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CY 2018 Quality Payment Program Proposed Rule

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Agenda

- Merit-Based Incentive Payment System
  - Eligibility
  - Quality
  - Cost
  - Advancing Care Information
  - Improvement Activities
  - Scoring and Payment Adjustment
- Advanced Alternative Payment Model Participation Incentives
  - Advanced APMs
  - Qualifying and Partial Qualifying Participants
  - All-Payer and Medicare Payment/Patient Thresholds
  - Physician-focused Payment Models

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CY 2018 QPP Proposed Rule

- Released June 20, published June 30, *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; do not score cost for 2018 performance period
  - 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%
  - 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 individual clinician level only
- Comments due August 21, 2017

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How To Submit a Comment

CMS QPP proposed rule

– Comments due 60 days from the date of display (August 21, 2017)

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-P” 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.

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

2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026

Permanent repeal of SGR

Updates in physician payments

0.5% (7/2015-2019) | 0% (2020-2025)

TRACK 1

PQRS pay for reporting

2015	2016 & beyond
-1.5%	-2.0%

Meaningful Use Penalty (up to %)

2015	2016	2017	2018
-1.0%	-2.0%	-3.0%	-3.0%

Value-based Payment Modifier

2015	2016	2017	2018
± 1.0%	± 2.0%	+2/±4.0%	±2/±4.0%

Measurement period

Merit-Based Incentive Payment System (MIPS) adjustments

2019	2020	2021	2022 & beyond
+/-4%	+/- 5%	+/- 7%	+/- 9%

MIPS exceptional performance adjustment; ≤ 10% Medicare payment (2019-2024)

0.25% update

TRACK 2

Measurement period

Advanced APM participating providers exempt from MIPS; receive annual 5% bonus (2019-2024)

0.75% update

PREMIER

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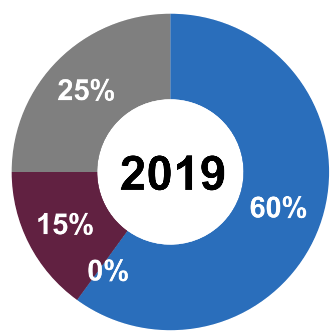
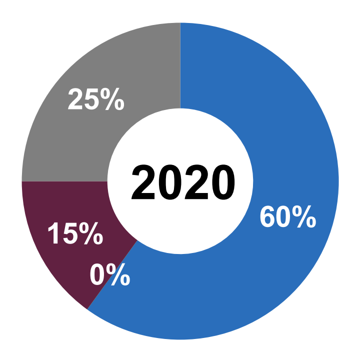
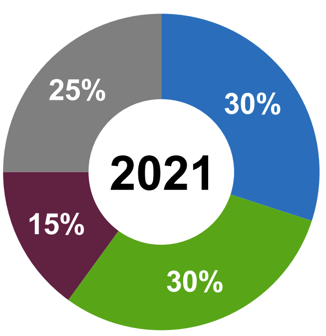
MIPS Overview



