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Premier's Comments on the CY 2018 Quality Payment Program Proposed Rule

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NOTES

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QUESTIONS

Use the "Questions and Answers"

RECORDING

This webinar is being recorded.
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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

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

How To Submit a Comment

CMS QPP proposed rule

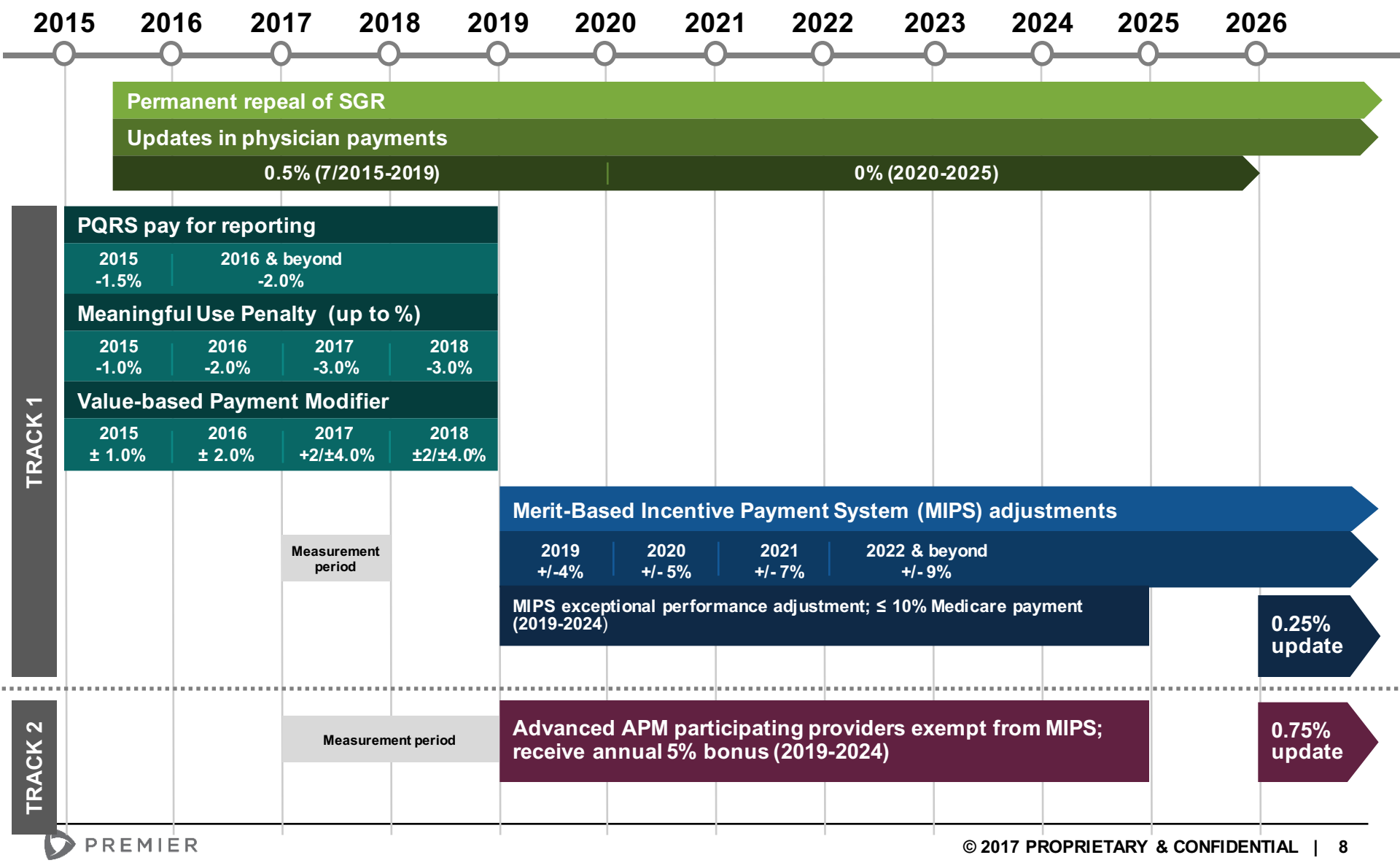
– Comments due 60 days from the date of display (August 21, 2017)

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.

