Hello and thank you for joining today's Quality Payment Program Year 2 Overview Webinar. Today, representatives from the Centers for Medicare and Medicaid services will provide detailed information about the Quality Payment Program Year 2 Final Rule. CMS subject matter experts will address specific requirements for both the Merit-based Incentive Payment System and the Advanced Alternative Payment Model tracks for the performance year 2018. The presentation will be followed by a question-and-answer session where attendees will have the opportunity to ask questions. You can listen to the presentation through your computer speakers. If you cannot hear the audio through your computer speakers, please contact CMSQualityTeam@ketchum.com. Questions will be taken via the phone line and question box. We will be distribute the phone number during the Q&A portion of the webinar. Subject matter experts will address as many questions as time allows. For any questions not answered during the call, please e-mail or call the QPP service center at qpp@cms.hhs.gov or 1-866-288-8292. The webinar slides, recording, and transcript will be posted on the CMS website in the coming weeks. I would now like to introduce Jean Moody Williams, deputy director of the Center for Clinical Standards and Quality of CMS. Miss Moody Williams, you may begin.

Thank you and hello, everyone. On behalf of our administrator and the entire team here at CMS, I'd like to thank you for joining the call today. I see we have a great number of people registered. We're already getting questions. I think we're going to be in for a great session today. As you're aware, we released the Final Rule for Year 2 of the Quality Payment Program on November 2nd. And because we wanted to keep getting your feedback, this is a final rule with comment period. So we are looking forward to hearing your comments on a number of items, and you'll get information later on in this session on how to do that. We understand, of course, that this program continues to be a big change. So we are still taking it slow. We're giving it flexibility, reducing some of the burdensome requirements, and offering new incentives for participation. We really considered more than 13,000 comments from interested stakeholders on our proposed rule for Year 2. And as I mentioned, we haven't stopped listening. We'll continue to take -- we'll listen and take actionable steps toward improving the program. And really do appreciate anything that we receive. You may also be aware that CMS, through its Patients over Paperwork initiative is really trying to move the needle to remove regulatory obstacles that get in the way of clinicians and providers spending time with patients and healthcare consumers. Now, while some regulations are essential to ensuring patient and provider safety and program integrity, we realize there is a fine line between helping and hindering. And so we're taking a close look at this. Its complex, and it'll take time, but we are making great strides already. We set up an agency-wide process to evaluate and streamline our regulations and operations with the goal of reducing burden, increasing efficiencies and improving the customer experience. We've heard about and we are working on payment policy, quality measures, documentation requirements, conditions of participation, and health I.T. Just recently, we introduced a meaningful measurement framework that will help us as we go about looking at having measures that matter. We will be doing a webinar on that framework later in the month, and we invite you to join us. We're also resetting our path related to alternative payment models. We're seeking broad input related to a new direction for CMS' innovation center that will promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers that provides price transparency, increases choice and competition to drive quality and improve

outcome. So we're asking if you could please submit comments on this request for information by November 20th of this year. We've already gotten quite a few really thought-provoking comments and look forward to more. So, as you can tell, there's quite a bit going on at CMS, but today, we've assembled our subject-matter experts to walk through the specifics of the Final Year 2 policy. We will have time for questions, and we look forward to your feedback. But just before I hand it over, I have to remind you that there really is still time to participate in the first program year. The first program year is concluding on December 31st, but it's not too late to participate so you can avoid a negative payment adjustment or earn a positive adjustment. If you decide not to participate and don't send in any information for 2017 by the deadline of March 31st of 2018, then you will get a negative payment adjustment. Now, the good news is that while you used to have to go to multiple places to submit data under various legacy programs such as PQRS and Meaningful Use, we are consolidating your data submission experience into one place under QPP. Starting in January, you can go to QPP at cms.gov, log into your authenticated accounts and submit data to satisfy OMNIP's reporting requirements. So, you just got to go, you're going to look for a new login button at the top of the page. And it will walk you through what will be necessary. We will be having sessions on this and technical assistance available for you, as well. And if you've been submitting data under the Legacy Program for those user accounts, it'll be the same in QPP. So you can set up new or update your existing accounts in the current system right now in CMS Secure Portals. And that will enable you to be ready when the time comes for your submission. And I think you're going to be pleased. We've been listening to practice managers, clinicians, and we've been able to incorporate your perspectives in the preferences. So, as usual, we'll tell you how to get more help. But at this time, I want to turn it over to our subject-matter experts that will lead you through the rest of this presentation. Again, thank you, and I look forward to working with you over the next couple of months at your meetings and doing presentations for you and those kinds of things. I think I'm turning it to Adam.

Yep, and thanks so much, Jean, and you all who are here with us today. We are excited to have this opportunity to discuss the Final Rule for Year 2 of the Quality Payment Program with each of you. So we do have quite a bit of ground to cover today, so we're going to jump right in. I'm just going to skip to slide three. Just a little general administrative housekeeping. We will have a question/answer session if time allows following the conclusion of our discussion today. I will note that many of our policy experts will be present in the chat feature today to try to answer some of your questions in real time. I'll also do my best to look for any trending questions and try to address these questions as we move throughout the presentation and certainly into our Q&A later on. Again, as Jean mentioned, this is the Final Rule of comment period, and we also have an interim final rule of comment. So as always, we do need to protect elements of the rulemaking process. So we'll do our best to address straightforward questions. But we do ask you to submit all comments through the formal process at the outline of the federal register and within the Final Rule itself. And we'll review these elements within the rule that are open for comment a little later on in the presentation. So, skipping on to slide four. Just another general reminder that comments must be submitted through the formal submission process. That is extremely important. And just to note, there is a 60-day comment period associated with this Final Rule, and all comments are due by January 2, 2018. So please note that date, and we will come back to that a little later on. I'm going to move on to slide six just to keep us moving today. Just the