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

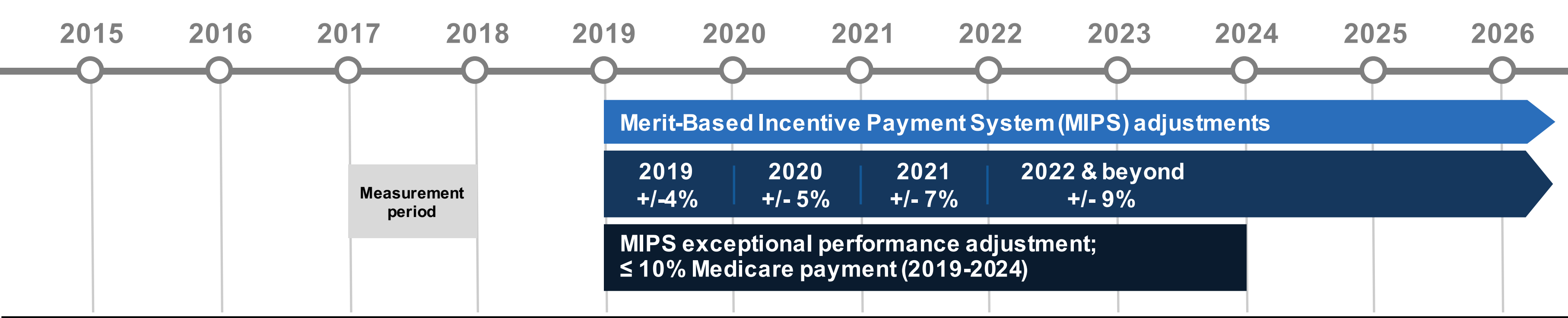


CY 2018 is performance period for CY 2020. Quality-Full year; ACI/Improvement-any 90 days



- **Quality** — PQRS 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; 15 in 2020 and median or mean in later years.**
- **Improvement scores for cost and quality in 2020 and beyond**



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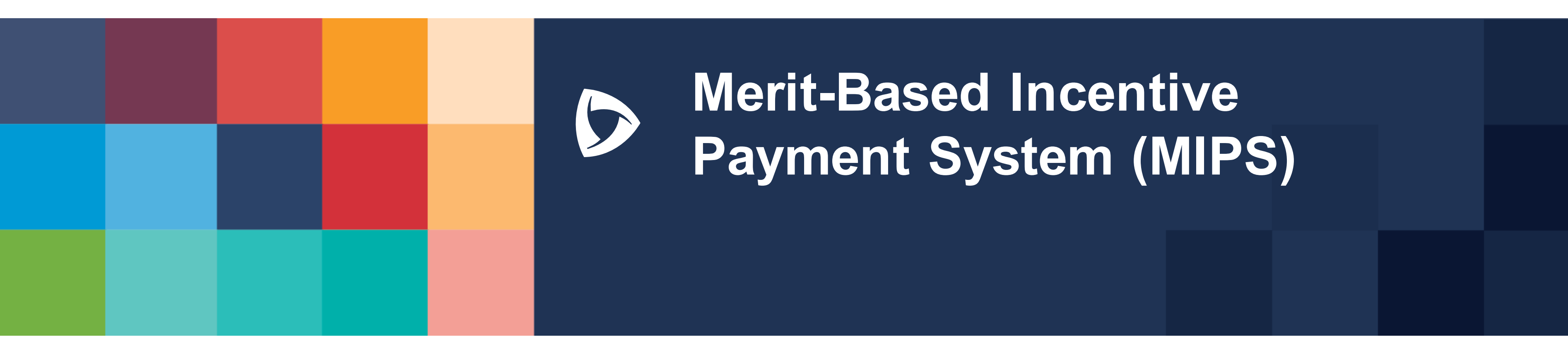


Merit-Based Incentive Payment System (MIPS)

