inventory to 218. You still have to report on six quality measures. One of the measures has to be an outcome measure or another high-priority measure, if an outcome measure is not available.

And then a reminder that a high-priority definition includes outcome, patient experience, patient safety, efficiency, appropriate use, care coordination, and opioid-related measures. If less than six measures apply, you should report on each applicable measure. You may also choose to report on a specialty-specific set of measures, or what we call specialty sets, and that's also available to you. Next slide, please.

Alright. In reference to the bonus points, outcome or patient experience measures receive two points after the first required outcome measure is submitted. Other high-priority measures will receive one point after the first required measure is submitted again. Each measure submitted using electronic end-to-end reporting will receive one point. Small practices bonus is up to six points. Next slide, please.

With regards to data completeness, data completeness means we're checking to see if you or your group have submitted data on a minimum percentage of your patients that meet the quality measures denominator criteria. For the 2020 performance period, we have finalized an increase in the data completeness threshold to 70% for data submitted on QCDR measures, CQMs, which are previously known as registry measures, and eCQMs on all-payer data.

That same 70% standard will be held for Medicare Part B claims measures, as well. Measures that do not meet the data completeness standard will earn

zero points. That small practices will also receive -- Small practices who do not meet the data completeness will receive three points if they fail to meet that criteria. We also refer reviewers or the audience to the 2020 Quality performance guide, which will provide more additional reporting requirements and measure-specific information. Next slide, please.

Alright. As I mentioned before, through the 2020 rule, we've chosen to remove measures that were identified as low-bar, standard of care, or more process measures, as our focus is typically on maintaining more outcome-based measures in other high-priority area and other measures that reflect high-priority areas within the program.

We did add a few specialty sets to our program. One for the speech language pathology, audiology, clinical social work, chiropractic medicine, pulmonology, nutrition and dietician, and endocrinology. We refer you to the QPP Resource Library, where we have extensive resources and materials for all of our measures. And to that point, we do have the 2020 Quality Measure Specifications based on each collection type -- CQM, QCDR measures, Web Interface measures, Medicare Part B claims measures, and their supporting documents available through the QPP Resource Library. Next slide.

And with this, I'm going to turn it over to Joel to address the Cost performance category.

Thank you, Sophia. Good afternoon, everyone. My name is Joel Andress, and I'm the Cost Measure Lead here at CMS. Next slide, please. Thank you.

As was previously noted, the Cost performance category remains 15% of your MIPS final score. And as has been the case in the past, it incurs no reporting requirement for you. All data for calculating the measures are pulled from the administrative claims here at CMS. The measure set has been revised to include the Medicare Spending Per Beneficiary Clinician measure and the Total Per Capita Cost measure, which you'll remember, but it has been revised from previous years, as well as an additional 10 episode-based cost measures that now supplement the original 8. It was finalized in the previous year. In order to be scored on a cost measure, you or your group need to have enough cases attributed to you by the measure logic that was developed for these measures when they were created. Which may mean you need to exceed the cases specific to that particular measure, which is defined within measure specifications. Next slide, please. Thank you.

As I noted, of the 20 cost measures that are included in the performance period, 18 of them are episode-based cost measures, 8 of which were carried over from 2019. The 10 new measures are part of the Wave-2 measure development for episode-based cost measures and were finalized in November of this past year and are being added to the cost performance category. As has been the case in previous years, if you are attributed to multiple cost measures, those will all be incorporated as part of the cost performance category and then weighted equally to determine your score for the category. Next slide, please.

The existing MSPB and TPCC measures have been revised as of this year. The revisions are substantial in detail and within the documentation that are available in the QPP Resource Library, as with the quality measures. But by way of summary, the TPCC now requires both a primary care E&M code, as well as additional primary care E&M or primary care service in order to trigger attribution to a given clinician.

We have now revised the measures so that costs are assigned only after seeing, or upon seeing given patients. So, the previous measure had assigned costs that were accrued prior to the initial encounter between patient clinicians is no longer the case. The measure also allows for multiple attribution to 10 NPIs and excludes non-primary-care specialists and clinicians that provide a high frequency of non-primary-care services. Additionally, risk factors are determined one year prior to each beneficiary. There are more up to date with the previous version of the measure. And there's no grouping of cost after a beneficiary's death, whereas previously, it had been annualized upon death.

For the revisions to the MSPB measure, we have separated attribution methodologies between medical episodes and surgical episodes. Surgical epsiodes now attribute surgical episodes to the surgeon performing the main procedure of an episode, whereas medical episodes attribute to TINs billing of substantial share of E&Ms during index admission and to TIN/NPIs teaming up in that care. We attribute medical episodes first at the TIN level, whereas before they had been attributed up to TIN/NPI. And like the TPCC, the revised MSPB measure allows for multiple attribution to TIN from TIN/NPIs. We have also excluded unrelated services specific to groups of DRGs that are aggregated by the MDC level. Next slide.