layout of our discussion. We'll start with a general overview of the Quality Payment Program. We'll follow that up by jumping right into the Final Rule for Year 2 with a discussion on the Merit-based Incentive Payment System as well as just a general overview, elements on who's included, the performance period. We'll take a look at some of the reporting and data submission options. We'll walk through the performance categories. And then we'll wrap up the MIPS section with a discussion on the performance threshold, the payment adjustment, and scoring elements. Afterward, we will move over to alternative payment models and advanced alternative payment models. We'll have just a general discussion on the overview of advanced APMs. We'll dive into an all-payer combination option and other payment advanced APMs conversations. And then we'll wrap up with some information on the APM scoring standard moving forward. We'll kind of wrap up our discussion today with a review of our resources that are available. As Jean mentioned, we do have the free technical assistance available to assist clinicians who are included in the program. And we will also have a question and answer session as time allows towards the end. So, moving right into our discussion, our overview of the Quality Payment Program. And I'm on slide eight. So, important here to emphasize that MACRA requires CMS by law to implement an incentive program, which is referred to as the Quality Payment Program that provides for two participation tracks. As you can see on screen, those are the Merit-based Incentive Payment System and Advanced Alternative Payment Models, both of which we'll be focusing on today. I will note that the Quality Payment Program takes a comprehensive approach to payment. Instead of basing that payment on a series of billing codes, we do add a consideration of quality through a set of evidence-based measures that were developed by clinicians. We also recognize and encourage improvement in clinical practice certainly through the improvement activities. And in tying everything together through the support and advances in technology that allow for the easy exchange of information and protecting patient privacy. I won't spend too much time discussing the nuances of each track of the program because we do have our policy experts here today. And they are going to cover quite a bit of ground during our time together today. But I will say that, as Jean mentioned, we understand this is a big program, and this is a big change. So we are continuing to take it slow, focusing on flexibility to help reduce burden and certainly offering those incentives for participation. One aspect that I hope each of you will notice as we go through the various policies today is that we are continuing many of our 2017 transition year policies while introducing some modest changes to ensure that clinicians are ready for full implementation in Year 3, which is performance period 2019. And again, as we mention, I think this is extremely important, we will continue to offer our free technical assistance to help clinicians participate in this program. And again, we'll touch on this a little later on. Moving on to the next slide, this is just a refresher for those who have been a part of our webinars or included in the program. This may be new to some, but these really are strategic objectives or considerations for the program. Of course, improving beneficiary outcomes is on the top of this list. But we're also extremely focused on reducing burden on clinicians. That was a major emphasis for us moving into Year 2. Certainly, maximizing participation in the program, increasing the adoption of advanced APMs to include more clinicians and to give clinicians more options. But also improving data information sharing and sharing operational excellence and definitely making sure that we have the I.T. systems that meet the users' need. Those are our top seven strategic objectives as we move forward with the program. So with that, I'm going to move on to the next slide. We'll begin our discussion on the Merit-based Incentive Payment system, and I'm going to turn it over to my colleague, Molly MacHarris.

Thank you so much, Adam, and thank you, everyone, for being here with us today. So I'm going to go ahead and jump right in because as Adam noted, there is a lot of ground to cover. So I'm starting on slide 11. So just a quick overview of what the world looked like prior to MIPS. Prior to MIPS, there were three programs which we refer to as legacy programs that clinicians had to participate in that included the Physician Quality Reporting System, or PQRS program, which dealt with quality measurement. There was the Physician Value-Based Payment Modifier program, which dealt with both the measurement of quality and cost. And then there was the Medicare EHR Incentive Program for eligible professionals, which dealt with the usage of certified EHR technology. And all three of these programs were separately authorized and required by separate legislations. And while us over here at CMS attempted to try to reduce burden and align requirements as much as possible, we weren't always able to do so. However, now under the MIPS program, those three legacy programs are ending. And as reflected on slide 12, we are now assessing clinicians performance under the MIPS program on four performance categories. And those four performance categories or three of those, rather, map directly to experiences that clinicians had under the legacy program. So quality, again, that's similar to what we measured under the PQRS program cost that was a component of the physician value modifier. And the advancing care information performance category, that is where we measure clinicians used to certify EHR technology. There is a fourth performance category under MIPS, which is improvement activity. And under that performance category, we look to see what clinical practice improvement activities clinicians have implemented. You'll also note on slide 12 that there are numbers associated with each of these performance categories. And they all roll up to a total 100 possible points. So why is that important? That's important because each clinician that is eligible under MIPS will receive a final score. And that final score will range between 0 and 100 points. Depending upon what the clinician's final score is in relation to the performance threshold. The performance threshold for Year 2 is the number 15. So for clinicians whose final score is above the performance threshold, will be receiving a positive MIPS payment adjustment. Clinicians whose final score is at the performance threshold will be receiving a neutral payment adjustment. And clinicians whose final score is below 15 will be getting a negative payment adjustment. And that will directly impact the total amount of Part B reimbursement clinicians will receive in 2020. So I'll talk about that in a lot more detail in future slides. I just wanted to make sure that folks were tracking to that high-level overview of the MIPS program. So let's go ahead and jump to slide 13 and then slide 14 to start with, what has remained the same, and what has changed for Year 2. So, as reflected on slide 14, who can participate in the program? The exact same types of clinicians who were able to participate for year one can participate for year two. So again, eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. And on slide 15, just want to give folks a reminder that when we say physicians, we mean not only MDs and DOs, but we also mean dentists, podiatrists, optometrists and chiropractors. So let's move on to slide 16 to talk about some of our exclusions. So, one of the exclusions that I want to spend a little bit more time on than the others is the low-volume threshold exclusion. So, as folks will recall, for Year 1, the low-volume threshold exclusion was clinicians who have billings greater than $30,000 and see more than 100 patients. Based off of all of the stakeholder feedback, everything that we have heard from all of you on the phone here today and through our various listening sessions, times when we've spent time in your officers. Based off of all of

that feedback, we felt it was appropriate to increase that low-volume threshold which gives us the ability to exclude additional clinicians from the program. And we felt that was appropriate because we still understand that there are a number of challenges for certain types of practices, particularly small practices to participate in the program. So in Year 2, clinicians who have billing that is greater than $90,000 and who see greater than 200 patients are excluded from the program in the second year. So, let's move on to the next slide, slide 17, to talk about the other exemptions. The other exemptions that we have in the program have remained the same. So we still offer the exemption that if you become newly enrolled in Medicare during the performance period, you don't have to participate for that year. So if you become newly enrolled in 2018, you don't have to participate. And we also have our exclusions for clinicians who have significant participation in advanced APM. My colleague, Ben Chin, will talk in more detail about some of the participation requirements for advanced APMs later on. So let's move on to slide 18. To start talking through some of our special statuses. So some of the special statuses that we have are additional statuses that we apply to certain types of clinicians. And with these statuses, some of these clinician types have to do something a little bit differently from other types of clinicians. So, we have the criteria to be considered a non-patient-facing clinician. Generally, this applies to pathologists, certain types of radiologists, anesthesiologists and nuclear medicine clinicians. So, we have our criteria to be non-patient-facing for individuals and for groups that have not changed. But we have additionally added criteria on how non-patient facing would apply to clinicians who choose to participate as part of a virtual group. And I'll talk about our new participation option virtual group in just a few slides. Let's move on to the next slide, slide 19. So, some of the additional special statuses that we have are the designation of being a small practice. We define under the quality payment program, whether you're part of MIPS or part of an APM, we define a small practice as a practice that has 15 or fewer clinicians. And then our additional status of rural and HPSA areas again, this status has remained the same from the first year. And if you are considered to be part of a small practice, a practice that is in a rural area or a HPSA area, again, your requirements are a little bit different. So for example, under the improvement activities performance category, you have to do a little bit less to get the same amount of points toward your final score. So let's move on to the next slide. And then the next slide again to talk about the performance period. So the changes for the performance period for Year 2 include that, for the quality performance category, there's no longer a 90-day participation option. Rather for the quality performance category, participation would be for the 12-month calendar year of 2018. For the cost-performance category, we are now measuring costs in the second year of the program. And that also has a 12-month performance period. Remember for costs, there's no separate submission that is required, no separate action that needs to occur. And again, I'll talk about cost in more detail a little bit later. What has remained the same for the performance period is that for improvement activities and advancing care information. You can still participate for a 90-day period. So one of the questions we've received since the Final Rule was released about a week or two ago was, was the pick your pace option still continuing? And the way that pick your pace worked in the transition year was that clinicians could participate for as minimal as a few days in the program and still avoid a negative payment adjustment. So, in the second year, we don' have all of the pick your pace options that were available in the first year available in the second year. However, as Jean noted, and as Adam noted, we still have a number of additional flexibilities for this flow transition to ensure that folks would be ready to participate

