Highlights of the 2020 QPP Proposed Rule
Transcript from Live Session

Wednesday, September 18, 2019

Quality Insights
Quality Payment Program Support Center

Laurie: Good afternoon everyone and welcome to today's session, Highlights of the 2020 QPP Proposed Rule. Today's session is being recorded and it will be posted on our website at www.qppsupport.org probably within a week. It can be found on Events tab under Archived Events.

Everyone entered today's session in a listen-only mode. If you have any questions, please enter them into the Q&A feature on the right of your screen. We will try and address all of the questions at the end of the presentation, as time permits.

Today's speakers are Marvin Nichols and Rabecca Dase. Both Marvin and Rabecca are Practice Transformation Specialists with the Quality Insights QPP Support Center. Kicking things off for us today is Marvin. I will now hand the presentation over to you, Marvin.

Marvin Nichols: Thank you, Laurie, and welcome everyone. I thought before we begin to decipher these 600 plus pages of the 2020 QPP Proposed Rule, I think it might be beneficial for us to go over what the QPP program is and what we need to do for 2019. Next slide, please.

The Quality Payment Program, known as QPP, is Medicare's version of the pay-for-performance program that was started in 2017. You might have heard of legacy programs called PQRS, Value-Based Modifiers and Meaningful Use. Medicare took those programs and created the Quality Payment Program. There are two ways to participate in the QPP. One is MIPS, the Merit-based Incentive Payment System, and the other way is the Alternative Payment Model, APM. Next slide please.

For 2019, January 1st was the first performance period date. December 31st is when the performance period ends. On January 2nd, your QPP quarter will be open so you can start submitting data for 2019. The QPP quarter closes for 2019 data on March 31st of 2020. Then in July 2020, you will receive a preliminary MIPS score and feedback reports. Next slide.

October 1st, 2020 will be the final day that you could request a target review if you believe that there was an error in your feedback report. Then sometime in late October to early November 2020 you'll actually receive a final MIPS score after all the targeted reviews have been completed. Remember from January 1st, 2021 to December 31st, 2021, your MIPS payment adjustments will be applied to all your Medicare Part B claims. Next slide.

In addition to our five eligible clinician types that have been a part of the program since its infancy, CMS added six more eligible clinician types, physical therapist, occupational therapist, speech language pathologist, audiologist, clinical psychologist and registered dietician. Next slide.

Any clinician who is MIPS eligible and does not report data will automatically receive a negative 7% payment adjustment. You have the potential to earn up to a 7% positive payment adjustment based on your final MIPS score and how many eligible clinicians will participate nationally and their MIPS scores as well. In addition, you also have the potential to earn an additional positive payment adjustment for exceptional performance if your MIPS score is 75 points or higher. Next slide.

The score threshold for 2019 is 30. Each year the threshold is going to be increased in the program. The minimum MIPS score for this year, in order to receive a neutral payment adjustment, will be 30 points. Next slide please.

How does that look? You see the middle 30 points will be a neutral payment adjustment. If you have 7.51 to 29.99 points, you'll receive a negative payment adjustment. Between zero and negative 7, zero to 7.5 points, you'll receive a negative payment adjustment of negative 7%. If you're 30.01 to 74.99, you'll receive a positive payment adjustment between zero and 7%. If you go over 75 points, you'll also receive that additional performance payment adjustment I just mentioned on the last slide. Next slide.

This is how your MIPS score will be broken down into categories. You have the Quality score. You have the Promote Interoperability score, or PI score. You have the Improvement Activity score. You have the Cost score. Bear in mind that if the Quality score is lower from last year and your Cost score is higher from last year, all those scores together will give you 100 points and that would be your MIPS points. Next slide.

Now, I'm going to discuss the Promoting Interoperability hardship exception. This is one of the resources/exceptions that just came out recently and I just wanted to make everyone on the webinar aware. Thank you. Next slide.

Under the MIPS program, you may qualify for a re-weighting of your Promoting Interoperability category to zero if you meet certain criteria. That window is open now and it closes December 31st. Next slide.

Who can apply? Clinicians in small practices if you have decertified EHR technology, if you have an insufficient internet connectivity, if you face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues, and if you lack control over the availability of your certified EHR technology. Those are the eligible clinicians, groups and virtual groups that can apply for a hardship exception. Bear in mind that lacking

certified electronic health record technology does not qualify you for re-weighting.

In addition, if receiving a hardship exception does not preclude you from the actual MIPS program, you still have to participate in the other two categories. If you fill out the application and you receive a hardship exception, you will still have to do your improvement category. You will have to do your quality category. It just will move the points to your PI category to quality and this will be displayed a little bit later on. Next slide.

How do you apply? If you're an individual, you need to have your NPI, your group name and your group TIN. If you're a group, you need to have your group name and TIN. If you're a virtual group, you just have to have your virtual group ID. That apply now is a live hyperlink. It takes you directly to the hardship exception application. The applications can be submitted now through the deadline of December 31st, 2019. Next slide, sorry.

