Welcome
Advisor Live: November 15, 2017

Our Presentation:

Reviewing the CY 2018 Medicare Physician Fee Schedule and Quality Payment Program Final Rules

Will Begin Shortly

Listen to Today's Audio: 888.221.6264

Download today's slides at www.premierinc.com/events

Advisor Live

CY2018 Medicare Physician Fee Schedule and Quality Payment Program Final Rules

November 15, 2017

Download today's slides at www.premierinc.com/events

@PremierHA
#AdvisorLive

Logistics

AUDIO

Dial in to our operator assisted call, **888.221.6264**

NOTES

Download today's slides from the event post at premierinc.com/events

QUESTIONS

Use the "Questions and Answers"

RECORDING

This webinar is being recorded.
View it later today on the event post at premierinc.com/events.

Faculty

Danielle Lloyd, M.P.H.
VP, policy and advocacy
Deputy director, D.C. office,
Premier, Inc.

Aisha Pittman, M.P.H.
Senior director, quality policy and analysis,
Premier, Inc.

Agenda

- Medicare Physician Fee Schedule (MPFS)
  - Appropriate Use for Diagnostic Imaging
  - PQRS/Value Modifier Updates
  - Medicare Shared Savings Program
- QPP: Merit-Based Incentive Payment System
  - Eligibility
  - Quality
  - Cost
  - Advancing Care Information
  - Improvement Activities
  - Scoring and Payment Adjustment
  - Extreme and Uncontrollable Circumstances Policy for the Transition Year Interim Final Rule with Comment Period
- QPP: Advanced Alternative Payment Model Participation Incentives
  - Advanced APMs
  - Qualifying and Partial Qualifying Participants
  - All-Payer and Medicare Payment/Patient Thresholds
  - Physician-focused Payment Models

Medicare Physician Fee Schedule (MPFS)

MPFS Final Rule

- Released Nov 2, to be published on Nov 15, *Federal Register*
- Conversion Factor $35.9996 (2017 CF $35.8887)
  - Update Factor is 0.50 percent
  - Budget Neutrality Adjustment is -0.10 percent
  - Misvalued Codes Target Recapture Amount is -0.09 percent
- Anesthesia CF is $22.1887 (2017 CF $ 22.0454)
- Specialty-specific impact on allowed charges
  - Greatest Positive Impact: Clinical social workers (+3 percent), clinical psychologists (+2)
  - Greatest Negative Impact: Diagnostic testing facilities (-4 percent), allergy/immunology (-3)
  - -2 percent: independent lab, nurse anesthetists, otolaryngology, physical/occupational therapy

MPFS Final Rule Overview

- Telehealth: Add 7 new codes, no longer require GT modifier
- Outpatient-provider based departments: Make payment to hospitals at a special Medicare Physician Fee Schedule (MPFS) rate for the non-excepted off-campus PBDs at 40% of OPPS rates for 2018, the PFS Relativity Adjuster
- RHC/FQHC Care Management: Create 2 new codes for RHC and FQHCs to bill for care management and psychiatric collaborative care model
- Biosimilars: Assign new biosimilars separate codes and pay separately

PFS: AUC for Diagnostic Imaging: CY 2018 Updates

- Consultation with AUC beginning January 1, 2020; voluntary reporting July 2018 to December 2019
  - Initial operations testing period for the initial year (2020), CMS will continue to pay claims whether or not information is appropriate
  - Ordering professional must consult with AUC through qualified CDSM
  - Furnishing professional must report the following on claims:
    - CDSM consulted by ordering professional
    - If/not service adheres to AUC or if AUC exist for the service
    - NPI of ordering professional
- Applies to facility and professional claims under PFS, hospital outpatient and ASC; does not apply to Part B imaging during an inpatient stay
- CMS does not finalize codes to implement reporting requirements
  - Commenters noted combination HCPCS modifiers and G-codes were too complex
  - During voluntary period will have one HCPCS modifier
  - CMS to explore use of unique consultation identifier instead of G codes
- QPP rule includes AUC consultation as an improvement activity; seek comment on development of quality measure

PQRS/Value Modifier Updates

- PQRS: CY 2018 payment/ 2016 performance
  - Reduce required measures from 9 measures/3 NQF domains to 6 measures in any domain
  - Eliminate outcome or high priority measure requirement
  - Eliminate cross-cutting measure requirement
  - Eliminate CAHPS requirement for groups of 100 or more
- Physician Compare: Do not report VM cost and quality tiers, will make de-identified information available
- Value Modifier: CY 2018 payment/ 2016 performance
  - If a successful PQRS reporter, held harmless from VM downward adjustment
  - Reduce automatic downward adjustment for non reporters
    - Groups with 10+: From -4% to -2%
    - Solo and groups up to 9: From -2% to -1%
  - Reduce the maximum upward adjustment
    - Groups with 10+: From 4.0x to 2.0x
    - Solo and groups up to 9: From 2.0x to 1.0x

PFS: Medicare Shared Savings Program

- Reducing Application Burden
  - SNF 3-day waiver: remove narrative description describing financial relationships, remove requirement to demonstrate affiliated SNFs have 3-star rating
  - Remove several aspects from the initial application and note that ACOs must furnish upon CMS request
- Compliance with ACO Participant TIN Exclusivity
  - If CMS finds that during a benchmark or performance year, an ACO participant bills for services used in assignment under more than once ACO, CMS will not consider any services billed through that TIN during the relevant performance year when assigning beneficiaries for the applicable benchmark or performance year
  - Provider remains on participant lists but ACOs must reconcile overlap prior to recertification of ACO participant list for subsequent years
- Beneficiary Identifiable Payment Made under a Demonstration, Pilot or Time-Limited Program
  - Benchmarks for agreements prior to 2018: all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot, or time limited program are included
  - Benchmarks for agreements 2018 and beyond/ 2018 performance year for agreement periods beginning 2015-2018: only final individually beneficiary identifiable payments made under a demonstration, pilot or time limited program will be included

PFS: Medicare Shared Savings Program

- Beneficiary Assignment Changes
  - RHC/FQHC assignment
    - Eliminate attestation by physicians who provide direct patient primary care in the ACO participant FQHC or RHC
    - Treat services reported on FQHC or RHC claims as primary care services in the beneficiary assignment methodology for ACOs
  - Primary care services definition
    - Add 3 chronic care management services: 99487, 99489 and G0506
    - Add 4 behavioral health integration services: G0502, G0503, G0504 and G0507
- Quality Measures
  - Allow CMS to redesignate measures as pay for reporting when substantive changes are made to the QPP quality meausres
  - Validation Process
    - Change audit threshold from 90% match rate to 80% match rate
    - Quality score adjustment if match rate is not reached: 1 percent for each percentage point away from match rate

PFS: Patient Relationship Codes

- Required by MACRA, CMS sought comments through two RFIs
- Require reporting through modifiers beginning January 1, 2018
  - Modifier will not be a condition of payment during an initial voluntary period
  - Length of voluntary period not specified

Number	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/Broad Services
2x	X2	Continuous/Focused Services
3x	X3	Episodic/Broad Services
4x	X4	Episodic/Focused Services
5x	X5	Only as Ordered by Another Clinician

Quality Payment Program (QPP)

CY 2018 QPP Proposed Rule

- Released November 2, to be published November 16, *Federal Register*
- Proposed changes to Merit-Based Incentive Program (MIPS)
  - Increase the low-volume threshold to $90,000 or less in Part B charges or providing care for 200 or fewer Part-B beneficiaries
  - Establish a virtual groups option where solo practitioners and groups of 10 or fewer eligible clinicians come together to "virtually" participate in MIPS for a performance period
  - Allow an option for facility-based clinicians to be scored based on the facilities performance in the Hospital Value Based Purchasing Program
  - Reward improvement in performance on the cost and quality categories;
  - Weight cost at 10%, quality at 50%
  - Set the performance threshold at 15 points and maintain the exceptional performance threshold at 70 points.
  - Set the payment adjustment at +/-5% x scaling factor, as required by law
- Proposed Changes to Advanced APM Bonus
  - Extends the 8 percent revenue-based nominal risk standard through 2020
  - Reduce the nominal risk amount for Medical Home models to 2.5%
  - Set requirements for the All-Payer QP determination and mechanisms for payers, clinicians and states to submit information for the determination
  - Calculates the All-Payer QP determination at the APM entity or individual clinician level
- Extreme and Uncontrollable Circumstances Interim Final Rule with Comment
- Comments due January 1, 2018