in the third year. So for example, clinicians would only need to have their final score be at 15 points to avoid the negative payment adjustments. We also still have the flexibility for two performance categories under MIPS. Again, the improvement activities and advancing care information performance category for clinicians to only participate for a 90-day period. And there's additional flexibilities that we have which I'll touch on throughout the presentation. So let's move on to slide 22. Just a high-level timeline. So again, for the second year of the program, for calendar year '18, the performance period for quality and cost is 12 months. For improvement activities and advancing care, it's any 90-day period during calendar year '18. All data for all performance categories need to be submitted no later than March 31, 2019. We will then issue feedback during 2019. And then your claims will begin being adjusted on January 2020. And that will range from a total of 5%. So if you do absolutely nothing for the second year, you would be receiving a negative 5% reduction in your claim. And we really want to avoid that as much as we can. So I'll go over additional ways to do that in just a few slides. So, let's move on to the next slide and then the slide afterwards to talk about the reporting and data submission options. So on slide 24, there are now three ways to participate in MIPS. So the first two options, participating as an individual or participating as a group, those are exactly the same as they were for year one. Individual participation is based off of the unique TIN, the unique tax identification number, and the unique NPI, which is the national provider identifier. Participating as a group is where two or more clinicians have reassigned their billing rights over to the TIN. And then the new way of participating in MIPS in the second year is as part of a virtual group. And virtual groups are the process and participation options whereby clinicians who are either solo practitioner or a group with ten or less clinicians can virtually form a group for purposes of participating and reporting in the MIPS program. So let's move on to the next slide to talk about virtual groups in more detail. So again, what is a virtual group? So a virtual group, again, it's any combination of a solo practitioner in groups with ten or fewer clinicians. There's no restrictions on the types of specialties that can form a virtual group or the location of the practices. So a virtual group could be comprised of five solo practitioners and five ten-person groups which would make that virtual group, if my math is right, 55 people as part of that virtual group. A virtual group could also be comprised of any combination of solo practitioners or groups of less than ten. Let's move on to slide 26 for additional information on virtual groups. So, clinicians who want to be part of a virtual group must indicate that to us, CMS, through an election process. That election process is occurring now and will end December 31st of this year. And again, that will be for purposes of the 2018 year. By law, virtual groups must make their elections prior to the beginning of the performance period. So again, that's why all virtual group elections must be made by no later than December 31st of this year. Let's move on to slide 27. So generally, we are treating virtual groups as groups. So all of our policies, all of our scoring policies, all of our participation options, everything that is available to groups is available to virtual groups. Additionally, all clinicians that are part of a TIN that are part of a virtual group must participate in the virtual group. Virtual groups are also required to aggregate their performance category data across all of their participants that are part of a virtual group. And I also want to note that there may be some instances where clinicians who are participating in a virtual group may also join to be part of an APM. In that instance, that clinician would receive two final scores. One that is part of their participation in a virtual group, and the second as part of their participation in an APM. In that instances, we are using our waiver

authority to apply the APM final score to that clinician. In other instances, we would apply the performance that the clinician has as part of the virtual group. Let's move on to the next slide to talk about how clinicians can make an election. So there's a two-stage election process which leverages our technical assistance infrastructure. Again, technical assistance is free to small practices, and we highly encourage all of you to take advantage of that. So the first stage, it's an optional stage, and that's where clinicians who think they want to be part of a virtual group, they can work with their technical assistance organization to see if they meet the eligibility requirements. If clinicians do not choose to take part of stage one, then what they would do is they would send in all of the required information which I'll cover in the next slide. And then at that time, us here at CMS will determine if all of the participants are part of the virtual group. We do encourage folks, however, to reach out to their technical assistance organizations if they can because we feel that that will help clinicians who want to join a virtual group. So, let's move on to slide 29. So what information would need to be received by us here at CMS by no later than December 31st to be -- if virtual groups want to participate. The first is that each virtual group would need to have a formal written agreement between all of the members of a virtual group. The virtual group would need to name an official representative. And that official representative would e-mail the virtual group election package to the e-mail address box of MIPS underline virtualgroups@cms.hhs.gov. And again, that must be sent by no later than December 31st of this year. Additionally, virtual groups would need to have information about each TIN and NPI that's associated with the virtual group. We also have a lot of information about virtual groups. We realize that this is a new participation option which can be a little confusing. So we have more information on virtual groups and how you can participate as part of a virtual group as part of a toolkit that's available now. Again, we also highly encourage folks who are interested in participating as part of a virtual group to contact their technical assistance organization. And I'll also note that we will be providing an additional training session for clinicians or stakeholders who are interested in the virtual group participation option in the coming weeks. Let's move on to the next slide to talk about the available submission mechanisms. So in short, all of the submission mechanisms that we had available for Year 1 are available for Year 2. No changes were made. We did make a proposal in the proposed rule to allow clinicians to use multiple submission mechanisms within a performance category. We did finalize this requirement, but it will not take effect until Year 3. So let's move onto the next set of slides beginning on slide 32 to take a deeper dive into each of the four performance categories. So starting with quality. If you look at the left-hand side of the slide, let's cover the basics first. So, the first change for the quality performance category is the total amount of weight it contributes to each clinician's final score. For Year 1, quality counted for 60 points towards a clinician's final score. In Year 2, it now counts for 50 points towards a clinician's final score. The number of measures that we have available. We still have over 270 measures available. The criteria for participation in the quality performance category have not changed, which is that clinicians need to select six measures. One of which would need to be an outcome measure. If an outcome measure is not available, clinicians would need to select another high-priority measure. And again, clinicians can make that selection of six measures either from the comprehensive set of measures, or we have specialty sets. And we did add additional specialty sets for the Year 2. And then looking at the right-hand side of the slide, for the table, a couple other changes I wanted to go over. So again, I've talked about the weight towards the final score which has changed. Again,