How will you know the results? You'll be notified by email that your request of your Promoting Interoperability hardship exception was approved or denied. If approved, it will be added to your Participation Status Lookup Tool, although it might not appear to the submission window opens in January 2020.

Now, it might be an instance where your application might be put into a pending status, in which case you'll be notified by email. What will happen is CMS will check to see if you have any Medicare Part B data after the second MIPS eligibility determination period. If you billed Medicare Part B claims then CMS should approve your application and will notify you. Next slide.

If your application is approved, you do not have to report on your promoting interoperability measures and the category will be re-weighted to zero of your final MIPS score. The 25% weight of your PI category will be reallocated to the quality category. The quality category will be worth 70% of your final MIPS score. Next slide please.

The diagram that we showed previously, if you get approved of the Promoting Interoperability hardship exception and this is how your point distribution will look. You'll have 70 for Quality, you won't have to report for Promoting Interoperability, you have 15 for Improvement Activities, and your Cost category score will be 15. This equals 100 points. Next slide please.

What should I do if I am an APM participant? Clinicians who are part of a MIPS APM do not need to report data for the Promoting Interoperability category if they qualify for automatic re-weighting or have an approved hardship exception. If the performance category is not re-weighted for the entire entity, these clinicians will receive the APM entity score for Promoting Interoperability.

MIPS eligible clinicians who scored under the APM scoring standard will receive the APM entity's PI score. If these clinicians qualify for re-weighting at the individual or TIN level, they will be assigned a null value when calculating the average score of the APM entity. If you have any questions, just reach out to your transformation specialist in your state or your APM representative. Next slide please.

Now, can I submit Promoting Interoperability data after I submit promoting interoperability hardship exception application? Of course. You can still choose to report PI data even if you qualify for automatic re-weighting. Now, if you do submit your data, CMS is going to score your performance and the weight of the category is going to be switched back to 25%. Let's just say if you filled out the hardship exception application yesterday and you decided that in one of the performance periods, the 90-day performance period that you guys did real well in and you think you will get 100% of that category, you can still submit that data that CMS will recognize that you are submitting the PI data and your hardship application will not count. Next slide.

Now, I would turn over the presentation to my colleague, Rabecca, to discuss the QPP proposed rules for 2020.

Rabecca Dase: Hi everyone. Thanks Marvin. Moving into the 2020 Proposed Rule for the Quality Payment Program, you can move to the next slide, Laurie.

At the end of July, CMS released a very, very large document containing all the proposed policies for the 2020 performance year for the Quality Payment Program along with some other request for information in regards to some changes they want to implement. Ultimately, some of the proposed key changes that we're seeing now in the proposed rule that we wanted to highlight again, our presentation today is not all inclusive. There are things that we didn't touch on.

There are things that we just want to bring to your attention, as it pertains to the Quality Payment Program, to the practices that we serve. Ultimately, the proposed rule is there for you to go out and digest and sort through and pick through things that you think might impact your practice the most. Ultimately, we want to bring you some key changes that we saw again and highlight some things that we think that could most impact you.

I do want to mention, when you go out to look at the final rule on the link that's provided, I think we provided at the end too, it's a web-based final rule and it's hard to navigate sometimes. It's hard to search and filter through. If you're actually on the right hand side when you're looking at it, there is a box that says Document Details and there's a printed version option where you can actually download a PDF to your desktop so every time you had a question, you could actually review the final rule on your desktop and PDF. You weren't trying to locate the website and all that. It was actually easier.

For me, when I'm looking at it and when we are working on this presentation, its easier to identify page numbers that you want to reference when you're going back. Again, on the right hand side, you can export that out on to your desktop as a PDF to more easily manage that.

With that, some of the proposed key changes that we're seeing are increasing the MIPS performance thresholds, increasing the exceptional performance threshold, decreasing the Quality category weight while increasing the Cost category and then increasing the data completeness threshold for Quality measures.

Some additional proposed key changes that you'll see here on the next slide too are increasing the number of clinicians in a group who must complete an improvement activity to receive credit. Redefining what a rural practice is or how you become a rural practice. CMS is talking about adding 10 new episode-based measures and reviving the Medicare Spending per Beneficiary measure and the Total Per Capita cost measure.

Also, working on changing what it means to be a hospital-based group and how many clinicians in your practice would have that special status in order for you to get that determination or special status. Then at the very end, I will hand it back over to Marvin who will cover MIPS Value Pathways, which is a new program and is part of MIPS. But CMS is trying to request comment on this to help reduce the reporting burden on providers and things like that. Marvin will actually get into that later in the presentation.

Some of the policies we're seeing without changes in the 2020 Proposed Rule are the MIPS eligibility. You'll still have those three criteria, the 90,000 or more in Medicare Part B charges, the 200 Medicare beneficiaries and then 200 Medicare services. Also in the eligibility, the clinician types are remaining the same as well. What I was looking at, I didn't see any clinician-type proposals. They weren't bringing anybody else and they were going to remain what they were for 2019, which Marvin mentioned a little bit ago.