MIPS: 2020 Payment Year / 2018 Performance Year Proposed

Advancing care information: 100 points

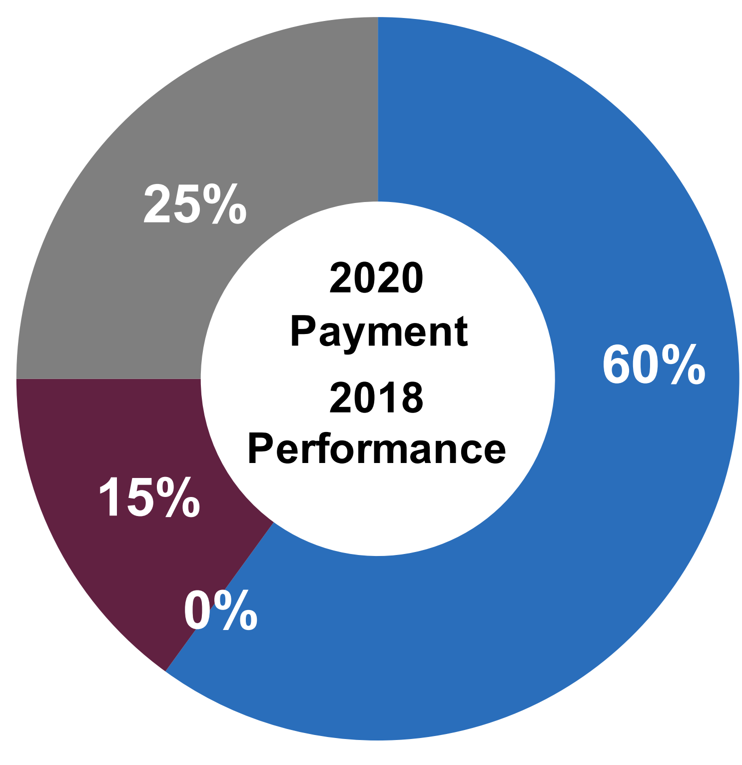
Base Score
- Security Risk Analysis
- eRx
- Provide patient access
- Send summary of care
- Receive summary of care

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 (1-3pts)

Cost: Not Assessed- Feedback Reports Only

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

*Total points possible vary by provider type and available measures

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MIPS: Eligible Clinicians

Years 1 and 2	Years 3+ (potential)
▪ Physician, ▪ Physician Assistants, ▪ Nurse Practitioners, ▪ Certified-Nurse Specialists, ▪ Certified Registered Nurse Anesthetists	▪ Physical or occupational therapist, ▪ Speech-language pathologists, ▪ Audiologists, ▪ Nurse midwives, ▪ Clinical social workers, ▪ Clinical psychologists, ▪ Dieticians, ▪ Nutritional professionals

- 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
    - » **Allow opt-in beginning in 2019**
    - » **Seeking comments on a threshold based on items and services provided (e.g. patient encounters or procedures**
  - Qualifying/ Partial Qualifying Advanced APM Participants

- 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
- 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	585,560	647,219	$14,096	$87,147
Qualifying APM Participants	74,920	572,299	$6,489	$80,658
Total Remaining		**572,299 (37%)**		**$80,658 (65%)**

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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
      - i.e. clinician prescribes and it dispensed/administered by a supplier that is also a MIPS EC)
  - Group Reporting- Split TINs
    - Optional for groups where a portion of the TIN is participating in a MIPS APM or Advanced APM
    - Seeking comments on creating subgroups
- Small groups– 15 or fewer ECs
  - Determine practice size using a claims determination period
  - 12-month period: September 1, 2016- August 31, 2017
  - Alternative determination options:
    - 24 months, with two 12-month determination segments, one before and one during performance period
    - Attestation for small practices not identified during determination
- 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

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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
    - 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 from mid-September to December 1 of prior year
- Virtual Group Agreements
  - Must have a written agreement between parties in the virtual group; CMS will provide a model agreement
  - Cannot be with other entities
  - Must cover obligations for reporting and how the group will encourage adherence to quality and improvement

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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

+ 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	50% of Medicare Part B patients seen during the performance period to which measure applies 2019 - 60%
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.*	50 percent of MIPS eligible clinician's or groups patients that meet denominator criteria (all-payer) 2019 - 60%
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-week period ending no later than February 28	Sampling requirements for their Medicare Part B patients

* Can report QCDR custom measures

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MIPS: Quality Performance Category: 60%

Measure Scoring

- No successful reporting requirements, each measure submitted is awarded points
- Topped out measure
  - Year 1: Identified as Topped Out
  - Year 2: Possible points capped at 6
  - After 3 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
- Transition Year Policy
  - 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

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

- 2017 (2019 payment)- 0% Feedback Reports Provided
- 2018 (2020 payment) 0%, seek comment on 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 ▪ 20 minimum cases