quality will count for 50% in the second year. The data completeness criteria has increased in Year 2 from 50% to 60%. And data completeness is that for every measure, there's a certain denominator that the quality action would need to be applied for. And so we're asking that you perform the quality measure 60% of the time. So again, data completeness deals with the overall rate of how often the quality action or the exclusion, depending upon the makeup of the measure of how often that would need to occur. An additional change that we made in the second year is that previously measures that did not meet data completeness received three points. Now those measures will receive one point. The exception is for small practices. Again, small practices. Any practice that has 15 or fewer clinicians, they will continue to receive three points. Let's move on to the next slide. So, some of the additional changes for the second year deal with the number of points that are available. So again, remember that for each quality measure, clinicians can generally receive between 1 and 10 points. And so, as reflected on slide 33, we don't have any changes for measures if the measure could not be reliably scored against a benchmark. If the measure does not have a benchmark, those measures will still receive three points. We also do have our bonuses that were available in the first year. Those are continuing in the second year, which is the pair of bonuses for quality measures that are submitting using end-to-end electronic reporting, as well as reporting on additional high priority measures. Let's move on to 34 to talk about topped out measures. So, what is a topped out measure, and why is it important? A topped out measure is a measure that has performance at such a high rate that meaningful distinctions can no longer be measured. So, what we finalized in this year's rule is that topped out measures will generally be identified, have a score and cap applied to them, and then removed on a four-year life cycle. Topped out measures with measure benchmarks that have been topped out for two consecutive years will receive 7 points. So for measures that have been identified for these two consecutive years, they would no longer be able to receive ten points. Their scoring would be capped at 7 points. We did identify six measures that are topped out that will have that scoring cap applied in the second year. And those are reflected on the next slide. I also wanted to note that while we have this four-year timeline, we will take into consideration additional factors before we remove any measure. And any measure that's removed will be removed through the rulemaking process which will allow all stakeholders to comment. So, looking at slide 35, again, the six measures here are the measures that will receive that 7-point scoring cap in 2018. So let's move on to slide 36 to talk about the cost performance category. So some of the basics for cost. So in Year 1, cost was not measured at all. In Year 2, cost will count for 10% of a clinician's final score. The two measures that we will be assessing clinician's performance on for cost is the Medicare spending per beneficiary measure and the total per capita cost measure. For those of you who have participated under the physician-value modifier program, you will be familiar with these measures. They are the same measures that were used under the cost side of the value modifier program. Also remember that for cost, no separate data submission is required. You simply see your patients and have your claims processed as usual. And us over here at CMS will do all the calculations. We had in the first year of the program ten episode-based measures as part of the cost performance category. We have removed those measures. We are working in a more collaborative process with stakeholders and with receiving front-line clinicians input and development of new episode-based cost measures. And we are currently providing testing on those measures to certain types of clinicians now. We do anticipate that in a future year, we will be able to adopt episode-based measures. So let's move on to slide 37. So again, for cost, as I mentioned a couple of times here,

there's no separate data submission that's required. The two measures, we will be comparing clinician's performance on is Medicare spending per beneficiary and the total per capita cost measure. The performance category will be based on an average of those two measures. If we can only calculate one of those measures, then that would count for the entire 10%. If we are not able to calculate either of those two measures for a clinician, then cost would be weighted at 0, and quality would be weighted at 60 points. So let's move on to slide 38 to talk about some of the improvement scoring that we've implemented. So for the quality and cost performance categories, by law, we had to implement improving scoring in the second year. For quality, improvement scoring will be occurring at the category level. And it will be based on the rate of improvement such as higher improvement results and more points. For cost, improvement scoring will occur at the measure level. Which will account for statistically significant changes at that measure level. So let's move on to the next slide, slide 39, to talk about the improvement activities performance category. Again, focusing on the basics, nothing has changed here for improvement activities. Improvement activities still has a 90-day performance period. Improvement activities still counts as 15 points towards a clinician's final score. We have over 100 improvement activities in the inventory available. We did make a few updates to some of those improvement activities, and we did add some new improvement activities, as well. And again, remember, for improvement activities, all that is required is a simple yes that the activity was completed. To receive the maximum number of points under improvement activities, each activity still has either a medium or high weight. Medium-weighted activities typically count for 10 points. High-weighted activities typically count for 20 points. And we will be looking for clinicians to hit 40 points to get the full 15% percentage points towards their final score. For patients in medical homes, we made a couple changes there. Remember that by law, if a clinician is part of a patient-centered medical home, they will receive the full 15 points for improvement activities. We recognize that the term "recognize" is equivalent to the term "certified" when it deals with patients at a medical home. We also have implemented a threshold for clinicians that participate as part of groups whereby 50% of their practice site would need to be part of a patient-centered medical home. Moving on to slide 40, again, I already mentioned that we have finalized some additional improvement activities and some changes to some of the existing improvement activities. We also have still continued to designate which improvement activities are eligible for the advancing care information performance category bonus. Let's move on to slide 41 to talk through the advancing care information performance category. Again, a lot of the basics here have remained the same from the first year. Advancing care information will still count for 24 points towards a clinician's final score. Participation and advancing care is built on a base score, a performance score, and bonus points. And there will continue to be two measures that's available for clinicians to choose from, which is based off of their addition of certified EHR technology they're using. So again, in 2018, clinicians can continue to use either 2014 or 2015-edition certified EHR technology. If a clinician uses exclusively 2015 edition certified EHR technology, they will receive a 10% bonus. A few other changes. For the measures and objectives, which is that we finalize exclusions for the prescribing and health information or HIE measures for scoring. Again, no changes to the base score requirements. For the performance score, clinicians and groups can earn now up to 10% for reporting to any one of the public health and clinical data registry reporting measures as part of the performance score. And then for the bonus score, a 5% bonus is available for reporting to an additional registry that is not reported under the performance score. Again, there are still the