The data collection and submission types were remaining the same. Claims would be for small practices. We have EHR, QCDR and registry. Those are main as well. MIPS scoring, as Marvin showed previously, you take each category, you add it together and that's your final MIPS score. That's remaining the same as well. Facility-based clinicians, how you become a facility-based clinician, how the scoring is applied, all that, that will remain the same as well.

Then the MIPS determination periods also will be the same, however reporting ranges are going to be different. Ultimately, they're taking them from the same part within the year to give you the status of your clinician for the MIPS performance whether or not you're eligible or not. I just want to include those dates so you could see what they would be for your 2020 performance.

On the next slide, you'll be able to see a timeline for participation, which would be your performance period opens on January 1, which we're all very familiar with that date. You'll start collecting data on January 1st. Then the period will close for the 2020 performance year on December 31st of 2020. Just like 2019, they're saying a submission portal will close, the submission for data will close on March 31st of 2021. Sometime later in the year you're going to be getting some feedback in 2021. Then the payments for your 2020 performance will be applied in 2022 because we have that two-year lag on payment adjustments.

We're going to talk about the proposed category weights. What we're going to see here is we're actually going to see 2019 to 2020, which you're going to see on the screen, and then a couple of slides we'll actually see how they progressed throughout the next few years. For 2019, as Marvin mentioned, we're at 45% for the category weight in Quality. You can see looking to the right that Quality does in fact go down to 40% of the total MIPS score. As Quality goes down, Cost is going up. For 2019, Cost is at 15%. In 2020, Cost will be 20% and that's what they're proposing. Improvement Activities and Promoting Interoperability will remain the same at 15% and 25%.

On the next slide, as I had mentioned, we're watching the program evolve. Quality is at 35% in 2021 or as proposed. Then as mandated by law, by 2022, Quality would need to be at 30, which also matches Cost at 30. Looking back at 2021, Cost goes from 25 jumping to 30%. Improvement Activities and Promoting Interoperability will remain the same at again 15 and 25%. They're slowly transitioning the categories to meet that deadline, which again is mandated by law where Quality would equal cost in 2022 for Year 6 of the program.

This snapshot here is actually showing you the thresholds of how to avoid a payment adjustment. For 2019, we do have the 30-point performance threshold for 2019 again and then to be an exceptional performer, you're at 75 points, which Marvin mentioned. Then your payment adjustments could be plus 7% or as low as negative 7%.

In the 2020 Proposed Rule, those continue to go up and it becomes harder and harder to avoid those penalties. In 2020, the MIPS performance threshold is going to be 45 points. It jumps 15 points and becomes harder. The exceptional performer bonus where you kind of get put in that extra pool of money becomes 80 points, and then again your payment adjustment is increasing, it's either up to 9% or as low as negative 9% depending on your participation.

Based on your previous participation in the MIPS program or what you're seeing for 2019, if these numbers are starting to look more and more difficult for you or you think I do need some extra help and you're not already working with somebody, that's what we're here for. Quality Insights is here to assist you and help you navigate the program and help you to meet the thresholds and talk about all those little nuances that can hopefully help you be successful in the program.

I did want to put a little note there at the bottom that they are proposing for 2021 that the threshold increases to 60 points, which is huge and the exceptional performer bonus then would go to, or rather threshold, will move to 85. When you start seeing those numbers, they do become quite worrisome because they're getting bigger and bigger to avoid the penalty. Just keep in mind that we are here to help you.

On the next slide, you will see the proposed payment adjustments for 2020. This is kind of just in addition to what Marvin showed earlier. Year 3, shown here on the left hand side, is how your payments would be potentially broken out based on your score. Then on the right side, you also see Year 4 in where you would need to fall for your points and where the payment adjustments then would be for that.

The comparison of the payment adjustments on this slide, I did just want to show you kind of how the program has evolved based on payment adjustment and where we are at and where we started. 2017, you're in the program transition year, the payment adjustments were plus or minus 4%, which we're seeing now in the Medicare Part B claims that we're receiving back or payment. 2018, Year 2, plus or minus 5. 2019, our current performance year, we're at plus or minus 7%. That's getting real big. Then 2020, they are proposing for Year 4, you're at plus or minus 9%, which you would see those payments corresponding with the 2020 payment year.

Moving from those, we're going to jump into the quality category. The Quality category weight as we discussed earlier will decrease. You can see on the next slide that Quality will decrease from 45% to 40%. As we look at those other years, you can see that this continues to be a trend. Cost is going down or Quality is going down, sorry and cost is going up.

CMS is working to again get us to that mandated 2020 where cost and quality equal each other, so we'll just highlight that. CMS is working to continue to remove low-bar standard of care process measures. They are beginning to focus more on high priority outcome measures. They are adding seven new specialty measures set. You can see here for what specialty.