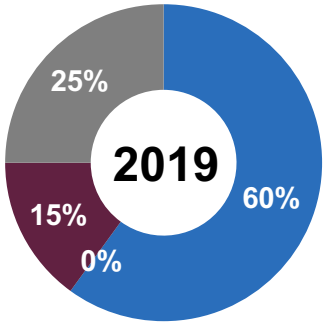
OR

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.

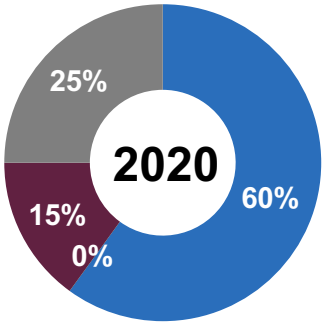
MACRA Reform Timeline
(Medicare Access and CHIP Reauthorization Act of 2015)



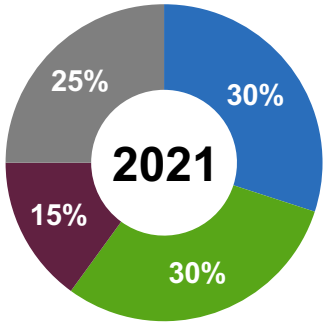
MIPS Overview



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

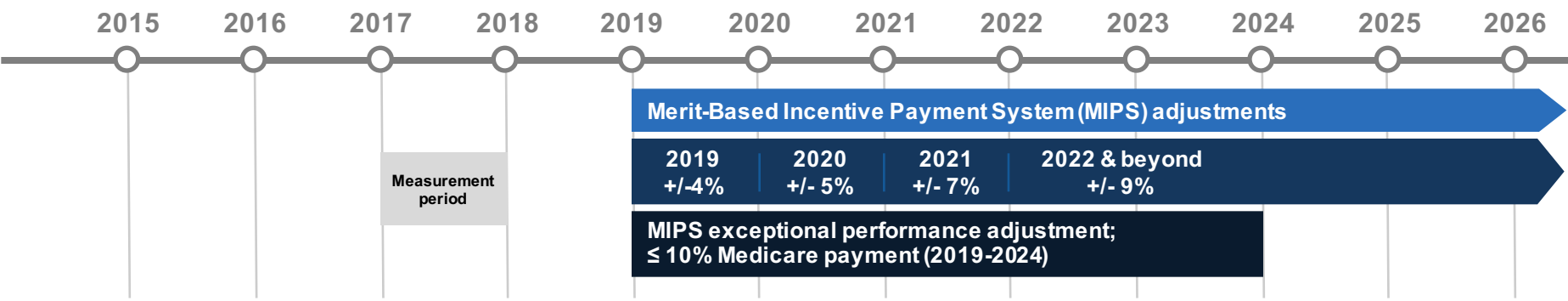


CY 2018 is performance period for CY 2020. Quality-Full year; ACI/Improvement-any 90 days



- **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**



Merit-Based Incentive Payment System (MIPS)

MIPS: 2020 Payment Year / 2018 Performance Year Proposed

Advancing care information: 100 points

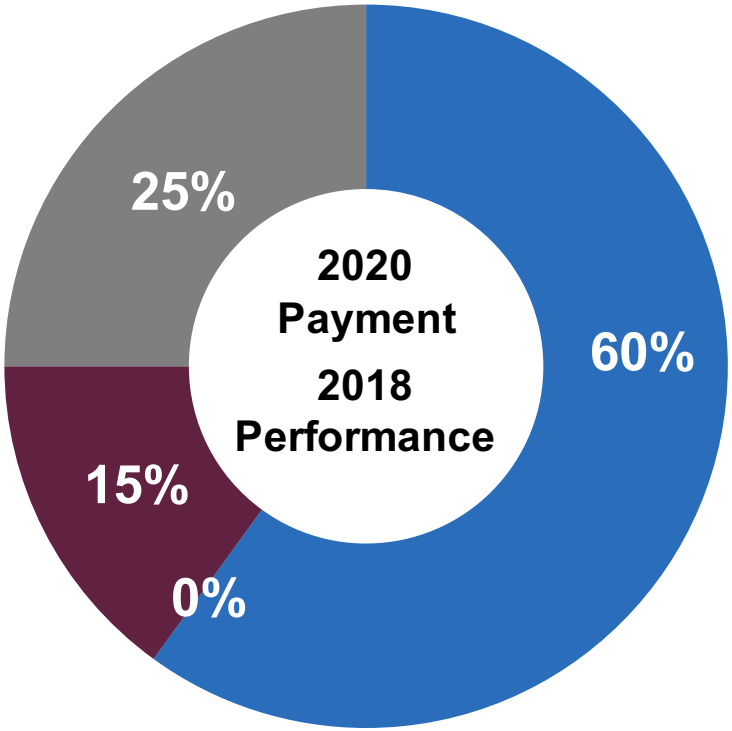
Base Score
- Security Risk Analysis
- eRx
- Provide patient access
- Send summary of care
- Receive summary of care