How To Submit a Comment

CMS QPP final rule and interim final rule with comment period

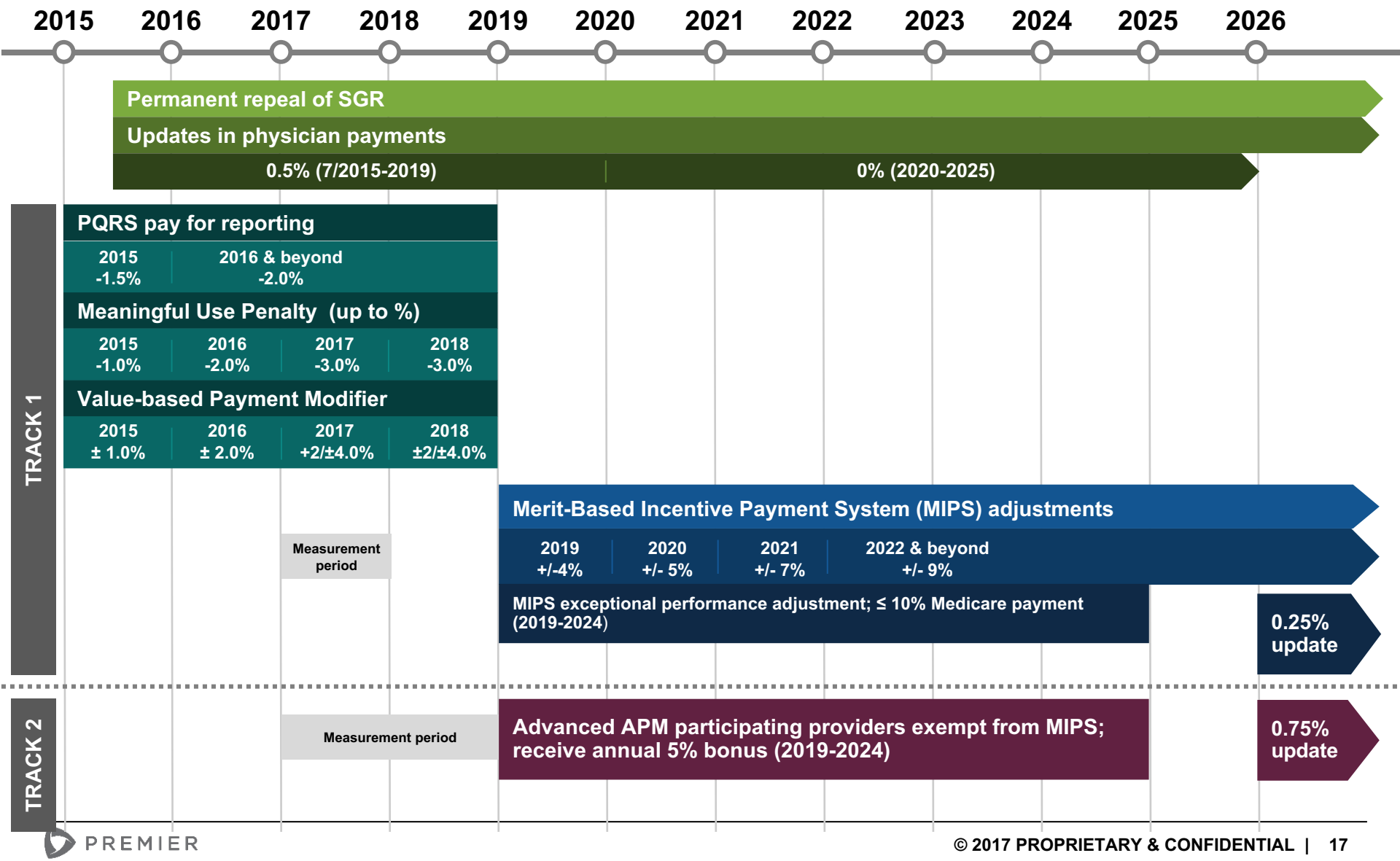
– Comments due 60 days from the date of display (January 1, 2018)

1. Go to proposed rule
2. Click “Submit a Formal Comment”, the green button on the right-hand side of the page below the title.

OR

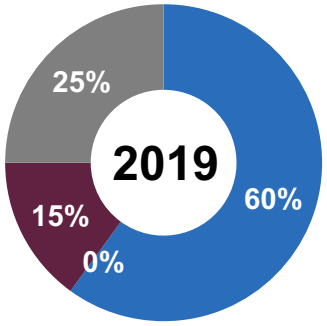
1. Go to http://www.regulations.gov
2. Type “CMS-5522-FC or CMS-5522-IFC” into the search box
3. Find “Medicare Program; CY 2018 Updates to the Quality Payment Program” (should be first selection)
4. Click on “Comment Now”, the blue button to the right of the title.

MACRA Reform Timeline
(Medicare Access and CHIP Reauthorization Act of 2015)

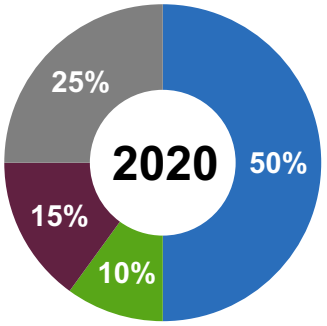


Merit-Based Incentive Payment System (MIPS)

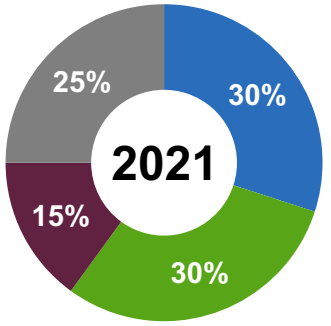
MIPS Overview



Any continuous 90-days in CY 2017 is performance period for CY 2019

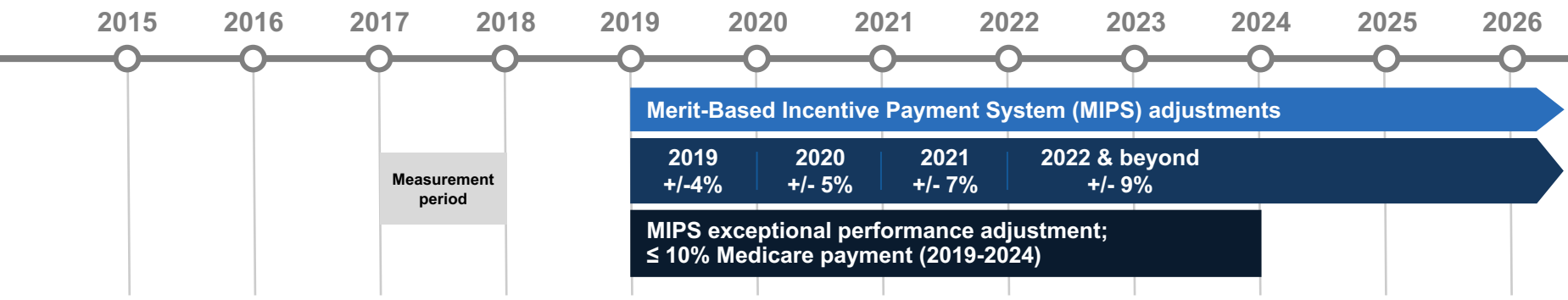


CY 2018 is performance period for CY 2020. Quality/Cost- Full year; ACI/Improvement- any 90 days



- **Quality** — Quality Measures, Readmissions
- **Cost** — MSPB, Total Per Capita Cost, ~~Episode-based spending measures~~
- **Advancing care information** — Modified Meaningful Use Objectives & Measures
- **Improvement activities** — Expanded access, population management, care coordination, beneficiary engagement, patient safety, social and community involvement, health equity, emergency preparedness, behavioral and mental health integration and Alternative payment models.

- **Sets performance targets in advance, when feasible**
- **Sets performance threshold at 3 in 2019; 15 in 2020 and median or mean in later years.**
- **Improvement scores for cost and quality in 2020 and beyond**



MIPS: 2020 Payment Year / 2018 Performance Year Proposed

Advancing care information: 100 points

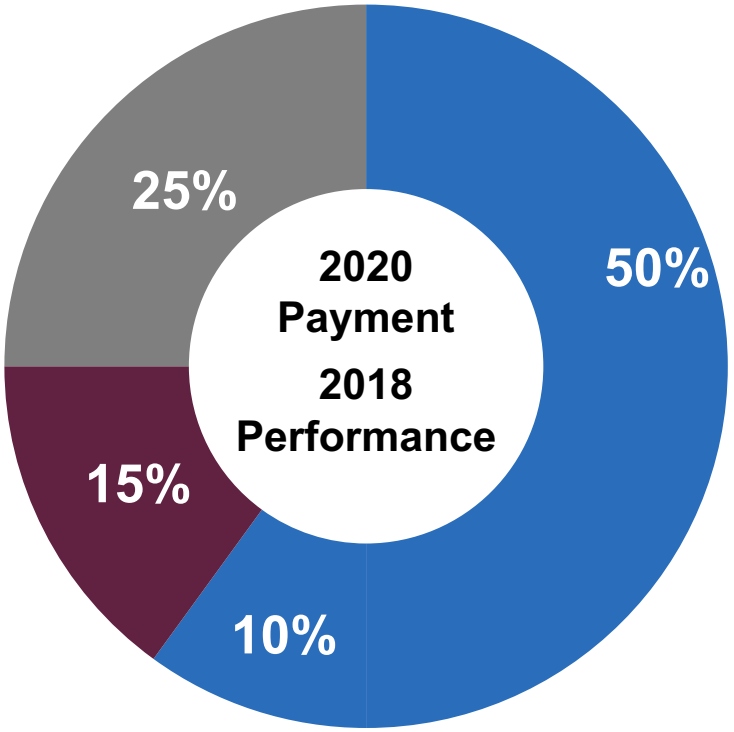
Base Score
- Security Risk Analysis
- eRx
- Provide patient access
- Send summary of care
- Receive summary of care

Performance Score
Bonus Points

Improvement activities: 40 points

High Weight: 20 points
Medium Weigh: 10 points

PCMH: 40 points
APM Participation:
At least 20 points



Quality: 60 points*

6 measures (one outcome)
Readmissions (groups of 16+ only)
Improvement points possible

Bonus points:
- Outcome, appropriate use, patient safety, patient experience, care coordination measures
- Report measures using end-to-end reporting

Final Score Bonus Points
- Small Group Practice (5pt)
- Complex Patients (1-5pts)

Cost:
Not Assessed- Feedback Reports Only

MSPB, Total Per Capita Cost, ~~Episode Payment~~

*Total points possible vary by provider type and available measures

MIPS: Eligible Clinicians

Years 1 and 2

- Physician,
- Physician Assistants,
- Nurse Practitioners,
- Certified-Nurse Specialists,
- Certified Registered Nurse Anesthetists

- Exclusions
  - New Medicare-enrolled eligible clinicians
    - » Enrolled during the performance year
    - » Not previously part of a group or billing under a different TIN
    - » Eligibility determined quarterly
  - Clinicians below the low-volume threshold
    - » $90,000 or less in charges **OR**
    - » Provides care to 200 beneficiaries or fewer
    - » **Seeking comment on best approach to implementing opt-in beginning in 2019, want to mitigate opt-in by high performers only**
  - Qualifying/ Partial Qualifying Advanced APM Participants

Years 3+ (potential)

- Physical or occupational therapist,
- Speech-language pathologists,
- Audiologists,
- Nurse midwives,
- Clinical social workers,
- Clinical psychologists,
- Dieticians,
- Nutritional professionals

- ASC/HHA/Hospice/HOPD: MIPS adjustment does not apply to facility payment
- CAHs: MIPS adjustment applies but not to facility payment
- RHC/FQHC: MIPS adjustment does not apply