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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 the group must have certification or recognition
  - CPC+ control group
- 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)
- Bonus Points (up to 15% for 2014 CEHRT, 25% for 2015 CEHRT)
  - Optional Public Health and Clinical Data Registry Reporting (5%)
    - Must be a different registry than those used to earn performance score
  - Improvement activities that are enhanced by CEHRT (10%)
- Total score is 100 points, 155 points are possible
- Reweighting ACI to 0% for certain clinicians
  - Hospital-based clinicians, ASC-based clinicians, small practices and practices in HPSA
  - Hardship Exemption, including decertification of CEHRT and small practice
  - 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
- 2018 performance would use FY2019 HVBP measures
- Scores derived from facility where clinician treats highest number of Medicare beneficiaries
- Seek comment on opt-in or opt-out mechanisms for this option

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
  - 1-3 points added to final score based on HCC risk score
- Small Practice Bonus
  - 5 points added to the final score
  - Seek comment on bonus points for rural practices

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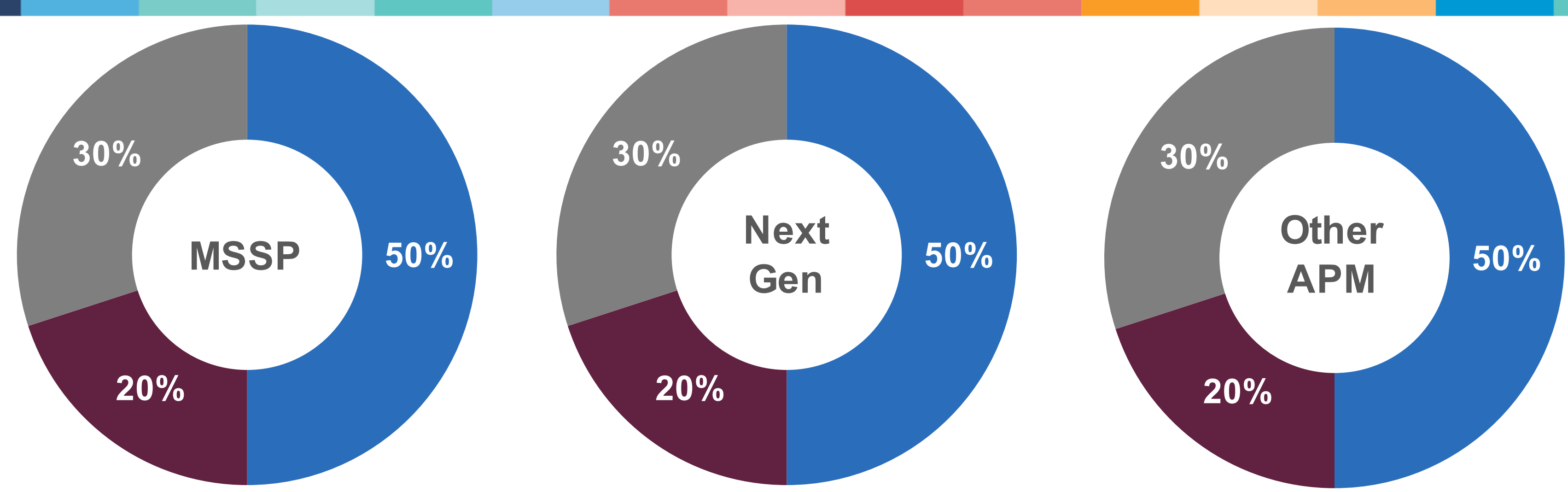
MIPS: APM Scoring Standard



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

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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