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

MIPS: Eligible Clinicians

Years 1 and 2

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

Years 3+ (potential)

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

Clarifications

- 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 Support
- CAHs: MIPS adjustment applies but not to facility payment
- RHC/FQHC: MIPS adjustment does not apply
- Rural Health/HPSA Designation: 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 Support

MIPS: Eligible Clinicians 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 Do Not Support- Bring clinicians into the program but ease reporting requirements
  - » **Allow opt-in beginning in 2019** Support
  - » **Seeking comments on a threshold based on items and services provided (e.g. patient encounters or procedures)**
- Qualifying/ Partial Qualifying Advanced APM Participants

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%)**

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)
    - Do not include in payment adjustment or eligibility determination
  - 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 Allow, do not set parameters
- 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

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
- Election process
  - Stage 1- Eligibility
  - 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
- Support creation of virtual groups
  - Agree that there should not be restrictions
  - Phase out election process over time, submit or attest to agreement at time of data submission

Other Recommendations

- Clarify ACI group reporting: Clinicians that qualify for zero weighting should not have to include data as part of the group, but the group score should apply
- Support using multiple submission mechanisms for an individual performance category; allowing additional QCDR measures can help mitigate the need for multiple submission mechanisms
- Support maintaining data completeness threshold at 50%, provide more information before increasing
- Allow API or third-party vendor submission for Web Interface
- Web interface measures: address ACO scoring changes

MIPS: Quality Performance Category: 60%

- 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
  - Support timeline, increase cap
- Improvement Score
  - Improvement Score/Prior Year Achievement Score*10
  - Must have fully participated in prior year
  - Assess at the measure level, delay to ensure benchmarks are stable

- Measure Classes
  - 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 groups are exempt
    - » Support, determine if other groups should have exception

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% Support, do not finalize policies for assessing improvement until episode-based payment measures and approach for scoring is finalized
- 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

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 Do not support, explore through CMS study
  - CPC+ control group Support
- APM Participation- At least half credit (20 points)

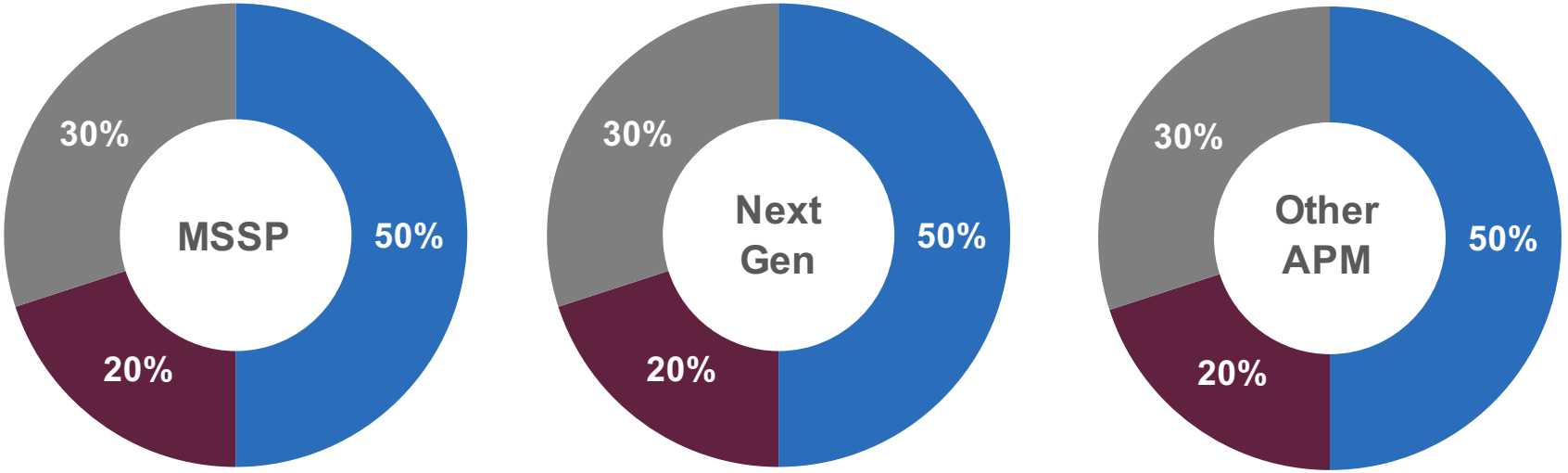
MIPS: Advancing Care Information Performance Category (25%)