CY 2018: Estimated # Ineligible/Excluded Clinicians

Exclusion	# Excluded	# Remaining	$ Excluded (M)	$ Remaining (M)
All Medicare Clinicians		1,548,022		$124,029
Subset of Eligible Clinicians	233,289	1,314,733	$22,296	$101,733
Newly Enrolled	81,954	1,232,779	$490	$101,243
Low-Volume	540,347	692,432	$12,996	$88,247
Qualifying APM Participants	70,732	621,700	$6,326	$81,921
Total Remaining		**621,700 (40%)**		**$81,921 (66%)**

MIPS: Eligibility Changes

- Clarifications
  - Part B Services
    - Part B items and services furnished by MIPS ECs; eligibility determination and bonus
    - Does not include Part B drugs or DME that cannot be attributed to an individual NPI
  - Group Reporting- Split TINs
    - Optional for groups where a portion of the TIN is participating in a MIPS APM or Advanced APM
- Small groups– 15 or fewer ECs
  - Determine practice size using a claims determination period
  - 12-month period: September 1, 2016- August 31, 2017
- Rural/Health Professional Shortage Area ECs/Groups
  - 75% of billing under the EC or group must located in a zip code designated as rural or HPSA; previously just if TIN zip is in a designated region
- Non-Patient Facing MIPS ECs
  - Individuals: 100 or fewer patient-facing encounters
  - Groups/Virtual Groups: More than 75% of NPIs in TIN meet the individual threshold
  - Determination made in two-segment analysis

Virtual Groups

- Two or more TINs composed of a solo EC or a group with 10 or fewer ECs that elect to form a virtual group for a performance period
  - All MIPS eligible clinicians within a TIN must participate in the virtual group.
  - The virtual groups MIPS score would apply to all MIPS ECs in the virtual group
  - Adjustment does not apply to clinicians who are not ECs
- CMS is not placing restrictions on virtual groups but will monitor how they are used
- Policies for groups also apply to virtual groups
- Election process
  - Stage 1- Eligibility (voluntary)
    - CMS determines eligibility over 5 month period: July 1- Nov 30 of prior year
    - Analysis will be done on rolling basis, TINs request eligibility determination beginning September of prior year
    - Election cannot be changed during the performance period
  - Stage 2- Elect by December 31 of prior year
- Virtual Group Agreements
  - Must have a written agreement between parties in the virtual group; CMS has posted a model agreement on QPP website
  - Cannot be with other entities
  - Must cover obligations for reporting and how the group will encourage adherence to quality and improvement

MIPS: Reporting Mechanisms

Reporting Mechanism	Quality+	Cost	ACI	IA+	Submission Deadline
Claims	✓ Individual only				60-day claims lag
Administrative Claims (no submission required)	✓ Readmissions only	✓			
Attestation			✓	✓	March 31 of year following performance period close
QCDR	✓+		✓	✓	
Qualified Registry	✓		✓	✓	
EHR	✓+		✓	✓	
CMS Web Interface	✓ Option for groups 25+		Option for groups 25+	Option for groups 25+	8 weeks following performance period close
Survey Vendor	Groups choosing to report CAHPS for MIPS				

Allow multiple reporting mechanisms in each category beginning with 2019 performance period

+ Bonus points possible

MIPS: Quality Data Submission Requirements

Measure Type	Submission Mechanism	Reporting Period	Submission Criteria	Data Completeness
Individual	Part B Claims	2017: 90 days or more 2018 and beyond: one year	6 measures at least 1 outcome ▪ If an outcome measure is not available, report another high priority measure. ▪ If fewer than six measures apply, then report on each measure that is applicable. Measures selected from all MIPS Measures or a specialty-specific measure set	60% of Medicare Part B patients seen during the performance period to which measure applies
Individual or Groups	QCDR Qualified Registry EHR	2017: 90 days or more 2018 and beyond: one year	6 measures at least 1 outcome ▪ If an outcome measure is not available, report another high priority measure. ▪ If fewer than six measures apply, then report on each measure that is applicable. ▪ At least one measure must include at least one Medicare patient Measures selected from all MIPS Measures or a specialty-specific measure set.*	60% of MIPS eligible clinician's or groups patients that meet denominator criteria (all-payer)
Groups	CMS Web Interface	One year	All measures included in the CMS Web Interface and ▪ First 248 consecutively ranked and assigned Medicare beneficiaries ▪ If less than 248, then the group would report on 100 percent of assigned beneficiaries.	Sampling requirements for their Medicare Part B patients
Groups	CAHPS for MIPS Survey	One year	▪ The survey would fulfill the requirement for one measure or a high priority measure if an outcome measure is not available ▪ Survey will only count for one measure; must use another reporting mechanism to reach 6 measures ▪ An 8-7 week period ending no later than February 28	Sampling requirements for their Medicare Part B patients

* Can report QCDR custom measures

MIPS: Quality Performance Category: 50%

Measure Scoring

- No successful reporting requirements, each measure submitted is awarded points
- Topped out measure
  - Year 1 and 2: Identified as Topped Out
  - Year 3: Possible points capped at 7
  - After 4 years of being topped out, CMS will consider removing the measure through rulemaking
  - Does not apply to WI measures
- Improvement Score
  - Improvement Score/Prior Year Achievement Score*10
  - Must have fully participated in prior year (at least 30% achievement score in prior year)
- Continuation of Transition Year Policies
  - Class 1 measure: 3-10 points
    - » Has a benchmark
    - » At least 20 cases
    - » Meet data completeness standard
  - Class 2 measure: 3 points
    - » Does not have a benchmark
    - » Does not have at least 20 cases
  - Class 3 measure: 1 point
    - » Measures that do not meet data completeness
    - » Small practices receive 3 points

Bonus Points

- High Priority Measures (up to 10% of total possible score)
- End to End Reporting (up to 10% of total possible score)

MIPS: Cost Performance Category: 10%

- 2017 (2019 payment)- 0% Feedback Reports Provided
- 2018 (2020 payment) 10%
- 2019 (2021 payment) and later- 30%

Measure	Description
Medicare Spending per Beneficiary	▪ Attribution: TIN providing plurality of Medicare Part B claims ▪ Evaluate observed to expected costs at the episode level ▪ Measure is average of assigned ratios ▪ 35 minimum cases
Total per Capita Cost	▪ Attribution: Two-step process: ▪ TIN of PCP providing plurality of primary care services ▪ TIN of Non-PCP providing plurality of primary care services ▪ Added two codes in attribution for complex care management ▪ 20 minimum cases

MIPS: Improvement Activity Performance Category (15%)

- 40 points total
  - High-weighted activities (14) = 20 points
  - Medium-weighted activities (79) = 10 points
- Small practice, rural, HPSA or non-patient facing: 1 high-weighted or 2 medium-weighted activities receive full credit
- At least 90 consecutive days for each activity
- CMS Improvement Activities and Measurement Study
  - Participants receive 40 points in recognition of burden associated with study
- QCDRs
  - Can help meet activity criteria for multiple CPIAs
  - Must select and achieve each activity
- PCMH Recognition- Full credit (40 points)
  - At least 50% of practice sites within TIN must have certification or recognition
- APM Participation- At least half credit (20 points)

MIPS: Advancing Care Information Performance Category (25%)

- Use 2014 or 2015 CEHRT, 10 bonus points for 2015 CEHRT
- Base Score (50%)
  - Report (a 'yes' or a one) on all five required measures
  - Failure to report on required measures will result in a score of 0 for the entire performance category
  - Protecting Patient Health Information is a Must Pass Element
- Performance Score (up to 90% points)
  - First Public Health and Clinical Data Registry Reporting (10%)
- Bonus Points (up to 15% for 2014 CEHRT, 25% for 2015 CEHRT)
  - Optional 2nd Public Health and Clinical Data Registry Reporting (5%)
  - Improvement activities that are enhanced by CEHRT (10%)
- Total score is 100 points, 165 points are possible
- Reweighting ACI to 0% for certain clinicians
  - Hospital-based clinicians, ASC-based clinicians
  - Harrdship Exemption, including decertification of CEHRT and small practice, practices in HPSA
  - NP, PA, CNS, CRNA- submit application by December 31 of the performance year

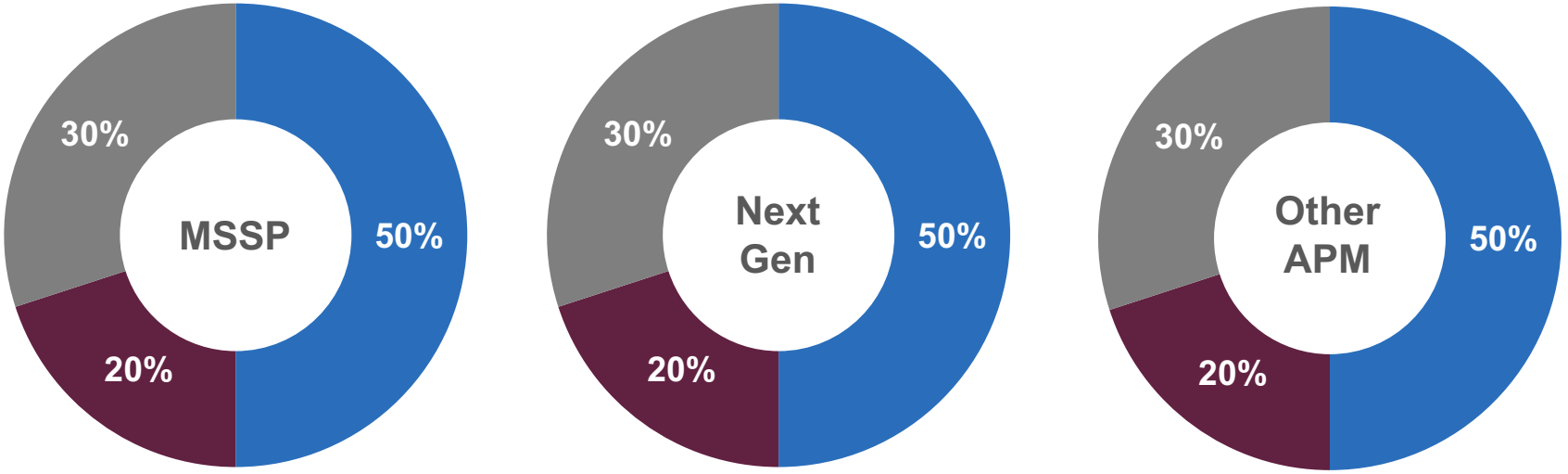
MIPS: Facility-Based Measurement

- Voluntary option to use HVBP scores for hospital in lieu of submitting cost and quality measures
  - Available to facility-based clinicians: more than 75% of care billed with POS codes 21 (inpatient hospital), 23 (ED)
  - Groups: 75% meet hospital-based definition
- Scores derived from facility where clinician treats highest number of Medicare beneficiaries
- Available for 2019 performance period
  - Additional time to look refine approach and consider eligibility (e.g. other POS codes)
  - Sought comment on opt-in or opt-out mechanisms for this option but not finalizing at this time
  - Proposed to use HVBP Total Performance Score methodology, not finalizing at this time
  - Improvement points and bonus points not awarded, finalized