And now, for the Improvement Activities category, I'll hand it over to Angela McLennan for her discussion.

Thanks, Joel. Good afternoon, everyone. I'm Angela McLennan. I'm the Improvement Activities Lead for CMS. You may be happy to know that not much has changed in the Improvement Activities performance category for 2020. It still makes up 15% of your MIPS final score. The biggest changes have taken place in the inventory. I'll speak to that a little bit on the next slide, but we have a total of 105 Improvement Activities for 2020.

The weights remain the same for the improvement activities. We have either medium-weighted activities, which are worth 10 points, or we have high-weighted activities, which are worth 20 points. You can select an activity and simply attest to completing the activity. To receive your full Improvement Activities category score, you must earn 40 points, and you can do that in any combination of medium- and high-weighted activities.

One thing to note is that for small practices, non-patient-facing clinicians, and clinicians located in rural or health-professional-shortage areas, we provide double weighting for the improvement activities. And for those eligible clinicians, they would need to report on no more than two activities to receive the highest score. Next slide, please.

So, for 2020, we've added two new improvement activities. We've modified 7 of our existing improvement activities, and we've removed 15. So, that's how we have arrived at the 105 that we currently have available for 2020. Next slide, please.

And now I would like to turn the presentation over to Elizabeth Holland, who will go over the Promoting Interoperability performance category. Elizabeth?

Thank you, Angela. I'm Elizabeth Holland, and I am the Promoting Interoperability Performance Category Lead at CMS. Next slide, please.

As you may recall, we did an overhaul beginning with the 2019 performance period, so that we really reinvented what this performance category looked like. It is still 25% of your MIPS final score, and you must use 2015 edition Certified EHR Technology.

We made a change in the last round of rulemaking, where groups and virtual groups will now qualify for automatic re-weighting of this category when more than 75% of the clinicians in the group or virtual group are hospital-based. That same policy applies to non-facing patient groups, as well. All other group types will only be re-weighted if 100% of the clinicians in the group qualify for some sort of re-weighting.

There are four objectives under this performance category -- e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. Next slide, please.

So, now we're looking at the objectives that I just mentioned with their associated measures. So, each measure, you can earn a maximum number of points. How the scoring works, for example, for e-Prescribing, if you submit a numerator and denominator of 50/100, for example, you would earn 5 points out of the maximum of 10.

And there are exclusions for many of these measures, and I'm going to refer you to our specification sheets for the Promoting Interoperability category. We have specific specification sheets for each measure, and they include all of the information about how the measure is scored, other policy items related to the measure, as well as the exclusions that you might be able to qualify. When you submit your data, you need to claim the exclusion for you to receive the exclusion.

The other one thing I'd say is there are certain attestations that are required to report data under the Promoting Interoperability performance category. There's the attestation that you did perform the security risk analysis sometime during the calendar year, as well as information blocking attestations. If you go into the Promoting Interoperability module and try to submit your data, if you enter your performance period or your CEHRT number and you were previously approved for a hardship, submission of any data for PI -- that includes performance period or CEHRT number -- will void your hardship exception.

So, really, if you believe you have a hardship exception, and I understand that the people who are submitting right now, you can't actually see those hardship exceptions yet, they'll be available in our system sometime in February. But make sure, if you believe you have a hardship exception, do not submit anything for PI, or your data will be voided. Next slide, please.

Just to review, we did remove the Verify Opioid Treatment Agreement for 2020, and we did change the Query of PDMP measure from a yes/no attestation to -- I'm sorry, from a numerator and denominator to a yes/no attestation. And it is available for extra bonus points. So, now I'm going to turn it over to Dr. David Nilasena for the next part of our presentation.

Thank you, Elizabeth. I'm David Nilasena. I'm one of the scoring leads for the Quality Payment Program. And I'll be talking about sort of how these four categories roll up into your final score and payment adjustment. Next slide, please.

Now, as Molly mentioned at the earlier slide, each category has a weight. And so, the score for each category is multiplied by that weight. Those are rolled up. There's something also called a complex patient bonus that's added at the end to get a final MIPS score. And the final MIPS score is what determines the overall outcome of your performance relative to your Medicare payments.

For 2020, we have raised what's called the performance threshold to 45 points. It was 30 points in 2018. And the performance threshold is the minimum number of points you need in your MIPS final score in order to avoid a negative or downward payment adjustment. If you get exactly 45 points, you'll get a neutral, or 0% payment adjustment. If you're above 45 points, you'll get a positive payment adjustment.