improvement activities bonus points available. And the total bonus score is now up to 25%. Moving on to slide 42, some of the exceptions to the advancing care information performance category. So again, as folks will recall, the advancing care information performance categories similar to the Medicare EHR incentive program. So we wanted to continue a number of the exclusions and exceptions that are still applicable. Now in the second year, we have both the macro legislation as well as the 21st Century Cures Act which authorized some additional exceptions. For some of these exceptions, some are applied automatically, and some require an application. For those that are applied automatically, the exception for hospital-based MIPS eligible clinicians continues with the exception of nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists that continues. No application is required there. What is new is that for clinicians that are considered to be ambulatory, surgical-center based, they would now be excluded. And this becomes retroactive to the 2017 year. This was authorized as part of the 21st Century Cures Act. However, we did have to go through the rulemaking process to make this exception final for the 2017 and 2018 year. For exceptions that need an application includes a new exception for clinicians that are part of a small practice. So again, if you're part of a small practice, which is a practice that has 15 or fewer clinicians, you can file a hardship application, and your advancing care information performance category would be re-rated to quality. We also have new hardship exceptions if your EHR becomes decertified. And we also are not applying the five-year limit to these exceptions. There also is a new deadline of December 31st of the performance period for when the hardships exceptions application will need to be received. So let's move on to the next set of slides to talk about the performance threshold and payment adjustment. Let's begin on slide 44. So now that we have an understanding of the basic eligibility and then the four performance categories, let's talk about how we actually calculate and create a clinician's final score and their payment adjustment. So as I mentioned previously, the performance threshold for the second year is now at 15 points. So as you can see on slide 44, that's a slight increase from where the performance threshold was in the first year. The exceptional performance bonus continues at 70 points. Again, that's that separate payment adjustment that we have available for the first five or six years of the program where there's a separate bucket of $500 million that we can distribute to high performers. For the regular MIPS payment adjustment, however, the total amount of payment that can be distributed has increased from 4% to 5%. So some of the questions we've received since the rule has been issued is how could a clinician actually achieve 15 points? There's a number of ways that are reflected on the slide here. This is not inclusive of every possible option. These are just a few possible ways that a clinician could hit 15 points. The first is by doing everything that's required of you under the improvement activities performance category. You could also meet the advancing care information performance category base score and submit a quality measure that meets data completeness. You could also submit six quality measures that meet data completeness.

Molly, just one second. I think we're having some technical difficulties. I'm trying to get the slides moving forward. Just to our technical team, I think we've got them going now. Okay, perfect, we got 'em.

Okay, thank you, Adam. Thank you for stopping me. I want to make sure that people are seeing the slides as I'm going through this. So we should be on slide 45 now. Okay? So, this is just a table that summarizes the performance thresholds and the point structure in how that relates to a clinician's

final score. So let's take a look at the Year 2 table, and let's start from the bottom up. So as you can see, clinicians whose final score ranges from 0 to 3.75 points, they will receive a maximum negative-5% adjustment. For clinicians whose final score ranges between 3.76 points and right below 15 points, they would still be receiving a negative payment adjustment, but it could range somewhere between that 5 range and the neutral range. So a question that we've receives is why do we have the 0 to 3.75% bucket? That's required by law. By law, final scores that are in the lowest core tile must received -- the lowest core tile below the performance threshold must receive the maximum negative payment adjustment. So again, we really want to ensure that all clinicians are receiving a positive adjustment if not a neutral adjustment. But we definitely want to try to avoid as much as possible clinicians that would be receiving that maximum negative payment adjustment. So then again, clinicians whose final score ranges from 16 to 69 points, they would be receiving a positive adjustment. And then clinicians whose final score is at 70 or greater, they would be eligible to receive not only their regular MIPS payment adjustment, but also that exceptional performance adjustment. Let's move on to slide 46 and 47 to talk about calculating the final score. So then there's the four performance categories. We all know now that they comprise of two 100 possible points. And that's important because each clinician will receive a final score which ranges from 0 to 100 points. Final scores that are above the number 15 will be getting a positive adjustment, which means more money in your pocket in 2020. So, let's move on to slide 48 to talk about some additional bonuses that we've offered in the second year to maximize your score. So on slide 48, we have finalized a complex patient bonus. And this is for those clinicians that treat the most medically complex and vulnerable patients. This adjustment will be based off of using the percentage of dual-eligible beneficiaries, as well as the HCC risk score. And this bonus can range between 1 to 5 bonus points. And to be eligible to receive this bonus, a clinician would need to participate in at least one performance category. So again, we really encourage folks to take advantage of these bonus points that we're offering. Moving on to slide 49. A general theme that folks are probably hearing by now in this presentation is that we really want to reduce burden as much as possible for small practices. For those small practices, again, a small practice is any practice that has 15 or fewer clinicians. If they participate in MIPS and at least one performance category, they will get an automatic 5 points towards their final score. Okay? Let's move on to slide 50 to talk about facility-based measurement. I won't spend too much time on this here today. The facility-based measurement option was an additional participation option for those clinicians that are facility-based and who participate in the hospital value-based purchasing program. Due to technical constraints, we were not able to offer this option beginning in the second year of the program. We will, however, offer this option in the third year of the program. So stay tuned for more information on facility-based measurement, and you will see more information on facility-based measurement in our proposed rule next year. So let's move on to slide 51. To talk about our extreme and uncontrollable circumstances policy. So, we recognize that there have been a number of natural disasters that have occurred during calendar year '17, specifically hurricanes Harvey, Maria, and Irma. And those hurricanes have impacted clinicians' ability to participate in the quality payment program. So as part of the Final Rule with comment, we also finalized an interim Final Rule with comment, which allows us here at CMS to provide relief to clinicians that are impacted by hurricanes Harvey, Maria, and Irma. So for the 2017 year, clinicians that are in the impacted areas that are based off of the FEMA major disaster declaration areas, you don't have to do anything for the Quality Payment

Program. You don't have to file an application. What we will do is we will use your practice address, which is available within our payco system here at CMS. And we will apply to you a final score that's equal to the neutral point for the transition year. So again, for clinicians that are impacted by hurricanes Harvey, Irma, and Irma, no separate application is required to receive relief from the MIPS program. We will use your address that's available to us within our payco system. And you will receive a neutral payment adjustment. And then on slide 52, our policies for extreme and uncontrollable circumstances, which includes natural disasters for the second year, due to the way that our proposals were structured, we aren't able to offer a no-application approach for the second year. So if clinicians do have a natural disaster or any other extreme and uncontrollable circumstance that affects them during calendar year '18, we would need to receive an application for those instances. And those applications would need to be received no later than December 31, 2018. So let's move on to slide 54. I think this is the last MIPS slide. As both Jean and Adam noted, the Final Rule is also a final rule with comment. So there are a handful of areas where we are looking for specific policy feedback on. That includes our definition of a group and how we apply the low-volume threshold. We're also looking for any feedback clinicians or other stakeholders may have related to QCDR measures. Also how our MIPS scoring methodology and our bonuses are applied. We've heard from stakeholders that the current process can be a little complicated and a little confusing, so we're interested in feedback on ways to simplify it. And then of course, our policies for the interim Final Rule that is an interim Final Rule with comment. So we welcome any comments or feedback there. So at this point, on slide 55, I'll go ahead and turn the rest of the presentation over to my colleague, Ben Chin. Ben?