MIPS: Other Scoring Changes

- Improvement Points
  - Quality: Improvement measured at category level, up to 10 percentage points
  - Cost: Statistically significant changes at the measure level
- Complex Patient Bonus
  - 1-5 points based on formula: (Average HCC Score + Dual Eligible Ratio) *5
  - Points assigned based on quartiles
- Small Practice Bonus
  - 5 points added to the final score

MIPS: APM Scoring Standard



Participant List Snapshot Dates: March 31, June 30, August 31, December 31 (full TIN only)

Quality — Measures reported by APM

MSSP/Next Gen: Web Interface measures: 14 measures, + CAHPS for ACO; 2017: 11 measures

ERRD/OCM/CPC+: Measures used in the APM model that are tied to payment, available for scoring, have a benchmark

Cost — Not assessed

Advancing care information — Average of individual clinicians submitting as individuals or groups

MSSP: Weighted average of score for TINs

Improvement activities — Automatically receive half of the points

Models awarded full points: Shared Savings, Next Gen, Comprehensive ESRD Care (all arrangements), Oncology Care Model (all arrangements), CPC+

MIPS: Final Score

- 2020 (2018 performance): +/-5% x 3x scaling factor

2017 Final Score	2018 Final Score	Payment Adjustment
>70 points	>70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4- 69 points	16- 69 points	• Positive payment adjustment
3 points	15 points	• Neutral payment adjustment
0 points	0 points	• Negative payment adjustment • -4% in 2017 • -5% in 2018

Public Reporting on Physician Compare

- Additions: Final Score and category performance for each MIPS EC
- Quality: All measures
- Cost: Statistical and user testing to determine which measures, all available in downloadable database
- Improvement Actives: Indicator for meeting category; additional testing for how and where to report specific activities
- Advancing Care Information: Indicator for meeting performance category; Additional indicators for certain objectives/measures
- Benchmarks:
    - Achievable Benchmark of Care is the average performance of top (10%) of performers
    - Used as benchmark on Physician Compare and to determine 5-Star rating for each measure

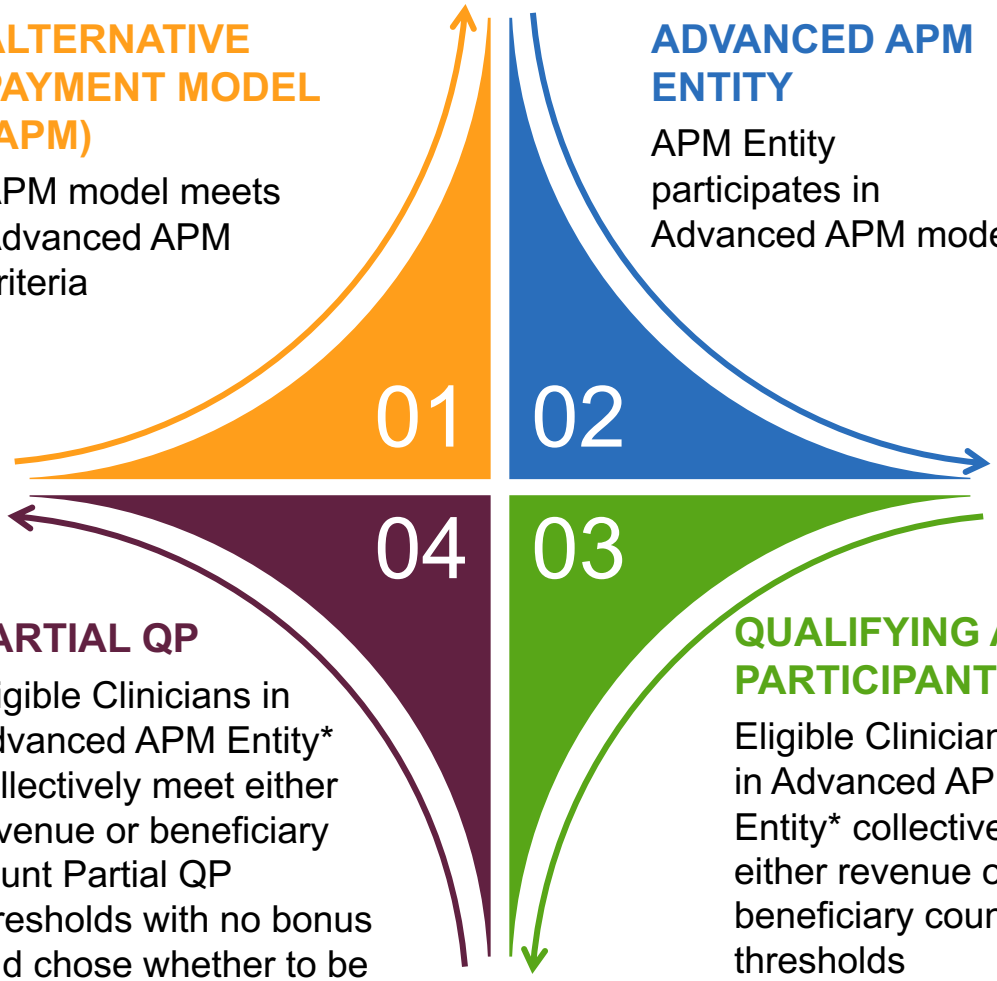
Interim Final Rule: Extreme and Uncontrollable Circumstances

- Extreme and uncontrollable policy for quality/cost/IA in effect for 2018 performance period
  - Policy for 2017 performance period only applies to ACI, with Dec 31, 2017 application deadline
- Automatic extreme and uncontrollable policy for 2017 performance period and beyond for triggering events
  - ECs not required to apply
  - Policy does not apply to groups
  - CMS will have discretion of determining triggering events: Hurricanes Harvey, Irma and Maria are considered triggering events
  - PECOS will be used to identify MIPS in areas with a triggering event
  - If a clinician submits data they will be scored

Advance Alternative Payment Model (APM) Incentive

Advanced APM

FIGURE B: Program Overview

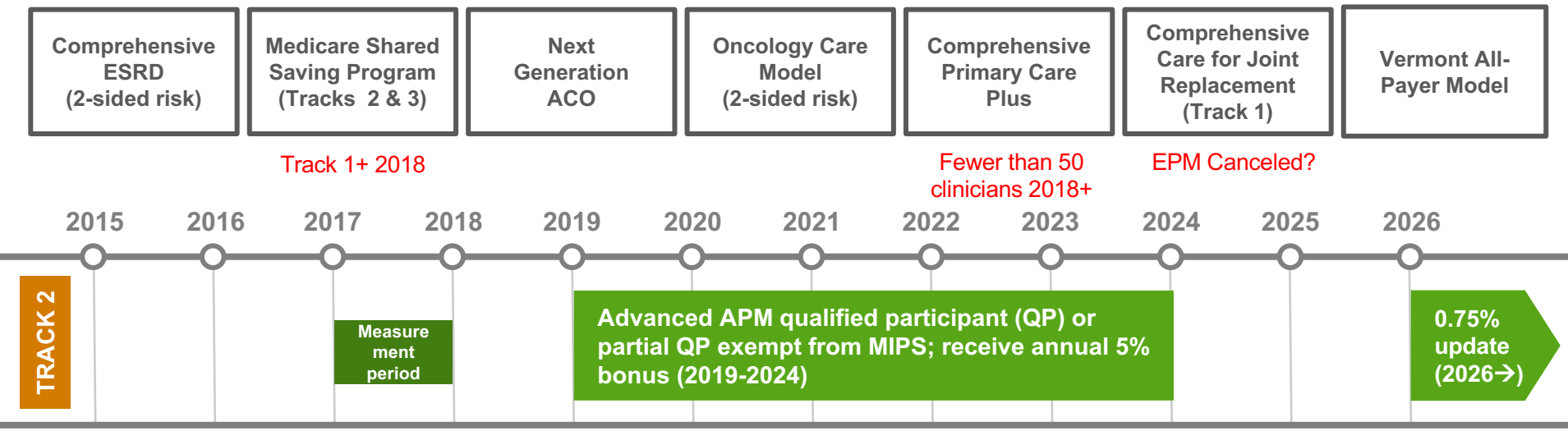


Qualifying APM Participants (QPs) are excluded from MIPS and get a lump sum incentive payment equal to 5% of the prior year's Part B covered professional services from 2019 – 2024. In 2026 and beyond, QPs get a 0.75% update vs. 0.25%.

*Individual level if CJR, an EP fails under multiple AAPMs, or choice of individual or entity if using Other Payer Combination

Track 2: 5% Bonus for Advanced APMs

Advanced Alternative Payment Models (APM) as proposed:



Advanced APM Entities Must:

1. Uses certified EHR technology,
2. Pays based on MIPS comparable quality measures, *and*
3. Bears more than "nominal" financial risk for losses.

Inclusion in Advanced APMs triggers exclusion from MIPS.