- Use 2014 or 2015 CEHRT, 10 bonus points for 2015 CEHRT Support
- 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 Simplify by removing immunization from performance score and counting all registry reporting as bonus points
  - Improvement activities that are enhanced by CEHRT (10%)
- Total score is 100 points, 155 points are possible
- Reweighting ACI to 0% for certain clinicians Support, clarify rules for group reporting
  - 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
- Do not support at this time
  - Most hospital-based clinicians are able to report in MIPS currently
  - Set additional parameters (e.g. area of practice relates to HVBP measures)
  - Ensure measures are harmonized across clinician and hospital levels of analysis

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: Other Scoring Changes

- MIPS APMs
  - Support fourth snapshot
  - Support adding CAHPS for ACO
  - Other APMs: Support adding quality but ensure measures are stable and do not overlap with cost category
- Improvement Points
  - Quality: Improvement measured at category level, up to 10 percentage points Assess at the measure level, ensure benchmarks are stable
  - Cost: Statistically significant changes at the measure level Support approach but address after episode of care measures are finalized; do not penalize for a decline in some measures
- Complex Patient Bonus
  - 1-3 points added to final score based on HCC risk score
  - Support, consider more robust approaches to account for social risk factors
- Small Practice Bonus
  - 5 points added to the final score
  - Seek comment on bonus points for rural practices
  - Support