There's an additional performance threshold that we've also defined for exceptional performance. And we've set that at a level of 85 points for 2020. So, a slight increase from the prior year. And if you get at or above the additional performance threshold, then in addition to the regular MIPS upward payment adjustment, you qualify for an additional bonus payment adjustment for exceptional performance.

So, basically, we compare your MIPS final score to these two thresholds, and that's what determines your overall Medicare payment adjustment. And this adjustment can be as low as a -9%. That's set by the MACRA statute. And it can be up as high as plus-9%, subject to a scaling factor, depending on the overall distribution and MIPS scores. So it may be higher or lower than 9%, depending on that distribution. Next slide.

So, the next slide just shows sort of the same thing in a little bit finer detail. And so, you'll see the green bar is the 45-point performance threshold. And so, again, if you landed right on that, you would get a neutral payment adjustment. Below that level, you would get between a -9% negative payment adjustment at the bottom, if you're in the lower quartile below that threshold. Or if you're somewhere in the middle, you would get between -9% and 0%. And then if you're above that line, you would get a positive payment adjustment. And then at the level of 85 points, which is the additional performance threshold, you would qualify for the additional exceptional performance bonus. And that starts at a minimum of 0.5% above where you were from sort of the regular payment adjustment.

Now, it's important to understand these payment adjustments for the 2020 performance year would kick in January 1st of 2022. And so, your Medicare payments starting January 1st of 2022 will be adjusted upward or downward based on your performance in 2020. Next slide.

Okay, so, even though today's session has been sort of a high-level overview and just covering the updates for 2020, there is a lot of detail in the MIPS program and the Quality Payment Program. But fortunately, we have a variety of resources for help and support. The first starting point would be our QPP website at qpp.cms.gov. There's a variety of very useful tools and resources on that website.

Probably the most important to start off is the QPP Participation Status Look-up Tool. You can type in your NPI number, and it will bring you back information about whether you're eligible for MIPS as an individual or as a group, whether you meet a variety of our special statuses, including

facility-based and hospital-based clinicians, and also information about your participation with Alternative Payment Models.

We have tools that allow you to explore the measures and activities for the four performance categories. In our resource library, there's a variety of very detailed technical documents that explain all aspects of the program. There are also a set of recorded webinars you can use to review the information about the program. I think actually, today's webinar might be included in that at some point. And then there's an overall help and support page, which gives you additional information about other resources. You can also sign up for our QPP Listserv to get updates on the program and announcements about important deadlines and times for your participation in the program. Next slide.

So, if you're just getting started with the QPP, again, I would start with the QPP website. That gives you information that's either very basic or a very detailed level, depending on your needs. Again, check your participation status using the Look-up Tool. And then, once you've decided or determined whether you are included in MIPS or if you're not, if you think you might want to opt-in, as Molly talked about early on, then you would need to decide if you want to participate as an individual or as part of a group or potentially as part of a virtual group, although that would be for not this year, for next year, since the deadline is at the end of the previous year.

You would also need to identify the measures and activities that you plan to report, relative to your practice. And importantly, to begin capturing that data, especially for the Quality performance category, since there is a 12-month reporting period for that category. Now, there's also a 12-month reporting period for the Cost category, but you don't have to report data on your own from that. That's all derived from our Medicare data, at least currently.

And then, if you are going to opt in, then you would need to sort of plan for that. And that would not occur at this point in time, but would occur during the data submission window, which would be following the end of the performance period. You can also reach out to various forms of our free support, and I'll talk about those in more detail on the next slide.

So, we currently have two -- well, sort of three ways of getting free support. If you are in a small or solo practice, we have a special resource that is authorized and funded through the MACRA legislation to support small, underserved, and rural practices. This is known as our SURS support contractor. And so, if you're in a group of 15 or fewer clinicians, you would be eligible or that support. And we have, I think, 11 different SURS organizations that provide that support for all 50 states and the District of Columbia and Puerto Rico. So, you can look up, on our QPP website, which of these organizations covers your geographic area, and you can contact them for support.

For everybody else, we have our QPP website. We also have our Service Center, where you can either call them toll-free or submit an e-mail question to them to get technical assistance on all aspects of the program. If you happen to be in one of our Alternative Payment Models, they have specific learning systems, or learning networks, that support their particular models. And so, they are able to get additional support tailored to their particular APM participation. So you can learn more about these

technical assistance resources through our QPP website at the link shown at the bottom of this slide. And if we go to our next slide -

Alright, so, that's the end of my portion, and we'll now go to the Q&A session. I'll turn it back to the conference call moderator.