Thanks, Molly. So let's move on to discuss the policy of changes for Year 2 that will affect the advanced APM track of the quality payment program. As a refresher, the MACRA statute defines APMs fairly broadly to include all CMS innovation center models. The Medicare assured savings program. And any demonstrations under the healthcare quality demonstration program or any other demonstrations required by federal law. However, to be an advanced APM, a model must meet three requirements which we finalized in last year's rulemaking. First, the APM must require participants to use certified EHR technology. Second, the APM must provide payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category. And third, the APM is either a medical home model expanded under CMS innovation authority. And I'll note that to date, no such model has been expanded under innovation center authority. Or alternatively, the APM requires participants to bear more than a nominal amount of financial risk. Again, in order to quality for 5% APM incentive payment, model participants must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an advanced APM during an associated performance period. In last year's rule, we finalized -- we established standards for the criteria just described. In general, we are keeping those standards, but we did finalize a few changes. Next slide. So in last year's rule, we finalized two ways that APMs could meet the nominal amount standard. APMs could meet the standard if total potential risk under the APM is equal to at least either 3% of the expected expenditures an APM entity is responsible for under the terms of the APM. And this expected expenditure standard or benchmark based standard was finalized for all performance years. Or 8% of the average estimated parts A and B revenue of providers and suppliers in participating APM entities which was only finalized for the 2017 and 2018 performance period.

And this year, in the Final Rule, we finalized extending the 8% revenue-based nominal amount standard for an additional two years through performance period 2020. Moving on to the next slide. In addition to the general nominal risk standard, last year, we also finalized a separate definition of a medical home model that only applies to the quality payment program. And a special financial risk criterion specifically for medical home models. As defined by the quality payment program, medical home models start with a pair arrangement where the participants are focused on primary care. They empanel patients to primary clinicians and require a patient/clinician link. There are also seven model design options that the model can incorporate which means four must be met. We finalized two changes related to the special medical home financial risk criterion which I'll discuss over the next couple of slides. Next slide. It was finalized last year that starting in performance year 2018 and thereafter, the medical home financial risk standard would only apply to the APM entities and advanced APMs with fewer than 50 clinicians in their parent organization. We finalized and maintained that standard this year with a limited exception. Specifically, we are proposing to exempt round one or current participants in the comprehensive primary care plus model from the requirement that the medical home model financial risk standard applies only to APM entities with fewer than 50 clinicians in their parent organization. All future participants in CPC Plus, including their 2018 starters will be subject to the 50-clinician cap policy. Next slide. We are also finalizing one additional change to the medical home model nominal amounts standard. In last year's rule, we finalized that total potential risk for an APM entity must be equal to at least 3% in 2018, and that it would gradually ramp up to 5% in 2020 and thereafter. We are changing the nominal amounts to enter for medical home models so that the minimum required amount of total risk increases more gradually. And we are maintaining the standard at 2.5% in 2018, and then ramping up to 5% in 2021 and thereafter. And we believe this approach may allow for greater flexibility and encourage more participation in medical home models and be more sustainable for the type of APM entities that would potentially participate in medical home models. Next slide. And so now we'll be moving on to the All-Payer Combination Option and other paired advanced APMs in this next set of slides. And so the All-Payer Combination Option, along with the Medicare option is one of two pathways through which eligible clinicians can become a QP or a partial QP. Beginning in performance year 2019, QP determinations under the All-Payer combination Option are based on an eligible clinician's participation in a combination of both advanced APMs and other payer advanced APMs. It is important to note that QP determinations are conducted sequentially so that the Medicare option is going to be applied before the all-payer combination option. And only clinicians who do not become QPs under the Medicare option will have the opportunity to participate in the all-payer combination option. Next slide. So, moving on to how we will make other payer-advanced APM determinations. Last year, we finalized that eligible clinicians or APM entities on their behalf would report information about the payment arrangements they participate in after the 2019 QP performance period. This year, we established a process for payers to submit information to CMS regarding non-Medicare payment arrangements prior to a given QP performance period. So CMS can determine whether the payment arrangements meets the criteria to be an other payer advanced APM. This payer-initiated process would be available for Medicaid, Medicare health plans, including Medicare advantage, and CMI multi-payer models for performance year 2019. We do intend to add remaining payer types in future years. Next slide. So I just want to reiterate here that the payer-initiated process would be voluntary. Payers would be able to request a review of multiple other payment

arrangements through the payer initiated process. Though CMS would make separate determinations as each other payer arrangement. And like in the payer-initiated process, APM entities and eligible clinicians would also have an opportunity to request determinations of other payer arrangements they participate in. That process would take place after each QP performance period. Guidance and submission forms for both payers and clinicians will be made available for each pair type early in the calendar year prior to each all-payer QP performance period. And the specific deadlines and processes for submitting payment arrangements will vary by payer type in order to align with our pre-existing processes to meet statutory requirements. Moving along to the next slide. Now, switching gears a bit, we'll discuss some changes to the other payer-advanced APM criteria. And as a refresher last year, we finalized the criteria for determining whether a payment arrangement qualifies as an other payer advanced APM are similar but not identical to the criteria used within Medicare. And those are -- they require at least 50% of eligible clinicians to use certified EHR technology that the other payer-advanced APM would base payment for covered professional services and quality measures that are comparable to those used in MIPS and is either a Medicaid medical home model that meets criteria and that is comparable to a medical home model expanded under CMS innovation authority. Or they require participants to bear a more than nominal amount of financial risk. Next slide. So drilling down into that financial risk criterion, in last year's rule, we finalized that the nominal amount of risk for an other payer-advanced APM must be equal to marginal risk of at least 30%, minimum loss rate of no more than 4%. And that's a total risk of at least 3% of the expected expenditures the entity is responsible for under the terms of the payment arrangement. This year, we are maintaining the marginal risk in the minimum loss rate requirements, but we're also adding an 8% revenue based nominal amount standard that would apply to payment arrangements in which risk for entities is defined in terms of revenue. It would be an additional option. It would not replace or supersede the 3% expenditure based standard previously finalized for other payer-advanced APMs. Next slide. So, moving on to QP determinations under the all-payer combination option. Last year, we finalized that QP determinations under the all-payer combination option would be made at either the APM entity level as we make them under the Medicare option. We finalize this year that QP determinations would be made at the individual eligible clinician level and the APM entity level. Like in the Medicare option, the QP performance period for the all-payer combination option would run from January 1st to August 31st of each performance year. Next slide. So the next two slides, you'll provide a high-level overview of the timeline for the other payer advanced APM determination process. Again, guidance and submission forms for both payers and clinicians will be made avail bale for each pair type early in the calendar year prior to each all payer QP performance period. For Medicaid, the top timeline there. Both the payer and eligible clinician initiated process will take place in 2018. For the payer initiated process for Medicaid, the submission form will be available in January with a submission deadline in April. For the eligible clinician or APM entity process, the submission form will be available in September with a submission deadline in November of 2018. Again, for Medicaid, prior to the start of the relevant all-payer QP performance period, we intend to post the other payer-advanced APMs that we determine through the payer initiated process and the eligible clinician initiated process under title 19. I'm taking a look at the second timeline on this side for CMS multi-payer models. The payer initiated process will first take place in 2018. Submission forms will be made available in January with submission deadline in June. We will post an initial list of other payer advanced APMs