Threshold of payments in an Advanced APM to reach QP status

2019-20	*Medicare only*	25%	*Or, 20% beneficiary count*
2021-22	*Medicare* and all-payer*	50%	*Or, 35%*
2023 +	*Medicare* and all-payer*	75%	*Or, 50%*

- Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

* Minimum of 25% of Medicare payments must be in APM in all years, unless partial qualifying at with no 5% bonus and a choice of MIPS

Terms and Definitions

- Replace the term “QP Performance Period” with two terms, as contextually appropriate, in QPP definitions and regulations. Use “All-Payer QP Performance Period” only under the All-Payer Combination Option, and use “Medicare QP Performance Period” under both the Medicare and All-Payer Combination Options. This change supports the proposed revised All-Payer QP performance period timeframe (Section II.D.6.d.(2)(a)). **REMOVED**
- Remove the term “Advanced APM Entity” and replace it throughout the regulations with “APM Entity” as well as in the definitions of “Affiliated Practitioner” and “Attributed Beneficiary”. Remove the term “Advanced APM Entity group” and replace it with “APM Entity group”. **FINAL**

Terms and Definitions (continued)

- Apply the definition of “Attributed Beneficiary” only to Advanced, not Other Payer Advanced APMs.
- Clarify in the definition of APM Entity that a non-Medicare payment arrangement is an Other Payer arrangement.
- Clarify that a “Medicaid APM” must meet all Other Payer Advanced APM criteria.
- Revise monitoring and program integrity provisions (§414.1460) to separate rescinding QP determinations from recouping APM incentive payments, and to consolidate APM incentive payment reduction and denial policies.
- **ALL FINAL**

Advanced APMs Step 1: does the model qualify?

1. Model requires at least 50% of eligible clinicians to use Certified EHR Technology (**CEHRT**)
2. Model pays, at least in part, based on 1 MIPS comparable quality measure (if not an outcome measure, need another one) that are evidence-based, reliable and valid
3. There is more than a nominal amount of **risk** for monetary losses (withhold, reduce or clawback payments):
   - **Total Risk** (maximum exposure) must be at least the lower of:
     - » 3% of APM spending benchmark or target, or
     - » **8% of average estimated total Medicare A/B revenue of entity extended to 2019 and 2020**
   - Or, is a full capitation risk arrangement
   - **Or, for 2018+ is a Medical home model that has fewer than 50 clinicians at the parent level unless in the 2017 cohort or is certified and "expanded" by Innovation Center**

Medical Home Model: risk level

Financial standard same as other advanced APMs except 4th bullet:

1. Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;
2. Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians;
3. Require direct payment by the APM Entity to the payer, or
4. Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.
   - The Entity must potentially owe or forego at least the following percent of their total Medicare Parts A/B revenue:
     - » 2.5% in 2017,
     - » ~~3%~~ in 2018, **~~2% proposed,~~ 2.5% final**
     - » ~~4%~~ in 2019, **3% proposed and final**
     - » ~~5%~~ in 2020, **4% proposed and final**
     - » **5% 2021 and later proposed and final.**

Medicare Advanced APM Step 3 & 4: Can you meet thresholds to be Partial or Qualifying APM Participant?

- QP status will be determined based on either a percent of Part B professional revenue or patients, whichever is advantageous, in Advanced APM to demonstrate commitment.
- Calculations for Medicare are at the aggregate level using data for all eligible clinicians participating in an Advanced APM Entity.
  - Hospital-led APM where clinicians not on Participation list able to use an Affiliates list (e.g. CJR) and assess at NPI level
  - Clinicians participating in more than one APM that fails will have payments and patient counts combined across APMs for NPI
  - Entities in more than one program will not be able to combine payments, but will be able to combine patient counts
- If miss QP thresholds, there is a separate set of slightly lower Partial QP thresholds where the Entity can opt-in to MIPS

QP Payment Amount and Patient Thresholds—Medicare Option

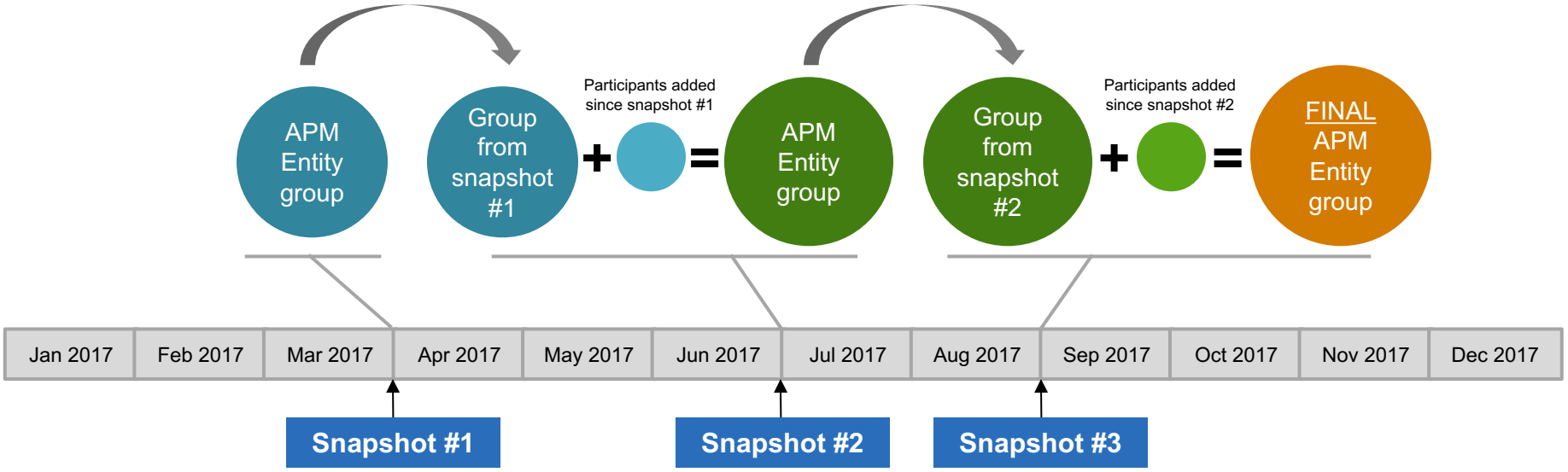
Medicare Option – Payment Amount Method						
Payment Year	2019	2020	2021	2022	2023	2024 and later
QP Payment Amount Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Amount Threshold	20%	20%	40%	40%	50%	50%

Medicare Option – Patient Count Method						
Payment Year	2019	2020	2021	2022	2023	2024 and later
QP Patient Count Threshold	20%	20%	35%	35%	50%	50%
Partial QP Patient Count Threshold	10%	10%	25%	25%	35%	35%

QP and Partial QP Determination Timeframe

- Three snap shots: March 31, June 30 and August 31
- Will assess claims for 3, 6 or 8 months
- Will use 3 month run out, so determination 4 months post
- Only need to be in and pass in one snap shot
- Use data only from dates during which an entity could participate in the Advanced APM, unless individual clinician in multiple APMs
- If Entity terminates mid-year, clinicians lose QP status unless in 3 or more AAPMs

FIGURE F: Determining the APM Entity Group Through Participation List Snapshots



QP and Partial QP Calculation: All- Payer Combination

- Allows private payer arrangements to supplement the Medicare calculation in 2021
  - Medicare Option will be calculated first then the All-Payer Combination Option if needed
- "Other Payer" includes Medicare Advantage and Medicaid
  - **CMS may establish a demonstration to allow MA to count earlier than 2019 and incent clinicians in Advanced APM like-structures within MA**
- Excludes DoD/VA payments; also excludes Medicaid if no Medicaid APMs or Medicaid Medical Homes are available
  - **CMS will assess whether a clinician has an applicable and available Medicaid Medical Home or Medicaid APM by county and specialty**

Other Payer Advanced APM

- Payment arrangements with non-Medicare FFS payer (Other Payer APM) can become an Other Payer Advanced APM if the arrangement meets three criteria:
  - Requires Certified Electronic Health Record technology (CEHRT) for at least 50% of eligible clinicians in APM Entity;
  - Includes at least 1 outcomes-based quality measure from MIPS list **or attest to the lack of relevant outcome measure**; and
  - The APM Entity either:
    - » bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or
    - » for beneficiaries under title XIX, is in a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act (none currently available)

Other Payer Advanced APM: risk standard

- Other Payer Advanced APM must, if actual aggregate expenditures exceed expected aggregate expenditures in a specified performance period:
  - Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;
  - Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or
  - Require direct payment by the APM Entity to the payer.
- The risk arrangement must have:
  - A marginal risk rate of at least 30%,
  - Maximum allowable minimum loss rate of 4%,
  - Total potential risk of at least 3% of expected expenditures, or
  - Capitation, or
  - **8% or more of the participating entities' total combined revenues as long as the agreement explicitly defines the risk in terms of revenue**
- **Does not finalize any standards specific to small/rural practices**

Other Payer Medical Homes

- CMS did not finalize an Other Payer Medical Home Model
- However, it maintains a Medicaid Medical Home Model and further graduates the nominal amount standard to require that the total amount the entity owes or foregoes exceed:
  - For QP Performance Period 2019, 3% of the average estimated total revenue of the participating providers or other entities under the payer.
  - For QP Performance Period 2020, 4% of the average estimated total revenue of the participating providers or other entities under the payer.
  - For QP Performance Period 2021, 5% of the average estimated total revenue of the participating providers or other entities under the payer.