I think something that is worth noting and I probably should have created a slide for you, I apologize for not doing that, CMS seems like they're almost doing an overhaul. They're saying this is going to possibly be the largest reduction in measures they've had since transitioning from PQRS. They are proposing the removal of 55 quality measures. Again, that's proposed. Remember, now is the time to get your comments in, if you have any questions or anything like that or concerns. The proposed rule includes removing 55 measures, adding four new quality measures and then the seven new measure specialty sets which I included here on the slide.

There are some measures as well but they're proposing substantive changes too where you can see these in the final rule. If you download the PDF document of

the final rule, which I suggested, these are shown in Appendix 1, which begins on page 452. It will show you the measures that are there for removal. They are showing you the measures that they are proposing changes to and the new measures along with the measure sets.

Table C is the actual location and I believe its on page 673, that they start talking about the 55 measures that they are removing. I know that we probably have a lot of primary care providers on the call. I did want to highlight that they are proposing the removal of certain measures that I know have been popular such as preventive care and screening for influenza because they're saying it's duplicative of a new measure that they're proposing, which is adult immunization status.

Going hand-in-hand with the influenza measure, they're also talking about removing the pneumococcal vaccine for older adults and the shingles measure because, again, they're trying to group those into that adult immunization status measure to make it a more robust measure. Those are popular measures that we've seen amongst our primary care specialists and things like that or primary care and some specialists. I just want to highlight those.

Then on table D, which is page 702, it would be measures with substantive changes if you were interested in reviewing those. Ultimately, when they're removing and adding measures, that can sometimes be where we're most impacted. I did want to highlight those for you.

Moving to the next slide, they are also proposing the change of the data completeness requirements. The past two years, I do believe it's been at 60% for Medicare Part B claims. If you are submitting claims, you have to report on 60% of your Medicare Part B patient. If you are doing QCDR registry claim or EHR, you would want to report on 60% of your patients across all payers.

For 2020 or Year 4, they are proposing to increase that number from 60% to 70%. Again, 70% of all of your Medicare Part B claims if you're reporting claims and 70% if you're using a registry QCDR or EHR. I was listening to a webinar before and they said that people are well above that 70% so don't let that panic you. They said what they've been seeing historically is people are having no problems meeting that data completeness threshold.

They (CMS) are also talking about what they can do in addition to what they already have for the measure removal criteria. What we've seen historically in previous performance years, measures have been considered for removal if the measures are no longer meaningful or measures that possibly could be tapped out. If a measure steward is no longer able to maintain a quality measure.

They are talking about adding the criteria if the measures no longer meet the case minimum and reporting volumes for benchmarking for two consecutive years. First thing they'll remove those. Then they're also considering removing

Quality measures if it is determined that it's not available for MIPS quality reporting by or on behalf of the MIPS eligible clinicians, including your third party intermediaries, your EHR, registry, things like that.

In addition to the measure removals, they're also talking about modifying how they benchmark certain measures. Beginning in the 2022 MIPS payment year, CMS is working at establishing a flat percentage benchmark for certain measures, which you can see at the bottom, hemoglobin A1c poor control and controlling high blood pressure. The reason why we're trying to work on something like this is that they could be least inappropriate or bad treatment of patients. Because in some cases, it doesn't necessarily link up to get the 100%. Them trying to modify the benchmarking, they're trying to avoid clinicians trying to achieve that aspect or achieving that 100%. What they're doing is they're trying to establish set benchmarks for these two measures.

Where as you can see on the next slide how the flat benchmarking works. If a clinician scored between a 90 and 100, they would be in that top decile. If they scored 80 to 89.99, they'd be in the second highest decile. Same thing if it was a 70 to a 79.99, they'd be in the third highest decile rather than what they've been doing previously, as your performance leads you to those deciles. Better performance technically would lead to better scores. Now, they're trying to group these together and again calling them flat benchmarks. Then something new that they're working on, so if you don't like the idea of flat benchmarking or you could think of maybe other measures, possibly submit those comments to CMS in regards to this topic because it is new.

The Promoting Interoperability category, we didn't see a lot of proposed changes for the 2020 year. One of the proposed changes we did see for 2020 that they're proposing again is the removal of the verified opioid treatment agreement measure, which currently for 2019 is optional. They do want to however keep the query of the PDMP measure, but keep it as optional. Those are two changes that we saw there.

Now, affecting your 2019 year, CMS is proposing that the query of the PDMP measure will require a yes or no answer rather than a numerator and denominator. I know a lot of the practices that I work with, especially at the beginning of the year, were like, “Our EHR doesn't have this. How do we report this measure?” I think a lot of people were maybe put in that same boat. I think CMS listened. Here we have just a yes or no response. Again, it's proposed. I see this probably being approved in November but don't quote me on that. It would be a lot easier than having the numerator/denominator to report so more people can probably report this measure.

When they came out last year, two of the final rules in regards to the PI measures, Promoting Interoperability measures, they did not have a place where they would redistribute the points if a group claims the exclusion on the support electronic referral loop by setting a health information or those CCBs. They did in fact come out and propose that if you claim an exclusion on that

measure, the points will be re-weighted to the “Provider Patient Access to their Heath Information” measure. That was a change there.