determined through this process in September. For the eligible clinician initiated process, submission forms will be available in August of 2019. And will be due at the beginning of December 2019. An updated list of their payer advanced APMs will be posted by the end of December 2019 before the all-payer QP determinations are released. Next slide. Looking at top timeline on this slide, which pertains to Medicare health plans, including Medicare advantage, the payer initiated process will first take place in 2018. It will be run in conjunction with Medicare advantage bidding process using the HPMS system. Submission forms will be available in April as part of the HPMS bid package with a submission deadline that is in June. We will post an initial list of their payer advanced APMs determined through this process in September as we will for the other CMS multi payer models. And for the eligible clinician initiated process, submission forms will be made available in August of 2019 and are due at the beginning of December 2019. Again, we'll post an updated list of other payer advanced APMs by the end of December in 2019. Before all payer QP determinations are released. Looking at the remaining timeline on the bottom of this slide, for remaining other payer payment arrangements, or any other commercial arrangements, the other payer advanced APM determinations will not be made prior to performance payer 2019. Although we do intend to add this option in future years. We do want to note that there will be an eligible clinician enabled process for the remaining other payer payment arrangements. And submission forms will be made available on August of 2019 and will be due in early December 2019. Next slide. So now we'll move on to discussing some of the Year 2 changes for the APM scoring standard and for MIPS APMs. AS a reminder, the APM scoring standard finalized last year offers a special minimally burdensome way of participating in MIPS for eligible clinicians and APMs who do not meet the requirements to become QPs. They're there for subject to MIPS. Or for eligible clinicians who meet the requirements to become a partial QP and therefore able to choose whether to participate in MIPS or not. The APM scoring standard applies to APMs that meet the three criteria on this slide in that they have APM entities that participate in the APM under an agreement with CMS. They have entities that include one or more MIPS clinician on a participation list. And they base payment incentives on performance, on cost utilization and quality measures. Next slide. So last year, we finalized different scoring weights for the quality performance categories for ACO models, including the Medicare shared savings program and the next generation ACO model. In comparison to other MIPS APMs which had quality weighted to zero. For performance year 2018, we aligned a performance category weighting across all MIPS APMs and will assess all MIPS APMs on quality, which is reflected in this slide. Next slide. We also finalized additional details on how the quality performance category will be scored under the APM scoring standard for non-ACO models who had quality weighted to 0 in 2017. In 2018, participants in these models will be scored under MIPS using the quality measures that they are already required to report as a condition of their participation in their APM. So, participants in those models will not be required to separately report any quality information as a part of MIPS. We also finalized another significant change under the APM scoring standard, which is adding a fourth snapshot date of December 31st of four full TIN APMs for the purpose of determining which eligible clinicians are participating in a MIPS APM. This would allow participants who joined certain APMs, mainly the Medicare-shared savings program between September 1st and December 31st of the performance years to benefit from the APM scoring standard. Next slide. So that concludes the discussion of the proposed policy changes for the advanced APM track of the Quality Payment Program. And I'll turn it back to over to Adam to talk about resources and technical assistance.

All right, thanks so much, Ben. Thanks to both Molly and Ben today for taking us through the policy changes that were made for Year 2 of the quality payment program. I do just want to emphasize just one last time that we do have a number of resources that are available to clinicians at no cost. All of these resources and forms of support really comprise our integrated technical assistance initiative. And just as you can see on this infographic, there are a number of options available. I'll go through these relatively quickly. Just so we can get to the Q&A session. So beginning at the bottom right, we have what we like to call our technical support component of technical systems. This includes all the information of the quality payment program, including our website, CMS.gov. The service center e-mail and phone number which is right at the beginning of our program today. And the APM learning systems which serve as the direct support for those clinicians participating in APMs and advanced APMs. So now moving counterclockwise, we have what I like to call three on the ground branches of technical assistance. So these include the small, underserved, and rural supported initiative. We have 11 organizations supporting that initiative. And this is support for clinicians who are in small practices, 15 or fewer clinicians. And with priority given to those in rural HPSA medically underserved areas. We have the transforming clinical practice initiative, which is comprised of 29 practice transformation networks. This is for practices that are moving along in practice transformation. Interested in participating in MIPS, but also eventually in transitioning to an advanced or an alternative paying model and an advanced alternative payment model. These organizations will help you move along that path. And then finally, we have the quality innovation networks and quality improvement organizations. We have 14 of those organizations, and they are supporting our larger practices. So more than 15 clinicians. For those clinicians who are included in MIPS for 2017 transition year and certainly into future years. So, we'll say all these branches are comprised of very professional experience organizations who have worked with CMS on a number of quality improvement related programs over the last several years. They are very knowledgeable organizations and groups of people that area available to help clinicians immediately and at absolutely no cost. So certainly, take advantage of this free support and spread the word to other clinicians and your peers. So moving on from that slide, just a reminder, one last time that this is a Final Rule with comment. Comments are due January 2, 2018. Please write that date down if you are interested in submitting comments. And at this time, we are going to open it up for question and answer session. We will have the phone lines available, so please dial in. We'll try to get to as many questions as our time allows today. We are still also answering questions within the chat box. So please continue to submit your questions. As folks are starting to dial into the phone line, I did want to bring up one question that we saw that was trending throughout the presentation today. And just kind of understanding the difference between the and or when we come to applying low volume threshold. So Molly, I don't know if you can touch on that for us.

Oh, sure. Thanks, Adam, and great question. So the way that the low volume threshold works and the way that we talk about it as an and or and or, it depends upon the context. So, we would say that a clinician -- let me just go back to that slide real quick. So a clinician would be eligible if they bill more than $90,000 and see more than 200 patients. A clinician would be excluded, meaning they are not eligible if they bill less than or equal to $90,000 or see 200 patients. So the or and the and flip depending upon the context that we're talking about. I realize that can get a little confusing.

It unfortunately draws in a double negative and some Boolean logic, which we did not originally intend to implement. But again, just to be really clear on this, you are eligible in the program if you bill more than $90,000 and you see more than 200 patients. You are excluded from the program if you bill less than or equal to $90,000 or if you see less than or equal to 200 patients.

Great, thank you. We're going to turn it over to the phone lines now. Again, we do have our experts working through the chat. We'll take questions from the phone at this time.

Our first question comes the line of Ron Rockwood. >. Hey, guys, thanks for the presentation. Can you hear me?

Yep, absolutely.

Great. Which organizations expect the 2018 MIPS benchmark information to be released?

Sure, this is Molly. That information will be up within the next few months, no later than December 31st.

Thank you.

Thank you.

Our next question is from the line of Toma Hudson.

Hi, this is Toma. Can you hear me?

Yeah.