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

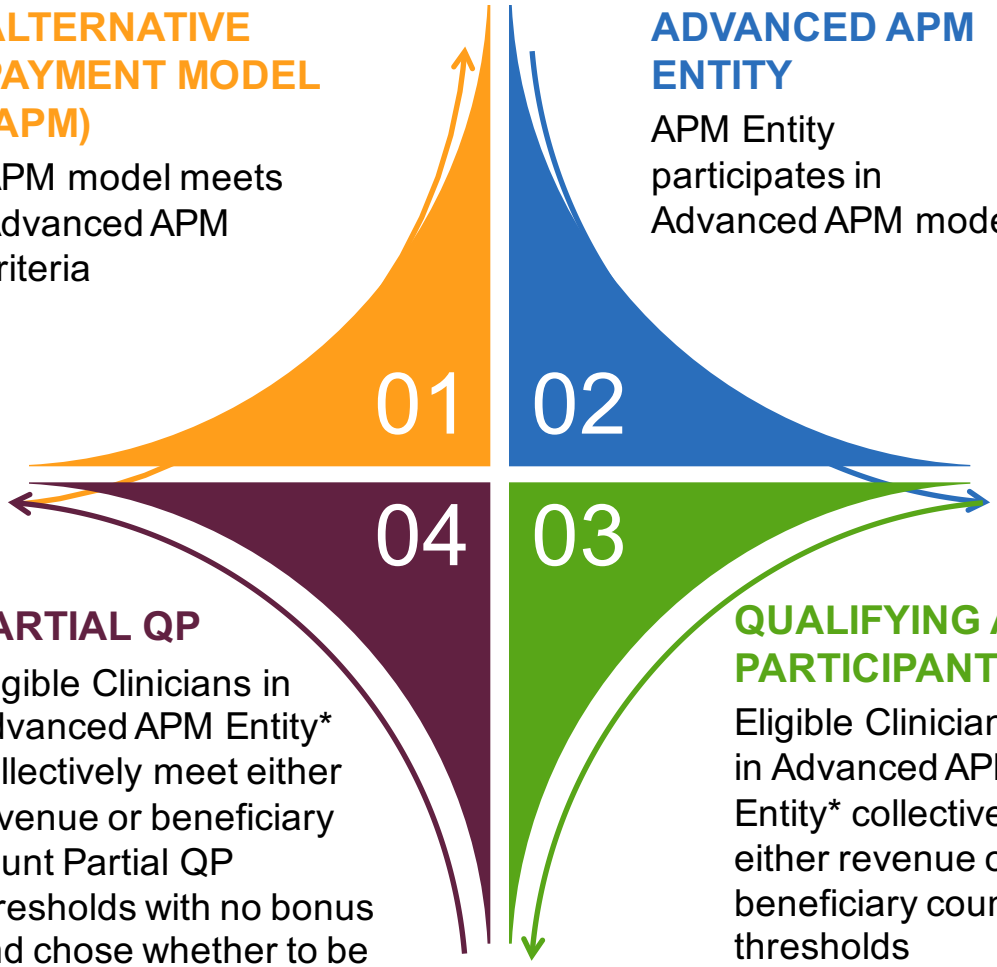
Public Reporting on Physician Compare

- 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
- Make information readily available in downloadable database, test to ensure information on public profile pages is meaningful to consumers

Advance Alternative Payment Model (APM) Incentive

Advanced APM

FIGURE B: Program Overview

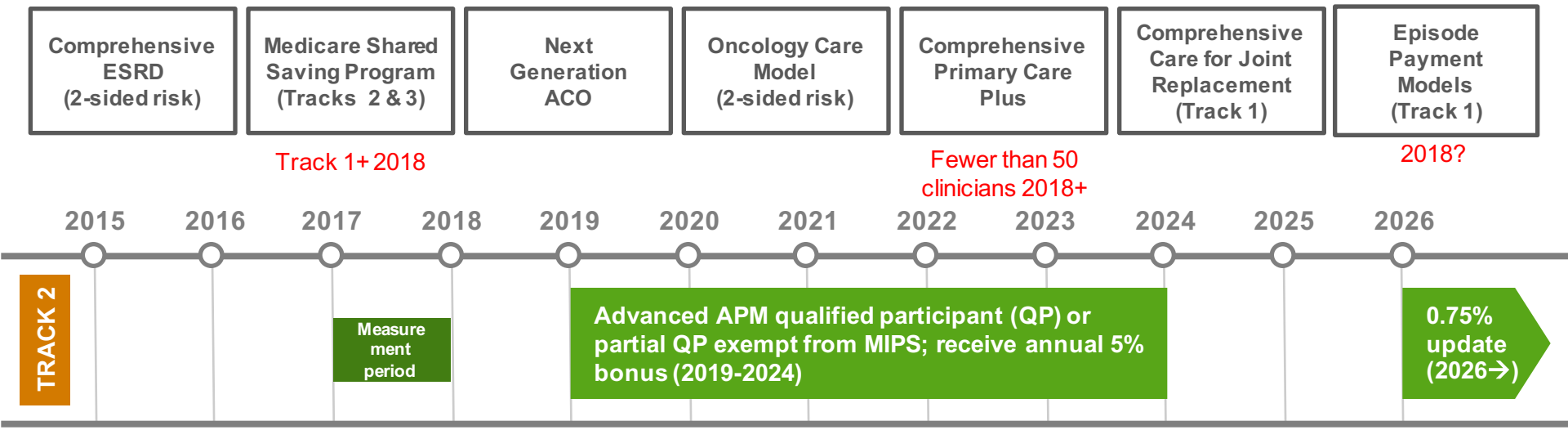


Qualifying APM Participants (QPs) are excluded from MIPS and get a lump sum incentive payment equal to 5% of the prior year's Part B covered professional services from 2019 – 2024. In 2026 and beyond, QPs get a 0.75% update vs. 0.25%.