One of the other proposed changes that we are seeing that could potentially impact how you were reporting and potentially reduce burden is going to be how a group was identified as hospital-based. In 2019, a group was identified as hospital-based and eligible for the automatic re-weighting of the Promoting Interoperability category if 100% of the MIPS eligible clinicians in that group met the definition of a hospital-based clinician.

Now, for 2020, they're actually reducing that to be 75%. I do see that potentially being a burden reduction for some groups, especially those multi-specialty practices or hospital-based practices and things. Yeah, 75% they're proposing to reduce. The non-patient groups remain the same at 75% for the automatic re-weighting. Now I just want to highlight that there is no change in the definition of a hospital-based clinician. It's just how your group would qualify for that special status.

Again, like I said, we didn't see a lot of changes for the PI category in this proposed rule, but CMS is seeking comments in several key areas and they kind of highlight them here. Review this slide. I'm not going to read them all to you, but I think it's important as we continue this program, as we evolve, that CMS is getting your comments. What do you see as areas we could improve or where they could improve, what you could see meaningful to the practice?

One thing I noticed with bullet point number three is the metric to improve efficiency of providers within their EHRs. Maybe offer suggestion that when you are in the offices with your practices every day, you work with these EHRs, what are things that you could do to improve the efficiency. Sometimes, we hear it's more burdensome to use an EHR and things like that. They are listening. They want to have ideas and things that they could do to help implement these things and improve the use of the technology that we have.

The Improvement Activity category, which people typically do very well, there are some changes in this category. They have proposed to modify the definition of a rural area. Previously, it's been list based on the HPSA area and things like that and where your ZIP code fell. They are proposing to change it to mean a zip code as designated as rural by the Federal Office of Rural Health Policy and based on the most recent ZIP code file available.

This could potentially if approved or accepted to the final rule, this could potentially change the special status that some groups have, reducing the amount of Improvement Activities that you have to report and things like that, offering you special status. If this could be something that affects you, I highly recommend commenting on it if you like the idea of that. Once the determination is made and the final rule comes out, if this is accepted, you're definitely going to want to pay attention to your special status once the new MIPS eligibility file is posted on the QPP portal probably mid-2020.

Another requirement or change that they're proposing is that 50% of MIPS eligible clinicians in a group or virtual group must attest that they participated in or performed the Improvement Activity to receive credit. This is a big change because in the first three years of the program it has been if one doctor or one provider in the group performs the activity, the entire group would get credit for it. This is no longer the case. Well, they're proposing it no longer be the case and putting it at least 50% of the clinicians and the TIN would need to say and attest that they performed this activity. The activity would need to be the same continuous 90 days in that performance period.

Where I see this may be causing something strong is in multispecialty practices or maybe clinicians aren't focusing on the same thing or practices with numerous locations or different office settings and things like that. Ultimately, again currently if one clinician in the group could attest to an activity and everybody would get credit, they are proposing that that goes up to at least 50% of the clinicians in the TIN.

They are also talking about changing the inventory for the Improvement Activities. They are talking about adding two new Improvement Activities, modifying seven that already exist, removing 15, the conclusion of the CMS study that they've been working on for the past few years, the 2019 would be the final year where some groups that they participated in that study, they got credit for improvement activity. I did highlight Appendix 2 of the proposed rule outlines each activity, so similar to going into how you're going to review the quality measures and the changes proposed, that was Appendix 1. Improvement activities is going to be in Appendix 2.

Currently, there are no processes in place to remove Improvement Activity. They are working on establishing factors to help clean up their inventory, once that they remove activity. Here you can see they're talking about removing activities. If it's duplicative, if an activity doesn't align with other categories, there's no attestation for the activity for three consecutive years, the activity is obsolete, or the activity already exists that's similar with stronger relationships to quality of care or improvements in clinical practice.

Ultimately, that's what the goal of the Improvement Activities category is, to improve the quality of care, the delivery of care in practice and really aligning with all of those other categories in the MIPS program. Next slide please.

Another thing for the Improvement Activities that they're working on in the proposed rule is how a group would get credit if their patient-centered medical home status. Before you had to be accredited by a nationally recognized organization. Now, they're saying in order to receive credit for the Improvement Activities as a patient-centered medical home and then receive that designation, you would have to meet some of these criteria listed here. Again, if you're credited, great. You can knock that off. The practice is participating in the medical home model. The practice is a comparable specialty practice that

receive recognition through a specialty recognition program offered through a nationally recognized accreditation organization, that's a mouthful.

On the next slide, they also kind of offer some additional things that we would need to be able to meet and receive that patients that are in medical home on designation criteria if any Improvement Activity category and you kind of read through those there.