Okay, great. My question has to do with the wording on the HIE exception. And in the wording, it states that less than 100 referrals for the performance period. Does that mean less than referrals in that 90-day performance period? Of is that the reporting period and you're meaning performance period as in January through December?

Okay, this is Elizabeth, and it's whatever performance period you are submitting for. So for the Advancing Care Information Performance Category, your performance period can be anywhere from 90 days, consecutive 90 days up to 365 days. So if you choose to submit, like, 100 days of data, then the exclusion would have to be determined in that period. Does that help?

They have been disconnected. Hopefully that helps. We'll move on to our next caller.

Our next caller is Kim Sweet.

Yes, hi, thank you for taking my call, and thank you for this information today. My question has to do with the cost category in reference to the total per capita. And what I would like to know is, what I don't understand in using the administrative claims is what measures are actually being assessed for the total cost per capita? Are they just doing measures that have denominators in them? Or are they selecting the six measures that are being reported on through the quality performance category?

Yeah, this is Molly. For the cost performance category, we are assessing cost on two measures. So it's the Medicare spending per beneficiary measure and the total per capita cost measure. Both of those measures are based off of what we call administrative claims which, again, that's based off of all of the available part B claims data that we receive through normal billing practices that you and your office will normally do. That's separate and distinct from the quality measures that are available under the quality performance category. Those measures and the way that they can be reported including are regular claims options do require a pending something called a quality data code or a G code modifier to a claim if you choose to report those quality measures through claims. You could, for quality report using a registry in the HRR QCDR. But again, for the --

So the cost is just going to -- they're going to use just all of the Medicare part B and part A I understand for total cost per capita to determine the total cost per capita measure.

Correct.

All right, thank you.

Thank you.

Thank you.

Okay, great, thank you. I did want to pull one from the chat, and this is for our colleagues over at CMMI. Was a fourth QP, qualifying APM participant, determination snapshot date added for advanced APMs for 2018 such as the next generation ACO? Or will individuals who join a TIN that is participating in a next gen ACO after the third snapshot date have to do MIPS?

Thanks, Adam. So there's no fourth snapshot date that's been added for advanced APMs. The fourth snapshot only applied to full TIN APMs for the purpose of determination participation in the MIPS ACM?

This is Greg Woods from the team. I would also add that that fourth snapshot data applies to full TIN MIPS APMs. The next generation ACO model is not a full TIN APM in that it's not -- the model is not structured so that all providers who have assigned their billing to a given TIN are necessarily in or out of the model. So the fourth snapshot would not apply to a next generation ACO model.

Okay, great, thanks so much. We're going to turn it right back over to the phone lines. I believe we just have a few more callers. We'll take these questions.

Your next question is from G. Thong.

Hi. Thank you again for having this session. Quick question, on the part B drugs, does it apply to all drugs that are attributable to our TIN? We are paid on a physician fee schedule for our services, but we're paid on an ASP schedule by our Mac for our drugs.

Sure. I'm actually not sure if the team can go to the appendix slide, slide 79. And 80, if the Ketchum team could advance the slides. So, in short, great question. We've received a number of questions related to Medicare

part B drugs. We have the information related to this slide here. So generally, as folks know, the MIPS program applies not just to the physician fee schedule, which is how it worked under the legacy program, it applies to part B including part B drugs. So, part B drugs that are rendered under the physician fee schedule, those are, of course, included. We also have an example here on the slide which is for a clinician to keep medication in the office, and then bill Medicare for the drug as well as the office visit to administer the drug. And so the result is that the cost of the drug itself and the administration of the drug are directly attributed to you, the clinician, and those would be included for purposes of determining your MIPS eligibility and your MIPS team and adjustments. The other fees I wanted to note related to the Medicare part B drugs is we did just recently release a fact sheet related to part B drugs that's available under our resource library at qpp.CMS.gov for any other folks who have additional questions on part B drugs. I hope that helps. Thank you.

Thank you, Molly, and we have time for two more questions. We're going to get two more questions from the phone line.

Our next question is from Corinne Reuben.

Hi, this is Corinne Reuben from the American Medical Association. Can you please clarify with scoring cost improvement? So it's my understanding from the rule that in order to be scored, you have to have the cost measures or the individual cost measures. Medicare spending per beneficiary or total per capita costs attributed to you two years in a row. So will CMS be using 2017 for measuring improvement? 2017 and 2018 data, even though in 2017, the cost category was zero?

Hi, this is Molly. So yes, that's correct. Again, as required by law, we must start to begin measuring improvement for the quality and cost performance categories in the second year. So as you noted, in the first year, costs contributed to 0% of a clinician's final score. However, we will still be calculating the Medicare spending per beneficiary until the per capita cost measures, they just won't apply to a clinician's final score. So when we look at improvement, for the second year, we will be looking at improvement on the measure basis from the 2017 year, from year one, to the 2018 year to year two. Thank you.

Thank you, and our last question today?

Our last question is from Roxanne Barrera.

Hello, can you hear me?

Yep.

You guys really didn't touch upon hospital-based providers or non-patient facing physicians. I work at an acute care facility, and that's mainly what we're focusing on. All the reweighting and the notifications you'll be sending out to non-patient facing providers.

Sure.

Will there be a future webinar going over just that piece of it?

So, this is Molly. I'll defer to my colleague, Adam, for information on future webinars. But for non-patient facing MIPS eligible clinicians, I did briefly go over the requirements, generally they have remained the same for year one to year two. So we still have a non-patient facing designations which would apply to a clinician. If a clinician receives that non patient facing designation, then the requirements are a little bit different. So for the improvement activities performance category, if you're non patient facing, your activities, medium, and high weighted are double weighted. So your medium activities would count for 20 points instead of 10 points. And your high weighted activities would count for 40 points instead of 20 points. Also, for the advancing care information performance category, typically for non-patient facing MIPS eligible clinicians, that category is not required, and instead, it would be reweighted to the quality performance category. So those are the general requirements for non-patient facing MIPS eligible clinicians. But again, have not changed from the first year. And then I'll let Adam weigh in for any future listening sessions or training sessions we have scheduled.

Sure, thanks, Molly. And this is a really nice segue, and we appreciate the recommendation for some additional guidance on this very important topic. We are building out the remainder of our education outreach on our webinar series throughout the remainder of this year and into next year. So this is something that will certainly take back to the team and consider having something specific to this topic.

Okay, with that, we are going to wrap it up. I did just want to mention, we did have a lot of questions pertaining to virtual groups. So I do want to mention that we are having a public webinar on virtual groups next Tuesday, November 21st, from 1:00 p.m. to 2:00 p.m. Eastern time. That registration is available on our upcoming webinars and programs page where everyone normally registers for webinars on a quality payment program. So please, if you have a chance, register for that event and come and learn a little bit more about the virtual groups participation option. So with that, I want to thank everyone for joining us today. Thanks to all of our policy experts for being here today, and we'll talk to you again soon.

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