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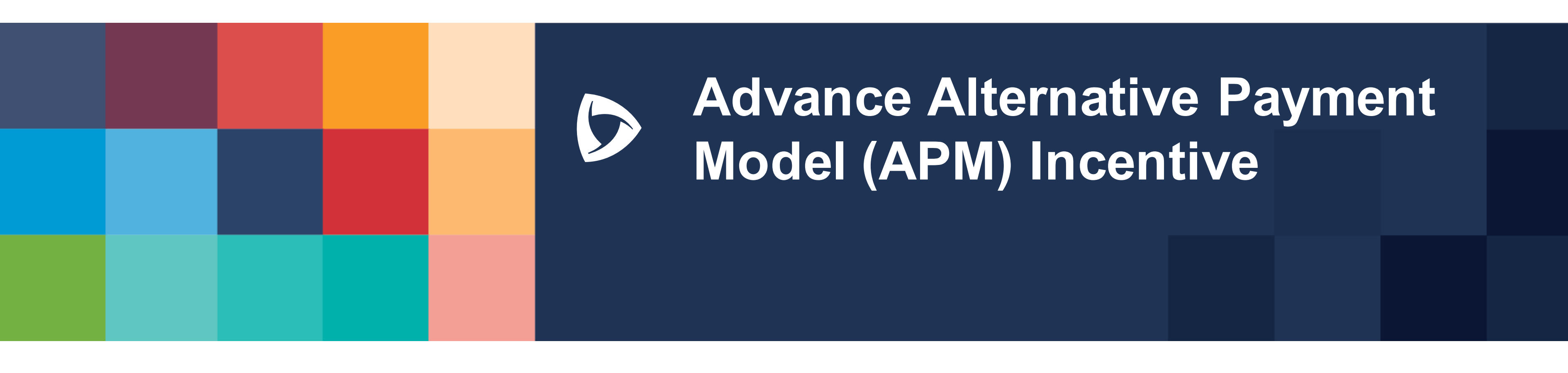

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Advanced APM

FIGURE B: Program Overview

ALTERNATIVE PAYMENT MODEL (APM)

APM model meets Advanced APM criteria

ADVANCED APM ENTITY

APM Entity participates in Advanced APM model

01

02

03

04

QUALIFYING APM PARTICIPANT (QP)

Eligible Clinicians in Advanced APM Entity* collectively meet either revenue or beneficiary count QP thresholds of participation

PARTIAL QP

Eligible Clinicians in Advanced APM Entity* collectively meet either revenue or beneficiary count Partial QP thresholds with no bonus and chose whether to be in MIPS

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/EPM, an EP fails under multiple AAPMs, or if using Other Payer Combination

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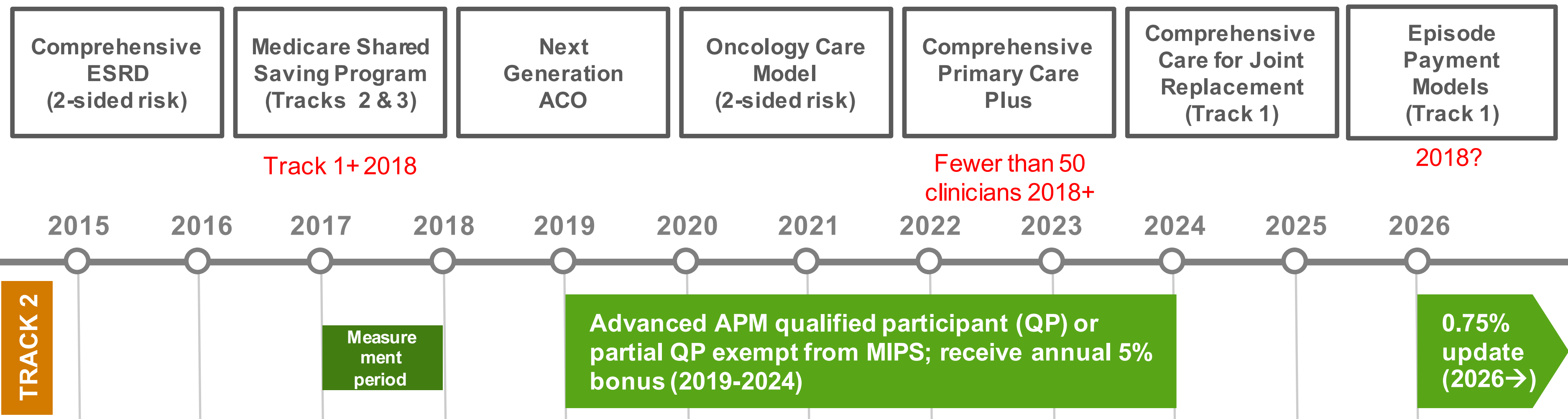
Track 2: 5% Bonus for Advanced APMs