QP Payment Amount and Patient Thresholds (All-Payer Combination Option)

All-Payer Combination Option – Payment Amount Method										
Payment Year	2019	2020	2021		2022		2023		**2024 and later**	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	**25%**
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	**20%**
			Total	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**

All-Payer Combination Option – Patient Count Method										
Payment Year	2019	2020	2021		2022		2023		**2024 and later**	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	**20%**
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	**10%**
			Total	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**

Other Payer AAPM Determination Process: EC Initiated

- Entity or Eligible Clinician submits for each payment arrangement:
  - Arrangement name;
  - Brief description of the nature of the arrangement;
  - QP Performance Period for which arrangement is available;
  - Locations (nationwide, state, or country) where will be available;
  - Evidence that the CEHRT criterion is satisfied;
  - Evidence that the quality measure criterion is satisfied;
  - Evidence that the financial risk criterion is satisfied; and
  - Other documentation as many be necessary for CMS to determine whether the other arrangement is an Other Payer Advanced APM.
- Prove CEHRT through EC (not entity) level documentation
- Form must go through Paperwork Reduction Act process

Other Payer AAPM Determination: Payer Initiated

- Voluntary process; same required fields as EC initiated
- Medicaid (FFS or plans), Medicare plans, and CMS Multi-Payer Model payers may request determinations in 2018 for 2019 Performance Period for the duration of one year
  - Payers may request concurrent determination for parallel commercial arrangements on a single form except for Medicare Health Plans or unless the model differs
- Multi-Payer Models
  - Advanced APM that includes at least one other payer arrangement designed to align with that of the parent CMS APM (e.g., CPC+ model, Oncology Care Model two-sided risk track); aligned payer can start payer-initiated process
  - State specifying uniform payment arrangements across state-based payers; state serves as payer to initiate (e.g. Vermont)
  - If Medicaid is an aligned payer must follow Medicaid process

Other Payer AAPM Determination

- Remaining payers (e.g., commercial), may request determinations for their payment arrangements in 2019 for 2020 All-Payer Performance Period.
- Guidance and Payer Initiated Submission Form available prior to first submission but after PRA process.
- Submitters can mark portions of the request confidential to exempt it from Freedom of Information Act disclosures.
- CMS will post publicly only payer name, location, and name of approved Other Payer Advanced APM on CMS Website.
- **REQUEST FOR COMMENTS:** on creating a multi-year approval and what should be submitted annually as an update for the Payer and Eligible Clinician Initiated Process

Other Payer AAPM Determination Timelines

Payer Type	Payer Initiated	Date	Eligible Clinician (EC) Initiated	Date
Medicaid Title IX	Guidance sent to STATES Submission Opens STATES	Jan 2018		Sept 2018
	Submission Closes STATES	April 2018		Nov 2018
	CMS Notifies STATES CMS Posts OP AAPM List	Sept 2018	CMS Notifies STATES & ECs CMS Post OP AAPM List	Dec 2018
CMS Multi-Payer Model (MPM)	Guidance available to PAYERS Submission Opens PAYERS	Jan 2018	Guidance available to ECs Submission Opens ECs	Aug 2019
	Submission Closes PAYERS	June 2018	Submission Closes ECs	Dec 2019
	CMS Notifies PAYERS CMS Posts OP AAPM List	Sept 2018	CMS Notifies ECs CMS Post OP AAPM List	Dec 2019
Medicare Health Plans (MHP)	Guidance sent to MHP Submission Opens MHP	April 2018	Guidance available to ECs Submission Opens ECs	Aug 2019
	Submission Closes MHP	June 2018	Submission Closes ECs	Dec 2019
	CMS Notifies MHP CMS Post OP AAPM List	Sept 2018	CMS Notifies ECs CMS Post OP AAPM List	Dec 2019
Remaining Other Payers			Guidance available to ECs Submission Opens ECs	Aug 2019
			Submission Closes ECs	Dec 2019
			CMS Notifies ECs CMS Post OP AAPM List	Dec 2019
September 2019	Latest time when EC can request Other Payer Advanced APM determinations and receive results notification prior to close of data submission period for QP determinations Submission period opens for QP determinations (for ECs and APM Entities)			
December 2019	Submission period closes for EC requests for Other Payer Advanced APM determinations; ECs will not receive results notification prior to close of data submission period for QP determinations Submission period closes QP determinations (for ECs and APM Entities)			

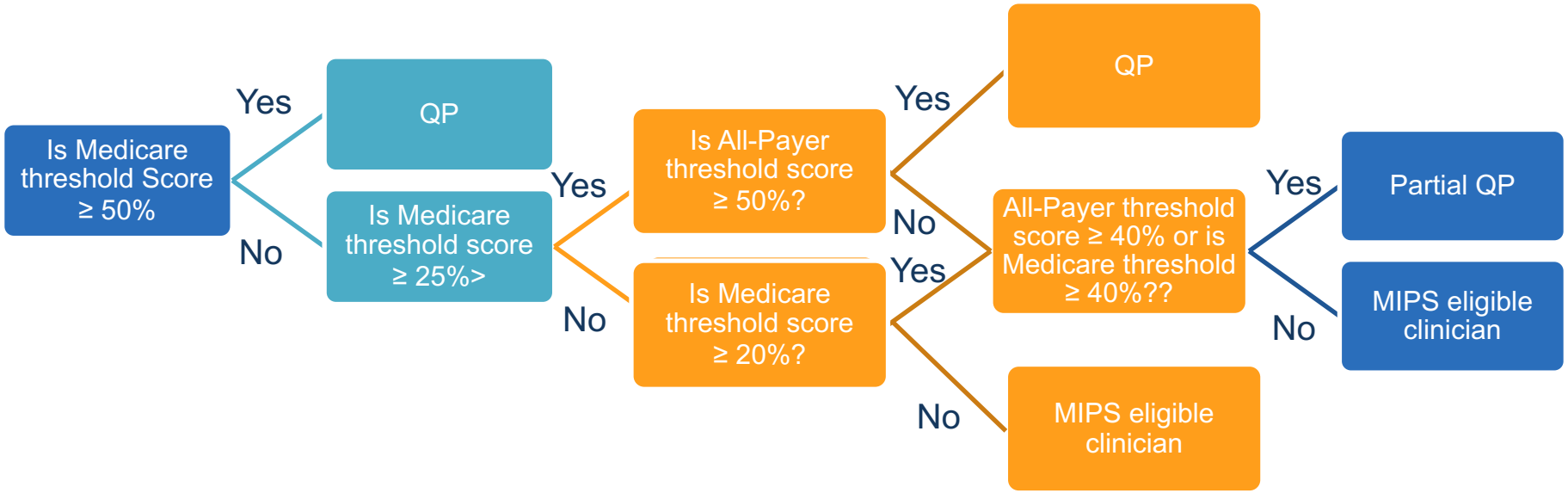
Submission of Information for Other Payer Advanced APM Determination and Threshold Score Calculation

- Must request QP determination for Other-Payer Advanced APMs by December 1 or relevant performance year on separate forms
- CMS recommends Entities/ECs apply for model approval, if payer has not, earlier enough to get the results in advance of this submission to prevent compiling the information needlessly
- Entities and/or eligible clinicians must submit certain information for CMS to assess whether other payer arrangements meet not only the Other Payer Advanced APM criteria, but also to calculate Threshold Scores for a QP determination under the All-Payer Combination Option:
  - By date and in a manner specified—the following data must be submitted—
    - » Payment arrangement information—financial risk arrangements, use of certified EHR technology, and payment tied to quality; and
    - » The amounts of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement, and the total number of patients furnished any service through the payer.

All Payer QP Determination

- Performance Period remains January 1- August 31
  - Considered shortening to 3 or 6 months but did not finalize
- Three snap shots: March 31, June 30 and August 31
- Determinations can be requested at either the EC or Entity level or both, unless assessed individually under Medicare
- Incorporating Medicare Data
  - Use relevant Medicare payment and patient data (EC or Entity level), **OR**
  - If at the individual level, compare the clinician's Medicare QP threshold score with the entity's (group-level) threshold score; if clinician's group score is higher, apply a weighted methodology
- Must request QP determination on approved Other Payer Advanced APMs by December 1 of the relevant year.

QP Determination Tree, Payment Years 2021-2022



Preparing for the path forward

PROVIDE EDUCATION

Enable leaders and providers on the facts and implications of the MACRA legislation

ASSESS OPTIONS

Understand the range of financial implications of each track and the strategic considerations perusing each (MIPS, MIPS+APM, A-APM)

SET DIRECTION

Develop a steering committee with health system leaders and providers to review options and determine direction

IDENTIFY APPROACH

Premier facilitated meeting with implementation team for deeper dive on identified operational issue (e.g. MIPS Quality Performance, Developing a MSSP ACO, etc)

Important Links

MPFS:

- Premier detailed summary
- Proposed Rule
- CMS press release
- CMS fact sheet

QPP:

- Premier detailed summary *coming soon*
- Proposed Rule
- CMS press release
- CMS fact sheet

Preparing for the path forward

PROVIDE EDUCATION

Enable leaders and providers on the facts and implications of the MACRA legislation

ASSESS OPTIONS

Understand the range of financial implications of each track and the strategic considerations perusing each (MIPS, MIPS+APM, A-APM)