Transitioning to Cost, there are some changes in the Cost category. Again, we've talked about it will continue to go up as the years advance in the program. For 2019, we're at 15%. For 2020, they are proposing that we move to 20%. Some of the things that we're seeing proposed for 2020 are additional episodes, new episode-based measures and the revision of the Total Per Capita Cost measure and the Medicare Spending per Beneficiary measure. You can see side-by-side. I like to use little boxes because it's nice to see what you do from year to year.

In Year 3, you can see the measures here. There was the Total Per Capita Cost measure and the Medicare Spending per Beneficiary measure. Then they just had eight episode-based measures and then list the case minimums.

For 2020, they're showing you that they're going to revise those, keep those eight episode-based measures there and then add 10 new additional ones while maintaining the no change to case minimums. I do want to know the case minimums you can see are 10 for the procedural episodes or 20 for the inpatient medical condition. Then the Total per Capita Cost is 20 case minimum and the Medicare Spending per Beneficiary measure is at 35 for a case minimum in order for those to be scored.

On the next slide, you can see the 10 proposed new episode-based measures. Again, these are just proposed. Look them over. Do they impact you? Make comment on them, anything like that. Again, everything in this webinar today we're talking is proposed rule so any comments that you have, CMS is always accepting them. They actually mentioned before we started our webinar today that they are up to almost 10,000 comments based on the proposed rule that came out. I think that's great. People are getting their voice out there and we'll talk about the very end where to send the comments and how to do that.

CMS is also proposing to how the measures are attributed to clinician. Currently, for the Medicare Spending per Beneficiary measure, simply put, there's always a lot more to it who build the plurality of Part B claims during an index submission or in the discharge state. Then for Total Per Capita Cost, beneficiaries are attributed to a single TIN NPI based on the amount of primary care services that beneficiary receives during the performance period and who provided the most of those.

What they're doing here is they're actually working on changing the attribution I'm assuming to make it reflect actually what's happening with the patients.

They're proposing requirement E&M service to be associated to the primary care service and things like that. I did include a specification link down here. I could never get into all the detail that they are including for these Cost measures and the attribution. I highly recommend looking at those and offering your comment as mentioned. I do want to highlight here that they did not propose any changes for the attribution in the episode-based measures, either the existing measures that were there for the measures that they're proposing, the new measures that they're proposing.

On the next slide, we are going to be moving into the clinical quality data registry or the quality registry. These are also referred to as third party. On the next slide, they're making some changes. Again, this portion right here, there was a lot proposed in the 2020 proposal in regards to the QCDRs and qualified registries and what their requirements are. A lot of that stuff I didn't bring in to my slides. The reason for that is because a lot of it I thought more applied to the vendor. I thought it got kind of confusing as we started talking about it at the practice level. A lot of times where you see it, tell me what I need to do, what do I need to report. A lot of times we're not worried about what the vendor needs to do to make this happen for us. It is there in the proposed rule. If you are a vendor something and you're interested in knowing more about I would highly recommend reviewing the proposal in that topic. The proposal fact sheet also does a really great job of breaking out what their requirements are too.

Beginning with the 2021 performance period, they're suggesting that qualified registries and clinical data registries become a one-stop shop that they handle the three categories, Quality, Improvement Activities and thePpromoting Interoperability category. Some of them already do, which is great but there isn't a requirement that they do. If you already work with one that does, then you're one step ahead. They are proposing that they do become the one-stop shop where they do assist clients for all categories.

They are also promoting that they enhance their feedback. I do believe feedback is something that has been required. They're trying to make it more meaningful to practices. They want them to provide it four times a year and provide information on how participants compare to other clinicians, within the QCDR or the registry. If you're a specialty, you could see how you compared and you're using a registry. If you're a clinician specialist, you could see how you compared to other clinicians, which I think is great just to kind of have that feedback and are you above par, are you below par. I think information and feedback is always beneficial to groups as you're willing to look at it. Then they are also encouraging them to deliver quality improvement services and what can you do within your practice to improve those services.

Switching gears toward the end, we're going to talk about final scores and targeted reviews. One thing that they actually didn't have anything in a formal policy for was what happened if there was data integrity issues and whatnot and what happens with that. What they did for 2020 is they actually came out and said they didn't offer a lot of detail. They are saying that we do have the

ability re-weight categories if there are events that are beyond your control or that CMS can identify, they can re-weight these two, the Quality category or the Promoting Interoperability category and then in rare cases, they can also redistribute points to the cost category.

They really didn't come out and provide a great deal of information on this. Again, they're working toward what happens if there are these issues. This could definitely be something that you offer your comments on.

For the targeted review process, they also are stating the next slide that currently they've just set a deadline. For 2019 as Marvin mentioned I think earlier, the targeted review deadline to submit if you have any issues of your 2018 performance feedback is going to be September 30th of 2019. For 2020, they are saying and this is beginning with a 2019 performance period so your information that you're submitting this year. Once you have that feedback back, you will have 60 days to submit your targeted review so they can set the dates.