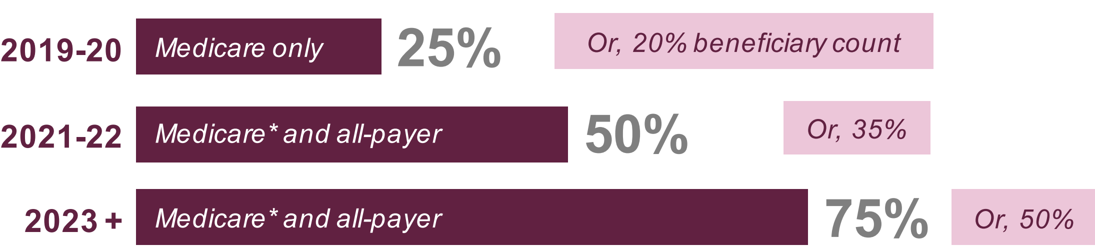


Advanced APM Entities Must:

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



- 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

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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 in 2017/2018
       - **Continue through 2020**
   - Or, is a full capitation risk arrangement

- Medical home models must meet same CEHRT and quality requirements, but have slightly different nominal risk standard, unless it is certified and "expanded" by Innovation Center

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Medical Home Model: risk level

Financial standard same as other 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.
   - **Only 2017 cohort of medical homes may have more than 50 clinicians at the parent level and still get AAPM credit in 2018+**
   - 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**
     - ~~4%~~ in 2019, **3% proposed**
     - ~~5%~~ in 2020, **4% proposed**
     - **5% 2021 and later.**

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Advanced APM Step 3 & 4: Can you meet thresholds to be a Qualifying or Partial 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 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 are 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%

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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
- “Medicare” QP Performance period to differentiate from All-Payer
- Use data only from dates during which an entity could participate in the Advanced APM

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

QP and Partial QP Calculation: All- Payer Combination

- Allows private payers to supplement the calculation in 2021
  - Medicare option will be calculated first then the All-Payer Combination Option if needed
- Medicare Advantage considered an "Other Payer"
  - **CMS seeks comments on this**
- Excludes payments made by DOD/VA and Medicaid in states without medical home programs or Medicaid APMs
  - **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;
  - Quality measures comparable to MIPS including one outcome; 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).
- Seeking comments on Other Payer Medical Home Model definition, arrangements that may meet this definition and how the 50-clinician cap may impact nominal risk standard

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.
  - 8% or more of total combined revenues from the payer of the entity's participating providers and suppliers.
  - Seeking comment on standards for small/rural practices

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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

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All Payer QP Determination

- Performance Period: Reduce from January 1- August 31 to January 1- June 30
  - Alternate proposals of maintaining existing or January- March
- Three snap shots: March 31, June 30 and August 31
- Determinations at the EC level
- Incorporating Medicare Data
  - Use individual's (not the entity's) Medicare payment and patient data OR
  - 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
  - Better result will be used in the All Payer determination

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Other Payer AAPM Determination Process: EC Initiated

- Eligible Clinician submits for each payment arrangement:
  - Arrangement name;
  - Brief description of the nature of the arrangement;
  - Terms of the arrangement (anticipated start and end dates);
  - 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
- Notify CMS of participation in approved Other Payer AAPM