SET DIRECTION

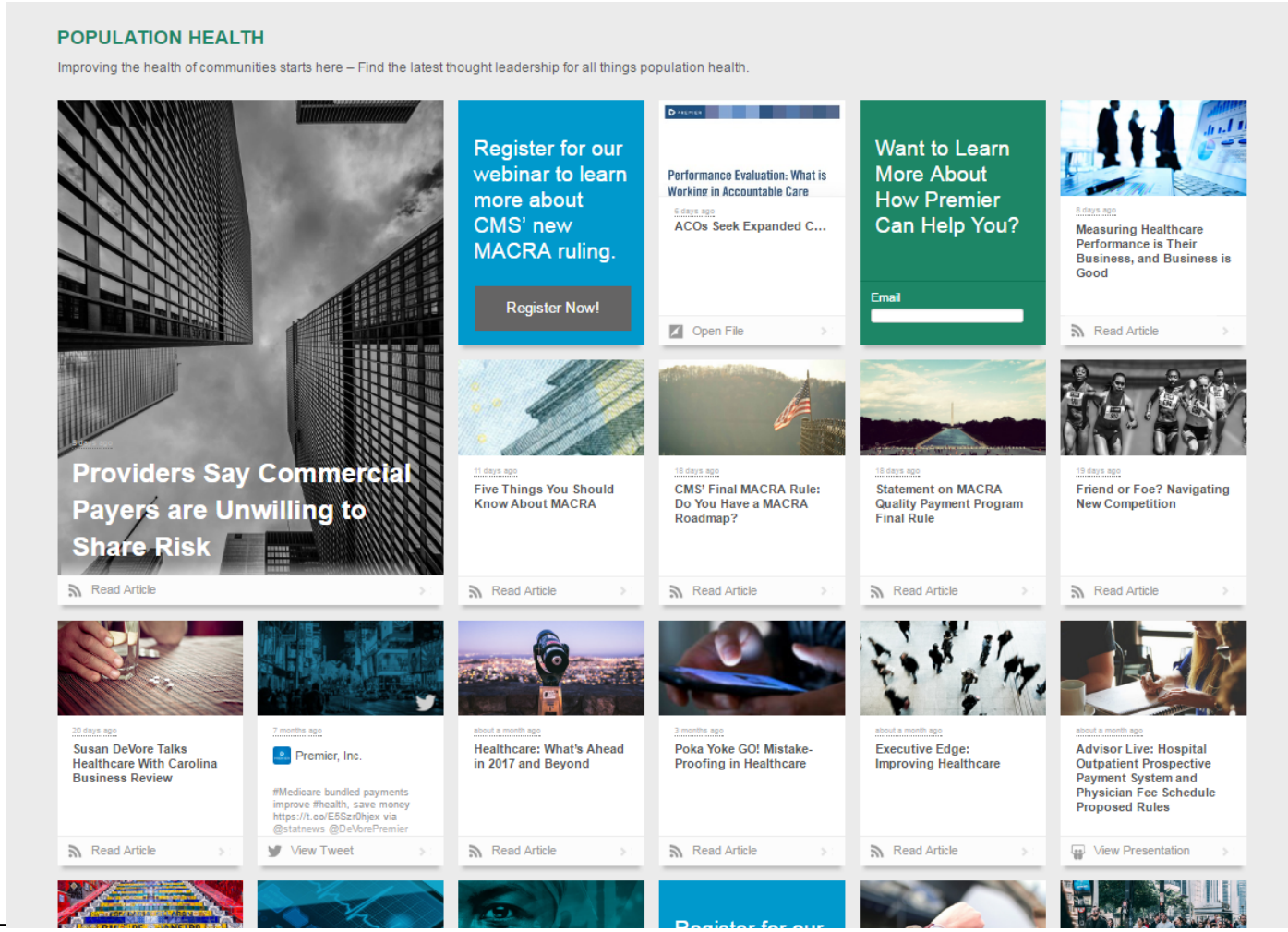
Develop a steering committee with health system leaders and providers to review options and determine direction

IDENTIFY APPROACH

Premier facilitated meeting with implementation team for deeper dive on identified operational issue (e.g. MIPS Quality Performance, Developing a MSSP ACO, etc)

Resources

Visit: https://learn.premierinc.com



Danielle Lloyd, M.P.H.
VP, policy and advocacy
Deputy director, D.C. office,
202.879.8002
danielle_lloyd@premierinc.com

Aisha Pittman, M.P.H.
Senior director, quality policy and analysis
202.879.8013
aisha_pittman@premierinc.com

Transforming Healthcare TOGETHER

64

Appendix

PFS: Medicare Telehealth Services

- Add 3 codes that are similar to services currently on telehealth services list
  - G0296: Counseling visit to discuss the need for lung cancer screening using low dose computed tomography (LDCT)
  - 90839 and 90840: Psychotherapy for crisis; first 60 min
- Add 4 add-on codes
  - 90875: Interactive complexity
  - 96160 and 96161: Administration of patient-focused health risk assessment instrument and Administration of caregiver-focused health risk assessment instrument
  - G0506: Comprehensive assessment or/and care planning for patients requiring chronic care management services
- No longer require GT modifier on claims since telehealth POS code is required

PFS: Outpatient Provider-Based Departments - Background

- Section 603 of the Bipartisan Budget Act of 2015, enacted on November 2, 2015, imposed new payment rules for certain off-campus outpatient provider-based departments (PBDs).
- Beginning January 1, 2017, non-excepted items and services furnished by non-excepted off-campus PBDs will no longer be paid under the OPPS; they will be paid under another payment system.
- The law does not apply to on-campus PBDs (main provider).
- The law provides exceptions for:
  - PBDs within 250 yards of a remote location (straight line measurement from any point of the inpatient hospital at the remote location).
  - PBDs billing prior to November 2, 2015. 21st Century Cures Act provides limited exceptions for PBDs not billing but in process as of that date.
  - Services furnished in a dedicated emergency department (ED). CMS clarified in rulemaking that exception will apply all services in a dedicated ED, not just ED visits.

PFS: Outpatient Provider-Based Departments

- CY 2017 OPPS Final Rule
  - CMS issued Interim Final Rule with Comment (IFC) to make payment to hospitals at a special Medicare Physician Fee Schedule (MPFS) rate for the non-excepted off-campus PBDs at 50% of OPPS rates for 2017, the PFS Relativity Adjuster
  - Billed on an institutional claim with new claim line modifier “PN”
  - OPPS payment policies (e.g. C-APCs, OPPS packaging) will apply
  - Partial Hospitalization will be paid at CMHC rate.
  - Services paid under other fee schedules (MPFS, Clinical Laboratory Fee Schedule and Ambulance Fee Schedule) will continue to be paid the same as currently without a reduction.
  - Separately payable drugs and biologicals will be paid at ASP + 6%.
  - OPPS geographic adjustor (wage index) and OPPS supervision rules will apply
- CY 2018 MPFS Final Rule Changes
  - Adjust the PFS Relativity Adjuster to 40% of the OPPS rates (up from the 25% in the proposed rule)
  - CMS estimates that this change will result in total Medicare Part B savings of $12 million.

PFS: Public Comment Solicitations in Proposed Rule

- Evaluation and Management Guidelines- CMS intends to work with stakeholders to review
  - Reducing burden and unnecessary documentation, relying on electronic health technology
  - Extending practitioner autonomy to determine volume of E/M services
  - Revision design that does not purposefully or inadvertently provide inappropriate performance or payment advantages to subsets of physicians
- Care Management Services- CMS will explore ways to pay for multiple practitioners coordinating care
  - Expansion beyond office visits
  - Reducing burden by harmonizing CMS requirements and CPT guidance
  - Addressing health disparities and disabled patients
- Clinical Laboratory Fee Schedule
  - Beginning January 1, 2018 CLFS payment based on weighted median of private payor rates; based on information collected during CMS data collection period

PFS: RHC/FQHC Care Management

- Codes and payment policies for general care management and psychiatric collaborative care model finalized in CY 2017 MPFS don't apply to RHCs and FQHCs
- CMS proposed using existing CPT and HCPCS codes but felt bundling the codes into G codes is more consistent with RHC and FQHC payment
    - RHCs and FQHCs will continue to receive payment for CCM services when CPT code 99490 is billed prior to Dec 31, 2017; code will be denied in 2018
    - Beginning Jan 1, 2018 RHCs and FQHCs must use the General Care Management code or Psychiatric CoCM code,
- General Care Management for RHCs and FQHCs only (G0511)
- Psychiatric CoCM for RHCs and FQHCs only (G0512)
- Psychiatric CoCM Services; first 70 minutes (99492)
- Psychiatric CoCM Services; subsequent 60 minutes (99493)
- Psychiatric CoCM Services; add on (99494)
- General BHI Services (99484)

PFS: Biosimilars

- CY 2016 final rule indicated that the payment amount for a biosimilar biological product is based on the average sales price (ASP) of all National Drug Codes (NDCs) assigned to the biosimilar biological products included within the same billing and payment code
- Proposed rule sought comments on:
  - New or updated information on the current biosimilar payment policy
  - Data on how individual HCPCS codes could impact the biosimilar market
  - Other policies to foster competition and increase access
- Policy effective Jan 1, 2018: Newly approved biosimilars with a common reference product will no longer be grouped into same HCPCS, CMS will separately code and pay for biosimilar products

PFS: Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

- PAMA directed CMS to establish a program to promote the use of AUC for advanced diagnostic imaging services
- CY 2016 rulemaking activities:
  - Advanced diagnostic imaging includes MRI, CT, PET, nuclear medicine and other services identified by stakeholders
  - Provider led entities(PLE to develop AUC –identified 11 qualified PLEs)
- CY 2017 rulemaking activities:
  - Requirements and processes for specification of qualified clinical decision support mechanisms(CDSMs)
  - The initial list of priority clinical areas: Coronary artery disease, suspected pulmonary emboli, headache, hip pain, low back pain, shoulder pain, cancer of the lung, cervical or neck pain without change
  - Exceptions to required consultation with AUCs

AUC: Implementation

- Definition of CDSM: interactive, electronic tool that communicates AUC information and assists the clinician in making the most appropriate diagnostic decision
  - Can be free-standing or incorporated into EHR
- Requirements for CDSM are not prescriptive about specific IT standards and functions on functionality
  - Applications deadline January 1 of each year
  - Approved CDSMs: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM.html
- Exceptions
  - Exception for “emergency medical condition” and Part A payment
  - EHR Incentive Program hardship
    - » CMS discusses MAC granting hardship exemptions or establishing another process for self-attestation of significant hardship for anesthesiology, radiology and pathology

AUC: Implementation

CDSM Qualifications and Requirements

1. Make available specified applicable AUC and its related supporting documentation.
2. Identify the appropriate use criterion consulted if the CDSM makes available more than one criterion relevant to a consultation for a patient's specific clinical scenario.
3. Make available, at a minimum, specified applicable AUC that reasonably address common and important clinical scenarios within all finalized priority clinical areas.
4. Be able to incorporate specified applicable AUC from more than one qualified PLE.
5. Determine, for each consultation, the extent to which the applicable imaging service is consistent with specified applicable AUC.
6. Generate and provide a certification or documentation at the time of order that documents:
   - Which qualified CDSM was consulted;
   - The name and national provider identifier (NPI) of the ordering professional that consulted the CDSM;
   - Whether the service ordered adhered to or did not adhere to specified applicable AUC; or whether the specified applicable AUC consulted was not applicable to the service ordered; and
   - Include a unique consultation identifier generated by the CDSM.
7. Modifications to AUC within the CDSM must comply with the following requirements:
   - Make available updated AUC content within 12 months from the date the qualified PLE updates AUC;
   - Have a protocol in place to expeditiously remove AUC determined by the qualified PLE to be potentially dangerous to patients and/or harmful if followed; *and*
   - Make available for consultation within 12 months of a priority clinical area being finalized by CMS specified applicable AUC that reasonably address common and important clinical scenarios within any new priority clinical areas.
8. Meet privacy and security standards under applicable provisions of law.
9. Provide to the ordering professional aggregate feedback regarding their consultations with specified applicable AUC in the form of an electronic report on at least an annual basis.
10. Maintain electronic storage of clinical, administrative, and demographic information of each unique consultation for a minimum of 6 years.
11. Comply with modification(s) to any requirements made through rulemaking within 12 months of the effective date of the modification.
12. Notify ordering professionals upon de-qualification.