Great. Thank you so much. Okay, so, we're now going to begin the Q&A portion of this webinar. You may ask questions via the chat box or over the phone. So, to ask your question via the phone line, please dial 1-866-452-7887. And when you're prompted, please provide the conference ID as 796 3535 and then press star-1 to be added to the question queue. And please note that with the time allowed, we may not be able to answer all the questions submitted by the Q&A box, so if your question is not answered, please contact the Quality Payment Program Service Center at QPP@cms.hhs.gov.

Okay, so, to begin, we have a few questions on submission points. So, if you could, please explain the difference between direct and sign-in.

Yeah, hi, this is David Nilasena. I think we probably don't have any of our operations folks on the call, but I'll take a stab at that. And you're talking about the two different submission mechanisms, or the submission types. So, for the direct type, as Molly mentioned, that's a sort of automated type using something called an API or Application Programming Interface. And so, that's where you would send in your information sort of electronically to CMS using that API. This is most often done by our third-party vendors such as Qualified Registries and QCDRs. It might also be done through an EHR vendor. And this is different from the log-in and upload mechanism, where you would actually sign in to the QPP website, or at least the data submission part of that website, and then you would upload a file. And most often, this is a file from your EHR, using the QRDA-3 format, but it may also be information related to Promoting Interoperability or IA -- Improvement Activities -- that could be uploaded using a file like that, as well.

Thank you so much. Alright, next question --

Sorry, you were breaking up, and we didn't hear that.

Oh, apologies. Let me try that again. Next question is for the Quality performance category. They'd like to know how CMS determines data completeness.

As we mentioned in slide 38, data completeness is what we look at in terms of the data that you've submitted to us on a given measure, and then how that meets the minimum percentage of your patients in order to meet the denominator criteria of that given measure. So, for purposes of data completeness, we need you to report performance or exclusion or exception data for at least 70% of your patients that are eligible for that measure's denominator. And so, that's what we really mean when we say data completeness.

Great. Thank you. Alright, next, "Can you please confirm whether physical therapists are excluded from the Promoting Interoperability category for the 2020 year?"

They're not excluded, but they can report. But they are automatically re-weighted and they don't have to report.

Alright, thank you. Next, "Is the Cost performance category pre-weighted if the case minimum is not met?"

Certainly. If the case minimum is not met on a given cost measure, then you are not calculated for that particular measure. If the case minimum is not met for any cost measures, then the Cost performance category is re-weighted.

Great. Thank you. Alright, Stephanie, do we have anybody on the phone line?

No questions at this time.

Alright. No worries. Going back to the chat box. "Is there a place where we can find the calculation as related to cost measures?"

I'm not clear on the -- exactly on what's being asked for here. I think you can find the calculation in your performance report. If you're looking for the methodology used to calculate the cost measures, then you would want to look on the QPP Resource Library, which provides those specifications and technical details for all of the cost measures.

Alright, thank you. Next, "Is there a requirement in 2020 for groups where 50% of providers must participate in Improvement Activities?"

Hi, this is Angela. Can you re-read that for me, please?

Of course. It asks, "Is there a requirement in 2020 for groups where 50% of providers must participate in Improvement Activities?"

So, the requirement is that 50% of the providers have to be performing an improvement activity. I just want to clarify. And that's for any 90 continuous days, unless it's otherwise specified within the improvement activity's description for the performance year.

Alright, thank you. Alright, next is for the Query of a PDMP. They ask, "How can you get points for PDMP if your state is not participating? Or will it suffice by just being able to show that you went to the state?"

You need to perform a query. So, if you're not able to query a PDMP in your state, it's possible you could query another -- there's a PDMP you can query that's sponsored by another level of entity, but you must do a query at least once to fulfill the measure.

Great. Thank you. Alright, next question asks, "What is the small-practice threshold for quality measures submitted by claims? Is this number for total providers in the group or total number of eligible providers in your group?"

Sure. This is Molly. So, just to clarify, we apply the special status of a small practice if the organization has 15 or fewer eligible clinicians. If you are a small practice, then you have further flexibilities for some scoring requirements as well as the ability to report on qualities in Part B claims. I hope that helps address the question. Thank you.

Great. Thank you. Alright, next question: "If you fall under one of the exceptions for QPP participation, such as low-volume, how is your payment rate determined?"

Sure. This is Molly again. So, if you are excluded from MIPS based off of one of those three exclusions that I talked about at the beginning of the presentation, such as the low volume threshold, if you become newly enrolled to Medicare during this performance period, or if you have significant participation in an Advanced APM, you would not be considered a MIPS-eligible clinician, which means you would not receive a payment update based off of your performance in the MIPS program. So, essentially, it means you're not required to participate in MIPS.