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Other Payer AAPM Determination: Payer Initiated

- Voluntary process; same required fields as EC initiated
- Medicaid, Medicare Health Plans, and CMS Multi-Payer Models, payers may request determinations in 2018 for 2019 All-Payer Performance Period
  - Payers may request concurrent determination for commercial arrangements
- Remaining payers (e.g., commercial, other private), 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
- Plans to post publicly only payer name, location, and name of approved Other Payer Advanced APM on CMS Website

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 proposes to:
  - 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

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Other Payer AAPM Determination

- 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
  - When Medicaid is an aligned payer must follow Medicaid initiated process
- Medicare Health Plans (including Medicare Advantage)
  - Seek comment on participation credit under the Medicare QP determination
- Other Payers
  - Defer payer initiated process to some point prior to 2020 All Payer QP Determination

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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)			

QP Determination Tree, Payment Years 2021-2022

- Is Medicare threshold Score ≥ 50%
  - Yes → QP
  - No → Is Medicare threshold score ≥ 25%>
    - Yes → Is All-Payer threshold score ≥ 50%?
      - Yes → QP
      - No → All-Payer threshold score ≥ 40% or is Medicare threshold ≥ 40%??
        - Yes → Partial QP
        - No → MIPS eligible clinician
    - No → Is Medicare threshold score ≥ 20%?
      - Yes → All-Payer threshold score ≥ 40% or is Medicare threshold ≥ 40%??
      - No → MIPS eligible clinician

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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
- Comments sought on
  - 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.

Important Links

[Premier detailed summary]

[Proposed Rule]

[CMS press release]

[CMS fact sheet]

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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★		0 or 10%
BONUS	Syndromic Surveillance Reporting★	Bonus	5%
	Electronic Case Reporting		
	Public Health Registry Reporting		
	Clinical Data Registry Reporting		
	Improvement Activities Using CEHRT	Bonus	10%

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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		0 or 10%
BONUS	Syndromic Surveillance Reporting	Bonus	5%
	Specialized Registry Reporting		
	Improvement Activities using CEHRT	Bonus	10%

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)).
- 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".

Terms and Definitions (continued)

- Apply the definition of “Attributed Beneficiary” only to Advanced, not Other Payer Advanced, APMs. This change supports the proposal to make All-Payer Combination Option QP determinations only at the individual, not group, level (Section II.D.6.d.(3)(a)).
- 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.

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Other Payer AAPM Determination: Required Information

Required Information Submission for Other Payer Advanced APM Determination		
Information Item	Payer Initiated	Eligible Clinician Initiated
Name of payment arrangement	X	X
Brief description nature of the arrangement	X	X
Term of the arrangement (anticipated start/end dates)	X	X
Participant eligibility criteria	X	X
Locations where arrangement will be available (county, state, national)	X	X
Evidence that CEHRT criterion is satisfied	X	X
Evidence that quality measure criterion is satisfied	X	X
Evidence that the financial risk criterion is satisfied	X	X
Other potentially necessary documentation needed for determination*	X	X
* For example, contracts, other governance documents, other payment-related documents		

All Payer QP Determination

Payment Method

- Numerator: Aggregate of all payments from all attributable only to the eligible clinician, under the terms of all (Medicare) Advanced APMs and Other Payer Advanced APMs for the periods of either January-March or January-June during the All-Payer QP Performance Period
- Denominator: Aggregate of all payments from all payers to the eligible clinician for the periods of either January-March or January-June during the All-Payer QP Performance Period

Patient Count Method

- Numerator: Number of unique patients to whom an eligible clinician furnishes services under the terms of all (Medicare) Advanced APMs and Other Payer Advanced APMs for the periods of either January-March or January-June during the All-Payer QP Performance Period
- Denominator: Number of unique patients to whom an eligible clinician furnishes services under all payers for the periods of either January-March or January-June during the All-Payer QP Performance Period

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