PFS: VM Current and Quality Tiering

Groups 10+						
Cost/Quality VM Payment Adjustment	Low Quality		Average Quality		High Quality	
	Current	Proposed	Current	Proposed	Current	Proposed
Low Cost	+0.0%	+0.0%	+2.0x*	+1.0x*	+4.0x*	+2.0x*
Average Cost	-2.0%	+0.0%	+0.0%	+0.0%	+2.0x*	+1.0x*
High Cost	-4.0%	+0.0%	-2.0%	+0.0%	+0.0%	+0.0%

Solo and Groups 2-9						
Cost/Quality VM Payment Adjustment	Low Quality		Average Quality		High Quality	
	Current	Proposed	Current	Proposed	Current	Proposed
Low Cost	+0.0%	+0.0%	+1.0x*	+1.0x*	+2.0x*	+2.0x*
Average Cost	-1.0%	+0.0%	+0.0%	+0.0%	+1.0x*	+1.0x*
High Cost	-2.0%	+0.0%	-1.0%	+0.0%	+0.0%	+0.0%

Non-physician Groups or Solo Practitioners						
Cost/Quality VM Payment Adjustment	Low Quality		Average Quality		High Quality	
	Current	Proposed	Current	Proposed	Current	Proposed
Low Cost	+0.0%	+0.0%	+1.0x*	+1.0x*	+2.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+0.0%	+0.0%	+1.0x*	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%	+0.0%	+0.0%	+0.0%

MIPS: ACI Scoring Stage 3 Objectives and Measures

Objective	Measure	Base Score (50%) Requirement	Performance Score (up to 90%)
Protect Patient Health Information	Security Risk Analysis MUST PASS	☑ Must attest "yes"	0
Electronic Prescribing	ePrescribing	☑	0
Patient Electronic Access	Provide Patient Access ★	☑	Up to 10%
	Patient-Specific Education★		Up to 10%
Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) ★		Up to 10%
	Secure Messaging★		Up to 10%
	Patient-Generated Health Data★		Up to 10%
Health Information Exchange	Send a Summary of Care★	☑	Up to 10%
	Request/Accept Summary of Care★	☑	Up to 10%
	Clinical Information Reconciliation★		Up to 10%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting★		Performance Score: 0 or 10% Bonus Score: 5% for one additional
	Syndromic Surveillance Reporting★		
	Electronic Case Reporting★		
	Public Health Registry Reporting★		
	Clinical Data Registry Reporting★		
BONUS	Improvement Activities Using CEHRT	Bonus	10%

MIPS: ACI Scoring Modified Stage 2 Objectives and Measures

Objective	Measure	Base Score Requirement	Performance Score/ Bonus
Protect Patient Health Information	Security Risk Analysis MUST PASS	☑ Must attest "yes"	0
Electronic Prescribing	ePrescribing	☑	0
Patient Electronic Access	Patient Access ★	☑	Up to 20%
	View, Download or Transmit (VDT) ★		Up to 10%
Patient-Specific Education	Patient-Specific Education★		Up to 10%
Secure Messaging	Secure Messaging★		Up to 10%
Health Information Exchange	Health Information Exchange★	☑	Up to 20%
	Medication Reconciliation★		Up to 10%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting★		Performance Score: 0 or 10% Bonus Score: 5% for one additional
	Syndromic Surveillance Reporting★		
	Specialized Registry Reporting★		
BONUS	Improvement Activities using CEHRT	Bonus	10%

Physician Focused Payment Models (PFPM)

- PTAC
  - Physician-focused payment model Technical Advisory Committee
  - Review and make recommendations to the Secretary regarding PFPMs that are APMs or Advanced APMs
- CMS sought comment son the following but did not make changes
  - Broadening the definition of PFPMs to include those with Medicaid or CHIP as a payer (even without Medicare as a payer);
  - Appropriateness of models focusing on conditions not generally applicable to Medicare (e.g. pediatric, maternal health etc.)
  - Limiting the expanded PFPM definition to those CMS/HHS can implement;
  - Investing PTAC resources into assessing Medicaid/CHIP proposals;
  - Engaging more stakeholders as a result of an expanded PTAC focus;
  - Whether PFPM needs to be an APM or payment arrangement;
  - Assessing support of states and other stakeholders in expansion; and
  - The Secretary's PFPM criteria more broadly and stakeholders needs in developing proposals that meet the criteria.

Advanced APM Principles and Goals

- **Principle:** Increasing quality and efficiency of care delivered in the Medicare program and across the health system.
- **Goals:**
  - Expand the opportunities for broad participation in APMs by a range of physicians and other practitioners;
  - Ensure participation is attainable, but only for those organizations that are truly transformative;
  - Maximize participation in Advanced APMs and other APMs
  - Remain flexible for future innovations;
  - Support multi-payer models and participation in innovative models in Medicaid and commercial markets;
  - Minimize burden on organizations and professionals;
  - Assess degree of participation not performance within the Advanced APMs.

Medicare Threshold score calculation: attribution

- An “attributed beneficiary” is one attributed to the Advanced APM Entity on the latest available list of such beneficiaries at the time of the QP determination, with attribution following that entity’s specific attribution rules.
- “Attribution-eligible beneficiary” would be one who:
  1. Is not enrolled in Medicare Advantage or a Medicare cost plan,
  2. Does not have Medicare as a secondary payer,
  3. Is enrolled in both Parts A and B,
  4. Is at least 18 years of age,
  5. Is a United States resident, and
  6. Has at least one evaluation and management service claim by an eligible clinician or group of eligible clinicians within an APM Entity for any period within the QP performance period.
- Only counts beneficiary once in numerator/denominator, but may count more than once across APMs

Medicaid Medical Home Model: eligibility

- Medicaid Medical Home Model must have the following two minimum elements:
  - model participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services, and
  - empanelment of each patient to a primary clinician.
- And, it must have at least 4 of the following elements:
  - Planned chronic and preventive care.
  - Patient access and continuity.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings, population-based payments).

Other Payer AAPM Determination: Medicaid APMs and Medicaid Medical Home

- Law excludes Medicaid payments/patients from All-Payer Combination Option QP calculations if state has no Medicaid Medical Home or APMs that meet Advanced APM criteria:
- To implement exclusion, CMS will:
  - Assess at the county level whether and where a state operates a Medicaid APM or Medicaid Medical Home
  - Identify counties or specialties excluded from participating in the Medicaid Other Payer Advanced APM
  - Make the Other Payer Advanced APM determinations at the request of states, APM entities, or eligible clinicians, doing so prior to the All-Payer performance period
  - Exclude all Medicaid payments and patients from the numerator and denominator of QP calculations for an eligible clinician when a Medicaid Other Payer Advanced APM is not available for participation by that clinician due to county or specialty APM restrictions

Incentive Payment

- Incentive Payment to eligible clinicians that achieve QP status for the year (2019- 2024) equal to 5% of the estimated aggregate amounts paid for Medicare Part B covered professional services furnished by the eligible clinician from the preceding calendar year across all billing TINs associated with the QP's NPI.
- Three months of claims run out will be included.
- Incentive payments likely paid 6-months into the year.
- Exclusions from estimated aggregate payment amount
  - MIPS, VM, MU and PQRS payment adjustments
  - Financial risk payments such as shared savings payments or net reconciliation payments
- Includes supplemental services payments (e.g. PBPM payments in lieu of services reimbursed under PFS) on a case by case basis
- Will not affect actual expenditures under an APM

Supplemental Service Payments

- Inclusion of supplemental service payments will considered on a case-by-case.
- If payments are for covered services that are in lieu of services reimbursed under the PFS, those payments would included in the APM Incentive Payment amounts.
- Incentive Payment amount will be included if it meets all of the following 4 criteria:
  - Payment is for services that constitute physician services authorized under section 1832(a) of the Act and defined under section 1861(s) of the Act.
  - Payment is made for only Part B services under the first criterion above, that is, payment is not for a mix of Part A and Part B services.
  - Payment is directly attributable to services furnished to an individual beneficiary.
  - Payment is directly attributable to an eligible clinician.

All Payer QP Determination- Payment

- **CMS proposed a change but did not finalize it.**
- ***Payment amount method*—**The Threshold Score for either an APM Entity group or eligible clinician will be calculated by dividing the value described under the numerator by the value described under the denominator.
- ***Numerator*.** The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, attributable to the eligible clinician or to the APM Entity group under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period.
- ***Denominator*.** The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, made to the eligible clinician or to the APM Entity group during the QP Performance Period.

All Payer QP Determination- Beneficiary Count

- ***CMS proposed a change but did not finalize it.***
- ***Patient count method***—The Threshold Score for either an APM Entity group or eligible clinician is calculated by dividing the value described under the numerator by the value described under the denominator.
- ***Numerator***. The number of unique patients to whom an APM Entity group or eligible clinician furnishes services that are included in the measures of aggregate expenditures used under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period.
- ***Denominator***. The number of unique patients to whom the APM Entity group or eligible clinician furnishes services under all non-excluded payers during the QP Performance Period.
- ***Unique patients***. CMS may count a single patient in the numerator and/or denominator for multiple different payers.