Great. Thank you. Alright, next question asks, "If their numbers are so close -- some years they are eligible and some years they are not -- should they plan to report every year, and can you please explain what the pros and cons are?"

Lauren, could you repeat the question for us, please? Thank you.

Of course. It asks, "For one clinic, their numbers are so close that some years they are eligible for MIPS and some years they are not. So should they plan to report every year anyway? And what would be the pros and cons?"

Oh, sure. So, I'd first highly encourage that organization to please make sure you're going to our Look-up Tool that I talked about earlier on just to make sure that the information that you're tracking to matches all the information that we've been able to ascertain about your organization. So, first and foremost, please go there. In instances where your organization may -- excuse me -- be eligible for the program one year and then excluded another year and you know whether or not you want to continue to participate in the years that you are excluded, we of course would encourage and, you know, recommend that. We see a lot of value to participation in Value Based Purchasing programs and Quality programs, even if that means that you wouldn't be MIPS-eligible, which means there wouldn't be a payment consequence. We think that the activities and measures and the things that you're doing provide a lot of value, hopefully not only to you, your organization, and clinicians, but ultimately, it's improving the health and outcomes of your patients. Ultimately, though, those are business decisions that each organization would have to make as they choose to participate within the program. I hope that helps. Thank you.

Wonderful. Thank you for clarifying. Alright, Stephanie, do we have anybody on the phone line?

We have a question from Donna McCarthy. Donna, if you'll press star-1 again... Go ahead with your question.

Thank you. We have providers who will be working for another organization and billing under their TIN. We will report for them. Do we have to do anything more? Is the other organization responsible for reporting for them under their TIN? Thank you.

Sure. This is Molly. So, yes, you would only be responsible for the information on your clinicians that, of course, you have access to, which would be the information that's part of your TIN, your organization. Those clinicians of yours that do practice medicine at another organization, another TIN, they should have those conversations with that organization to, one, determine whether or not they're actually eligible and required to report under that separate organization. And then, two, ensure that they've

been able to work through that with that organization as in how they would report what measures and activities they've chosen to do. Thank you.

Thank you.

No additional questions at this time.

Wonderful. Thank you. Alright, next question is for the Quality performance category. What does it mean when -- it says, "If less than 10 measures are reported on each applicable measure?"

If less than six measures report on each applicable? Applicable and available measure? Is that what the question was? Sorry.

I believe so. Just saying when they cannot submit all six measures.

Okay. So I believe to the extent possible, we prefer that clinicians -- I guess it really depends on how the clinician reports. We have specialty sets that have less than six measures, where if you report on that specialty set, that's all you are required to report. If you report on the individual measures, you would be held to that standard of having six measures -- the expectation is you will report on six measures, whether that be measures that you are specialty-specific or those more high-level cost-cutting measures that are applicable across specialties. Also, across the board, we also have QCDR measures. So, if you intend on continuously reporting individual measures, you'll be expected to report on those six measures and find applicable measures within either the MIPS inventory set alone or between the MIPS inventory set and QCDR measures. And if you're using a QCDR, if you're interested in reporting QCDR measures, you would have to do that through a QCDR.

Alright, wonderful. Thank you very much. Alright, next question is for the Promoting Interoperability category. It asks, "Do you have to complete all four measures in order for the category to be counted?"

Well, there's four objectives, but there's many more measures, and you need to -- for the numerator and denominator measures, you need a numerator of at least 1 for each of the measures to fulfill it. Of course, if you just submit a numerator of 1, your score will be very low because it's all performance-based now. Or you need to qualify for one of the exclusions that the measure might have. And if you qualify for an exclusion and claim it, then the points for that measure are actually redistributed to another measure. And all of that information of what points go to which measure is included in our Promoting Interoperability Specification Sheet.

Great. Thank you. Alright, Stephanie, do we have any more questions on the phone line?

We have a question from Bob White.

Hi, can you hear me?

Yes, we can.

Alright. My question has to do about data completeness. So, when we report measures, will our Medicare Advantage patients as well as straight Medicare patients be included in the denominator for completeness?

Sure. This is Molly. As we understand it, some Medicare Advantage plans do have some billing that falls under traditional Medicare Part B. It can differ plan by plan. So, to the extent that the Medicare Advantage plan does have billing associated under Medicare Part B, yes, we would highly encourage that to be included. Also, generally, as you saw in Sophia's portion of the presentation, for data completeness, we are looking for information across all payers for the majority of our collection types. There is, of course, some flexibility in instances where clinicians are submitting data on Medicare Part B claims that would be limited only to Medicare.