*Individual level if CJR/EPM, an EP fails under multiple AAPMs, or 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

Changes to Terms and Definitions

- QP Performance Period
  - Support distinguishing between All-Payer and Medicare QP Performance periods
- Advanced APM Entity
  - Do not support dropping Advanced before APM entity as it could create confusion with APM models that meet criteria for the bonus and those that do not
- Associated Beneficiary
  - Apply to both Medicare and Other-Payer relationships
- Other Payer APMs
  - Support that Other Payer is non-Medicare
  - Support defining a Medicaid APM as meeting the Other Payer Advanced APM criteria

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

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.**

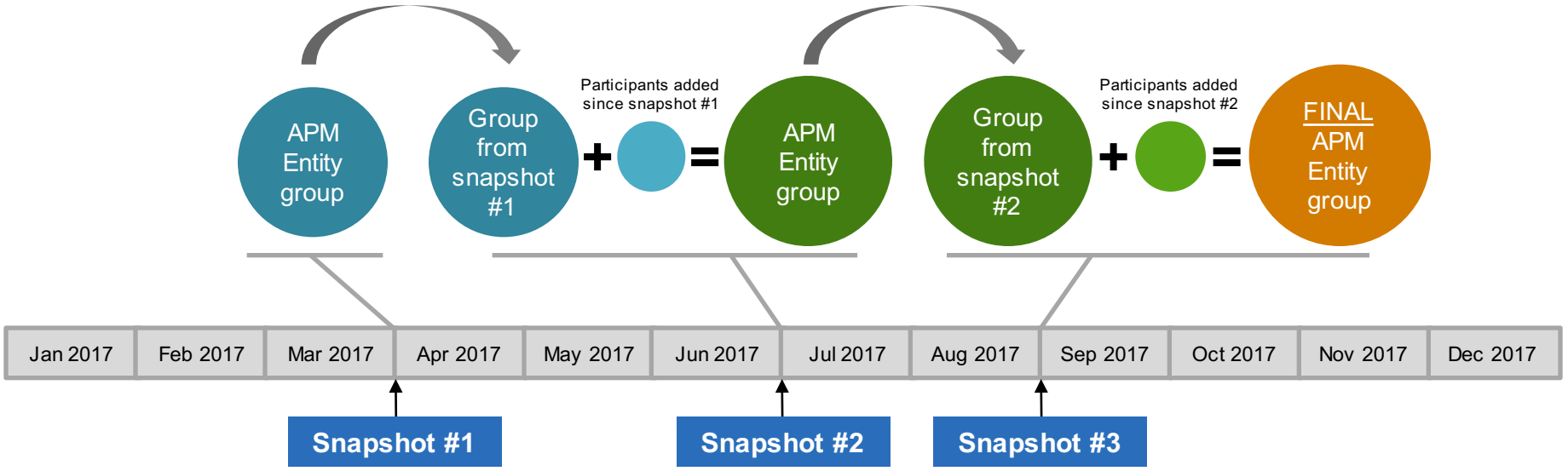
Risk Standard

- Revenue-based risk standard
  - Health system-based physicians are at a disadvantage
  - Including a hospital will trigger A/B threshold and increase required risk
  - Discourages collaboration between hospitals and physician groups
  - Revenue-based standard should be Part B only
  - Should be available for all provider types
- Medical Home Model
  - Create a pathway for specialty medical home to become AAPMs
  - Remove practice size constraints to level the playing field
  - Establish lower, comparable levels of risk for *all* APMs
    - Risk to owe or forego otherwise guaranteed payment is not equivalent to a baseline payment dollar at risk
    - Medical Home Entities should not have significantly lower risk
    - Will create market distortion as physicians will opt for this model over others with higher risk, and at the same time bifurcate hospitals into other models

Medicare QP/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; model must have been active for 60 days Support

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 should include MA as "Medicare" under the beneficiary count threshold starting in 2019**
- 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 Support method and that it is in advance**

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
  - Get rid of the marginal risk rate and the minimum loss rate
  - Lower the risk standards for all models and make them consistent