For instance, you get it on January 1, it would be due by ... Okay, not January 1, but we'll stick with that January 1 you got your targeted review or your feedback back. You would have 60 days to submit that information to CMS. If they came out late, in which we know happens sometimes, if they came up late, whatever date that was released, you would have 60 days from the day they're released to submit your targeted review back to CMS and challenge what issues you saw.

For APMs, they were very brief on what I've seen for this in that there hasn't been a lot of details that I've been able to find and I'll be interested to see how it unfolds. On the next slide, you can see that they are trying to offer some flexibility. CMS is proposing that MIPS eligible clinicians participating in APMs are allowed the option to report for MIPS quality performance category, again which is offering the flexibility and more meaningful measurement. Potentially, this could increase your reporting burden if this is something that you wanted to do or it does offer that great flexibility if you did want to submit that data in your part of an APM.

CMS is proposing that a MIPS APM quality reporting credit for APM participants in other MIPS APMs where quality scoring through the APM is not feasible including, a credit again to 50% of the MIPS quality category weight and a quality reporting exception for participants reporting within an APM entity similar to those available for the MIPS PI category, their Promoting Interoperability category. Next slide.

On the next slide here, we can see that they are changing how qualifying participant status is applied. For 2019 and the previous years, you can see a clinician who was a partial QP is excluded from MIPS and pertaining to advanced APMs, is excluded from MIPS at the NPI level including all TINs the clinician is associated with.

For 2020, they're proposing that a clinician who's a partial QP and you become partial QP if you have enough patients through the APM or enough paying amount through the APM or advanced APM. A clinician who is part of a partial QP is only excluded from MIPS in the TIN through which the clinician received the partial QP status. If you ever had any clinicians within your TIN that were impacted by that QP status from another advanced APM, they are proposing that that is removed for 2020.

There is some change in the marginal risk in regards to the other advanced APMs. Rather than using a set amount, they're actually talking about using the average marginal risk. I'm not going to read through this to you, probably put you asleep, but they are moving toward the average marginal risk rather than having a set amount. I will let you read through that.

As with that, I will stop talking. No, I have one more. Moving to the next slide, it's in regard to the *Physician Compare*. On the next slide, you can see that there's really ... Going back one more, on the *Physician Compare* one, there is no established schedule for release of the aggregate MIPS data on *Physician Compare*. What they're doing is they're saying starting with the 2018 performance period, that you submitted last year, as technically feasible, they want to aggregate the MIPS data including the minimum and maximum MIPS performance category and final scores and then they'll publish those to *Physician Compare*. Basically, on the details I've seen on that, but again, dive into the final rule or the proposed final rule and make your comments where necessary.

Now, I'm actually done. I will turn it over to my colleague, Marvin, who will talk about the MIPS Value Pathways.

Marvin Nichols: Thank you so much, Rabecca. I originally had a conversation, you can go back one, Laurie. I originally had a conversation with one of my dermatologist specialists. We were sitting there thinking about getting his Quality measures in line. We looked at all the Quality measures and we chose which ones and we looked at his clinical workflows. We ensured that it wasn't a burden on his staff and made sure that we were collecting the data correctly. We looked at that as an Improvement Activity, looked at that as Promoting Interoperability to ensure that the EHR was actually capturing the data that was being submitted.

Right in the middle of all this, he just stopped me and he said, "Marvin, why as a dermatologist do I have to know if my patients received a flu vaccine?" I was a little stumped. I was a little stumped, yes. The quality of your patients care and that you know that you should know that your patient is getting immunization, is that correct? Yeah, that's correct. Has it been real meaningful to that dermatology practice? I don't know. That's basically what he was trying to say to me is that these quality measures that he was capturing for MIPS were not as meaningful as they could have been. I think the MIPS Value Pathway is an avenue to where CMS is actually going to make the program more meaningful for the clinicians that participate in the program.

CMS is actually pivoting and significantly changing the MIPS program in part because of the comments that were made in option Year 1, Year 2 and Year 3. Now, next slide please.

How is this MIPS Value Pathway going to look? It's a conceptual participation framework that would apply to future proposals beginning in the 2021 performance year. This will become effect in 2021. Now, the framework is to align and connect measures and activities across all four MIPS categories because now, we know that we could pick at least six different quality measures. We can pick two to four different improvement activities and they do not have to align. The MIPS Value Pathways or MVP is going to attempt to align these categories together for the different specialties and conditions. Then we'll also leverage the PI measures in a set of administrative claims based quality measures that focus on population health and public health priorities.

I think a picture is worth a thousand words. You'll see on the next slide this is how the framework looks. Right now, you have many choices to do. I think there's over 256 different quality measures that you can choose. They really don't have to be meaningfully aligned and it's a highly reporting burden. What the MIPS Value Pathways, or MVP, is going to do is going to try to move that needle together so we have more value in the program. It's going to be cohesive. It's going to lower your reporting burden. It's going to focus participation around pathways that are designed for specialties and practices and public health priority.