Thank you.

Thank you.

Your next question is from Mike Botti.

Yeah, hi. Hello?

Yes, hi, Mike.

Hi. My question is with regard to a specialist that has office-based patients and hospital-based patients for an infectious disease specialty. She sees fewer than 200 in the office, but probably more than 200 in a hospital-based setting. My understanding was that the hospital-based -- we report claims bases -- that the hospital-based patients are not included in this whole calculation.

It would ultimately depend upon how that information is received in here at CMS, if ultimately, it's getting paid off of services rendered under Part B, under the Physician Fee Schedule. Those hospital-based patients could still be included in the calculation. You can, again, of course, always go to that Look-up Tool, which I've mentioned a couple times, and that will tell you based off of what we've seen, whether or not you have surpassed that 200-patient threshold.

Okay, so, any E&M visit, whether it's hospital-based or office-based, should be used in determining the quantity of patients and quantity of services. Alright, thank you very much.

Yeah. Great. Thank you.

Alright.

Our next question is from Takara Trumpf.

Hi, I was wondering, how did we go about updating our status with CMS in regards to participation in ACO, or actually, it's that we no longer have a relationship with an ACO, and therefore, we meet the low-volume threshold and would qualify for an exclusion? I just wasn't sure who to contact or how to report that.

This is Molly. You know, that's a great question. I don't know that we have any SMEs on the line here that can answer that. Lauren, is there the ability for us to take this question offline or work through it? I believe there's resources available specifically to ACOs, where you can make those updates.

We unfortunately just don't have those subject matter experts here in the room with us to be able to provide that specific information.

Okay, because on the website, I had trouble trying to navigate to find who my resource would be in order to clarify that information, since they're going off of last year's information, which would show that we were part of the ACO. If that relationship no longer exists, then we would actually be exempt.

Right. So sorry, Lauren, what do you suggest we do for this? Is this a question where we can get the information for this commenter and take it offline, or should we refer them to the Service Center?

Yep, so, what we can do is right after this, we will get your name and your e-mail offline, and if you could then just send us basically your question in that format, we can flag it for you, Molly, and get that sorted.

Okay, great.

Okay. Thank you.

Okay, was there anything else on the phone line?

One moment for the next question. Caller, please go ahead with your question.

Yes, I was wondering where we find the list of the specialty quality measures. And if we don't have one for our specialty and we don't find six that apply, what do you recommend?

So, the list of the MIPS quality measures -- it's posted in the QPP Resource Library. There is one -- There's individual measure specifications, but, two, there's an Excel spreadsheet that posts the 2020 measures list that will give you all the measures, and if you scroll to your right in that spreadsheet, it kind of marks off which measures belong to which specialty set.

Okay.

In terms of what you would have to report on, the measures within your specialty set, if your specialty set has less than six measures, then that's all you're required to report. If your specialty set has six or more measures, you would be required to report on six measures in general. The validation accounts for instances where a specialty set has less than six measures, but that's all it accounts for. So if you're not finding within the set that all measures are applicable, there's also the library of cross-cutting measures that are more broadly applicable across specialties. That includes care coordination, referral-loop kind of measures. In addition to that, there are, if you choose to report through a Qualified Clinical Data Registry, a lot of them have specialty-specific QCDR measures. So those can be reported in addition to MIPS quality measures to get you those six measures.

Okay, so, if our specialty is not listed as one of the specialties with the specialty set, we need to either select some broad category measures or use one of the other Qualifying Registry measures?

Yes. Do you mind sharing with us what your specialty is? We could probably tell you if there's a specialty set available.

Pain management.

I think we do have one. There should be one that's there. And we do have pain-management-related measures in the program. So you should be able to, even in the measure library, it's not updated for 2020 yet, the Resource Library, but the posting of the measures list in the Resource Library page, rather than the measures tool, includes that list. So you might be able to filter through that spreadsheet to identify all the pain-management-related measures and make your assessment from that point onwards.

Okay, thank you. And again, if there's only like three measures that come up, then I need to find other measures that are more cross-cutting measures?

If there is no pain management specialty set, which I believe there is, and if that specialty set has six measures, you'll be required to report on six measures.

Okay. Thank you.

Yep.

Caller, please state your question.

Hi, if we are a physician practice and we report via CMS Web Interface, are we still allowed to report via the QCDR or registry for bonus points?

This is Molly. You have options on how you can submit -- Sorry, I guess can you clarify, when you say "bonus points," which bonus points are you referring to?