All Payer QP Determination

- Performance Period: Reduce from January 1- August 31 to January 1- June 30 Support; shorten claims run out to 60 days, and allow submission to CMS by November 1 to get early 2018 determination
  - Alternate proposals of maintaining existing or January- March
  - Allow for partial year determination for new models as proposed for Medicare
- Three snap shots: March 31, June 30 and August 31 (claims run out only)
- Determinations at the EC level
  - Allow determination at the group 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- If you do individual this methodology is ok
  - Better result will be used in the All Payer determination

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

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

All Payer QP Determination Process

- Support both EC and payer initiated processes
- Do not limit payers who can use payer-initiated process
- Extend option for Medicaid managed care plans to submit information for determination to CMS, rather than relying solely on states
- Hard to comment without forms available
- Contract provisions may be confidential, err on the side of attestation with follow up audits for a small sample to reduce burden
- Support allowing an individual clinician's documentation to suffice for 50% CEHRT requirement
    - Accept CHPL identification number in lieu of EHR contract language

Important Links

Premier detailed summary

Proposed Rule

CMS press release

CMS fact sheet

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Transforming Healthcare TOGETHER

Appendix

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

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%

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.

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%

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: 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

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		

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)			

All Payer QP Determination

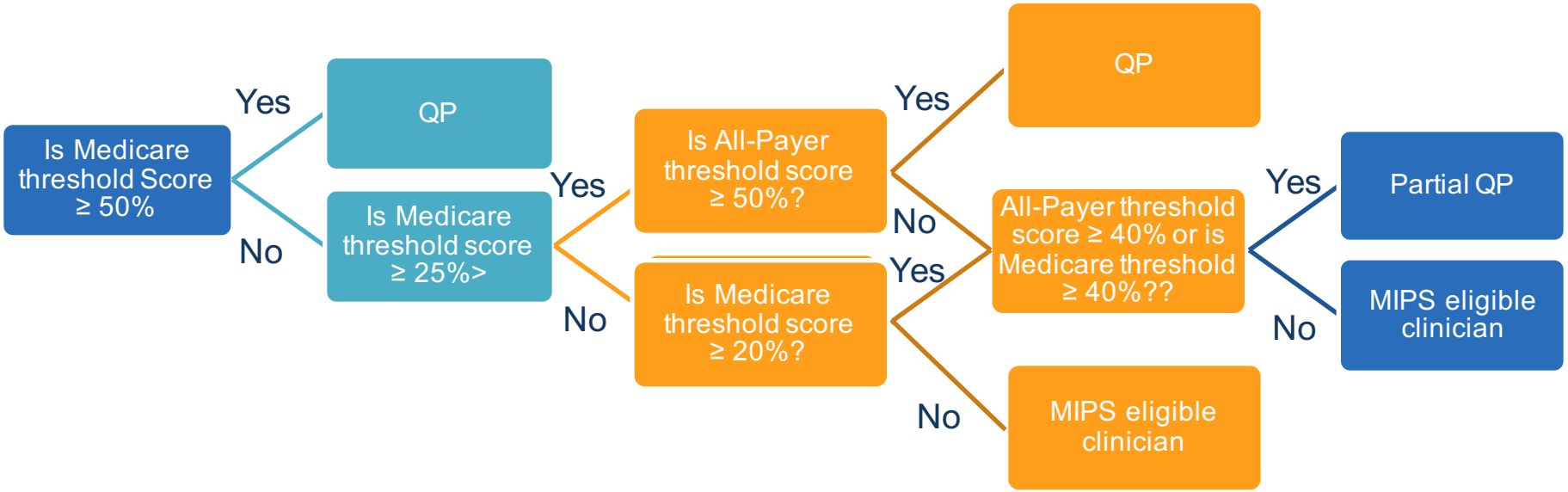
Payment Method

- 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

QP Determination Tree, Payment Years 2021-2022



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.

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
  - Consider an AAPM in 2019 and 2020 payment years
  - Stepwise approach for determination: Use MA only if don't meet QP with other Medicare options fist
- Other Payers
  - Defer payer initiated process to some point prior to 2020 All Payer QP Determination