Then in the future what CMS proposes is that MIPS will be simplified if you have an increased voice of the patient. There will be increased CMS provided data to you and also the way that this is designed, it facilitates movement to a more alternative payment model. Next slide please.

How does this look? If you're a surgeon, right now you have to submit six measures in Quality. You have to submit six measures in Promoting Interoperability. Improvement Activities, you have to do two more and then the Cost category, you have to do one. They don't necessarily have to be aligned. You can pick whatever you want to, whatever you want to.

For the new MIPS Value Pathway framework and you just look at that box in the middle, this will be the pathway for surgeons. There will be meaningful Quality measures. There is only three. It's not six. It's not immunization. It's not diabetes. Its Quality measures that are specific to that surgeon or surgery practice. You have Improvement Activities and then your Cost measures will be tied to that certain specialty. Next slide please.

Here's another example. This is diabetes. Now, diabetes, obviously your quality measures if you look at that box in the middle, your quality measures are hemoglobin, diabetes, medical anesthesia, evaluation of controlling high blood pressure. Those are meaningful for a primary care physician who most of his patients are either diabetic or have high blood pressure.

As opposed to just picking six different quality measures and six different promoting interoperability measures, it's going to be a focus on specific measures that are for your practice. Next slide.

Now, this is your program. We're at an opportunity time where CMS is asking for your comments, how do you want this program to be designed. Like Rabecca said, there are over 9,500 comments that are on this proposal. Usually, we know a government, usually they tell us what to do and we just do it. Right now, we have the opportunity to design this program the way that we want it to be more specific to us to make it our program. I challenge everyone on this webinar to at least submit one comment. There's at least one thing in the 10,000 pages of this document that you should have a comment on. This is your program. You design it the way that you want it to be designed.

You can have more information about the MVP program using hyperlink that's on this slide. Next slide please.

They're requesting a lot of feedback for this particular rule, the proposed rule. These are the different categories. I'm not going to go through all the categories, but they are requesting feedback for pretty much everything about their design of this program. Next slide, Laurie please.

I did want to bring to your attention particular questions about the small and rural practices. We have with small and rural practice, I usually have a burden with resources and things of that nature. All my small and rural practices need to submit comments to help our practices participate in this program. These are the specific questions that the actual RFI is asking. I will like for your guys to review these questions and submit a comment on one or as many as you want to. Next slide.

These are other MVP questions for small and rural practices. Like I said, I highlighted them because reviewing these slides, you can say, you know what, Marvin was talking about the MVP questions, boom, you have it right there. You don't have to go searching the document of the 2020 Proposed Rule. You can actually reference the questions that I pulled out. Next slide please.

Submitting comments for 2020 Proposed Rule. On the next slide, you have six more working days to submit. We have to have comments in by September 27th, 2019. When you're commenting, please refer to the file code CMS-1715-P. Fax transmissions won't be accepted. You need to use one of the following ways, either electronically, regular mail, express mail or hand or courier.

Laurie, if you go to the next slide, we provided you the actual addresses for regular mail and the express and overnight mail. You have six working days to come up with at least one comment. I suspect that that number should be about 15,000 when I look at it next week. I want all you guys, and I'm very serious about this, I want all you guys to really look and really answer the

questions, what does this mean to my practice? I need something meaningful for my practice because if I'm participating in this program and this is the way that you want to evolve, I want it to be the part of me, a part of my medical family. Next slide Laurie.

We have a list of resources that we went over in the presentation. We have the proposed rule. We have the press release. We have a link to the proposed rule. We have the Physician Fee Schedule Proposed Rule Fact Sheet. You have the QPP Proposed Rule Fact Sheet. We also have those diagrams that I went over regarding the MIPS Value Pathways or MVPs program.

We have one minute, if you have any questions, just please put them in the comment box and we will definitely answer them. Unfortunately, we don't have much time to take live questions. I would like to thank you all for your time today and turn it back over to Laurie.

Rabecca Dase: Laurie, before you take us out, this is Rabecca, I do just want to add one thing. Those links that we had on that last page, as I mentioned when I started talking about the proposed rule, you can download that into a PDF on your desktop and it's so easy to use the control F button and to type in topics or comments that you want to bring up that you were interested in. You can use keywords to filter sort and does make it easier to sort through the final rule or the proposed rule to bring up those topics and read through what you're interested in.

Laurie: All right, well, thanks so much Marvin and Rabecca. This is Laurie. I did want to remind everyone, I did send out a copy of this slide deck to everyone who registered for this session earlier this morning. That will then have all the live links in it to the resources that Rabecca and Marvin shared today as well as handy tools for you to share with other staff members in your practice.

With that, I'd like to thank everybody for joining us today. Thanks to Marvin and Rabecca for a great, informative presentation. I also want to remind you that as you close out of today's session, you will be directed to a very brief evaluation. We ask that you please just take a moment to answer those questions. Your feedback really does make a difference and helps us develop future programs that will best meet your needs. Thanks again for joining us. Have a great rest of the day. This now concludes the session. Thank you.

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