End-to-end, electronic reporting, and the outcome/high priority measures. So, we would report the 10 or 12 CMS Web Interface measures, and then we would report additional measures via QCDR or a third party registry.

Hmm. That's a good question. I know we did remove the bonus points associated with the Web Interface measures for those two, as you described. We would have to double-check what we've said within the rule on whether or not it is allowable to report on additional measures just for purposes of bonus points. We do have the ability, in 2019, for you to submit data through multiple collection types[1]. So, that's a great question. We are going to have to take a closer look at that. So, what you can do for this one, as well, is we can either get your contact information offline, or you can send this question over to our QPP Service Center and you can flag that it was something that was discussed on the webinar with CMS today and that you asked for it to get raised to our attention. We can do that.

Okay, thank you.

Thank you.

Caller, please state your question.

[1] It is possible to do this; however, it results in two separate submissions for Quality that would compete and the higher of the two is picked.

Hi, we're a small practice, and we have been struggling with the six quality measures. And I know there's been a lot of questions about that. My question is if we can only find five quality measures but we still are able to reach the 45 points, would we be penalized?

Well, sure – So his is Molly. The rule is that there should be six quality measures. One of those, as Sophia mentioned, used to be an outcome. Or if an outcome measure isn't available, another high-priority measure. In certain circumstances, if you truly do not have six measures available to you, we would only look at the measures that you can report on. However, what we see for the majority of practices is that they do have six measures they can report on. It can differ practice by practice, but, for example, if you are a primary-care-based practice, there are well over more than six measures that can be reported on.

If, however, after looking through all that, you determine, "We don't want to do the sixth measure. We just want to focus on five measures," what that means is that your total Quality performance category score, you could be missing out on some additional points. However, if you all perform really well on the measures that you do submit, if you also do have availability to try and achieve some bonus points -- I heard you say you are a small practice, which, as long as you have that special status designation within our Look-up Tool, you would be eligible for bonus points within the quality performance category. So you may be able to make up the points. But I would encourage you to take a really thorough look at the measures that we have available to make sure that you're not missing any. And if you do need additional resources on that, there's all of the resources that Sophia has described that we went over with the the two-ago gentleman caller, and we also have the ability that if you do want to reach out to our Service Center, they can actually work with you, and understanding your organization, they can also go over with you these are the types of measures that could apply to you.

Okay, perfect. Alright, thank you.

Okay, wonderful. Thank you. Alright, just a few questions from the chat box. The first is asking, "Can you please clarify what happens as a practice submits Promoting Interoperability, even if they have a hardship exception?"

If they submit Promoting Interoperability, they'll be scored. But if they submit anything -- so, if they submit the information blocking attestations, if they submit security risk analysis, if they enter data for their performance period or their CEHRT number -- any of that counts as a submission, and that will cancel their hardship exception. So be very careful. Don't start entering anything for Promoting Interoperability if you want the hardship exception to apply.

Great. Thank you. On the same strain, if a group has a hardship exclusion for last year, do they have to resubmit an application for this year?

Yes. Every year. And the applications for this year are not available yet. They'll probably be available in the summer.

Perfect. Thank you. Alright, "If an individual NPI does not qualify, but the group does, is the individual required to participate?"

Sure. This is Molly. So, assuming you're referring to eligibility requirements, so, no, those are choices that you, as the clinician and your organization, will have to make. So, it is possible, for example, if it's a 50-person organization, if there's some clinicians who see a low volume of Medicare patients. Let's say, for my example and for easy math, of that 50-person group, it could be that 25 of those people see a low volume of Medicare patients, and they could be excluded as individuals. But when you look at the aggregate, the performance of all 50 clinicians within that group, that entire group could be eligible. So those are decisions that the organization will need to make, as well as the clinicians, on how they choose to participate. Again, there is a number of pros, cons, trade-offs that organizations will need to think about when they decide how to report and participate within the program. Thank you.

Great. Thank you. Alright, next question is, "What is the deadline for upgrading to 2015 CEHRT for the Quality category for 2020 reporting? Was it December 31st of 2019, or will it be December 31st of 2020?"

We're just double-checking. This is -- hmm -- I believe it's 2019, though. We're just double-checking that. Oh, yeah, sorry. That was 2019. That's a 2019 policy. Apologies. I missed the initial part of the question.

No worries at all. So, it's 2019 -- December 31st of 2019?

Correct. That is when 2015 CEHRT must be in place.

Okay, thank you. Alright, "Our organization is transitioning EMRs in June. So is it acceptable to submit data from two EMRs?"

For Promoting Interoperability, yes, if they have two EHRs in their selected 90-day reporting period, although they could choose a longer reporting period if they want to. But for PI, they would need to add the data together and submit it.

And similarly, for if the organization wants to submit on their eCQMs, their Electronic Clinical Quality Measures, again, thinking about the 12-month performance period, the end result that we would need to see here is based off of the performance under the entire year. So there would need to be some aggregation of the data.

Great. Thank you. Alright, Stephanie, do we have any more questions on the phone line? We have about 5 minutes remaining.

We do have one additional question. Caller, please state your question.

Hi. Can you hear me?

Go ahead.

Yes.

Yes, thank you. For Quality category, if an eligible clinician reports as an individual and is also included as part of an ACO through the Web Interface, would CMS apply the best of the two scores, or would they choose only the CMS Web Interface?

Sure. This is Molly. So, the way that our scoring hierarchy works is, we, of course, want to, under the Quality Payment Program, we really want to incentivize participation under Alternative Payment Models. An ACO is considered to be an Alternative Payment Model. So, if we see, for a given clinician, a TIN/NPI, or an organization, if we do see that there is performance associated with an APM -- again, the Medicare Shared Savings Program ACO is considered one of those -- we would use that score first and foremost. If, however, there is not any -- let's say the example is different, and the question is, "If we get group data and individual data, which one would we take?" in that scenario, we would take whatever is the higher of the two -- the higher performance. But, ultimately, if we do have APM data, we will use that first and foremost. Thank you.

Okay, thanks.

We do have another question. Caller, please state your question.

Linda, my question is, we are a hand specialist -- hand surgeon. And it's been an ongoing issue with MIPS to be able to get the measures. And I'm wondering if that's got any specialty measures this year at all. It seems like we're kind of -- We're orthopedics, but we do mostly hands. So, with kind of a lot of those things, we're not eligible for. We really have to dig for the six measures.

Yeah, so, we currently have, in our specialty set -- of our specialty sets, we do have a general surgery specialty set. We don't have a subspecialty set specific to hand surgeons. So, actually, I'm not sure if you're aware, but currently, for 2021, we do have a call for specialty-set solicitation going on. And it was available through the QPP Listserv. And that was for stakeholders to provide us with recommendations on how we can improve our existing specialty sets for 2021, or even recommend new specialty sets for 2021. So, if you believe that there are enough hand-surgeon-specific measures in our program to create a hand-surgeon-specific subspecialty set, that is certainly a recommendation you could possibly submit to us for our consideration for rule-making.

Okay, thank you.

We do have another question. Caller, please state your question.

Hi. I tried submitting via the chat box, but I don't know if it went through. I was wondering, if a MIPS specialty measure set includes more than six measures -- let's say, it includes 10 measures -- but only four of those are reportable via claims, if the clinician is eligible for claims reporting, is it okay for him or her to report on only those four measures? And will they get full credit for reporting, or are they still required to look for two additional measures or a different reporting mechanism?

Sure. So, if within the specialty set, there is 10 measures, some measures are available via the Part B collection type, other measures are available at, say, for example, the MIPS CQMs, and are they required to only report using the Part B collection-type measures? For that, for clinicians to maximize their Quality Performance Category score, they would need to select measures as part of that specialty set that can be reported via another collection type. If in the scenario you're describing, the organization decided to only submit on those four measures, we would see that they could have reported on two other measures. So, again, their maximum amount of

points for that category, taking into consideration there could be other measures and other bonus points, but it would really be looking at the four out of the six measures.[2] And just to clarify, that is a new policy we have in place for the 2019 year, since now clinicians have the ability to submit data to us via multiple collection types. Thank you.

Okay, great. We've got a minute left. We do have one more question on submission types. So, "Are we allowed to use more than one submission type to submit our data? For example, third party intermediary for Quality and IA, but the CMS Web Interface for Promoting Interoperability."

So, yes, you can use any combination of submission types that we have available that was reflected on the slide earlier, to submit your data across the four performance categories. We do find some clinicians prefer, for example, for Promoting Interoperability, to just go in an log in and attest to that information. Maybe, for Quality, they want to use the Web Interface. And maybe, for example, for Improvement Activities, they want to work with their registry. That's allowable. Thank you.

Great. Thank you. Alright, so, that brings us to 4:00. We do not have time for more questions. But, again, you can contact the QPP Service Center if your question was not answered. Molly, would you like to close out the webinar?

Yes, that would be great. Thank you, everyone, again for your attendance today, as well as your questions. Really great to hear all the questions that you all are having. So, thank you again.

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

[2] If you are submitting via only Part B Claims or only MIPS CQMs, the validation process will not require you to submit via a different collection type to get six measures if there are fewer than six claims or MIPS CQMs in that specialty set.