

Quality Payment
PROGRAM

**PROPOSED RULE FOR
QUALITY PAYMENT
PROGRAM YEAR 2**



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- There will be a Q&A session if time allows. However, CMS must protect the rulemaking process and comply with the Administrative Procedure Act.
- Participants are invited to share initial comments or questions, but only comments formally submitted through the process outlined by the Federal Register will be taken into consideration by CMS.
- See the [proposed rule](#) for information on how to submit a comment.

Topics

- Overview
 - Quality Payment Program
 - Bedrock
 - How to Submit Comments
- Changes Proposed for Year Two
 - Merit-based Incentive Payment System (MIPS)
 - Alternative Payment Models (APMs)
- Resources

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

MIPS and Advanced APMs

The Quality Payment Program:

- We've heard concerns that too many quality programs, technology requirements, and measures get between the doctor and the patient. That's why we're taking a hard look at reducing burdens. By proposing this rule, we aim to improve Medicare by helping doctors and clinicians concentrate on caring for their patients rather than filling out paperwork. CMS will continue to listen and take actionable steps towards alleviating burdens and improving health outcomes for all Americans that we serve.

Clinicians have two tracks to choose from:



MIPS

The Merit-based Incentive
Payment System (MIPS)

If you decide to participate in MIPS, you may earn a performance-based payment adjustment through MIPS.

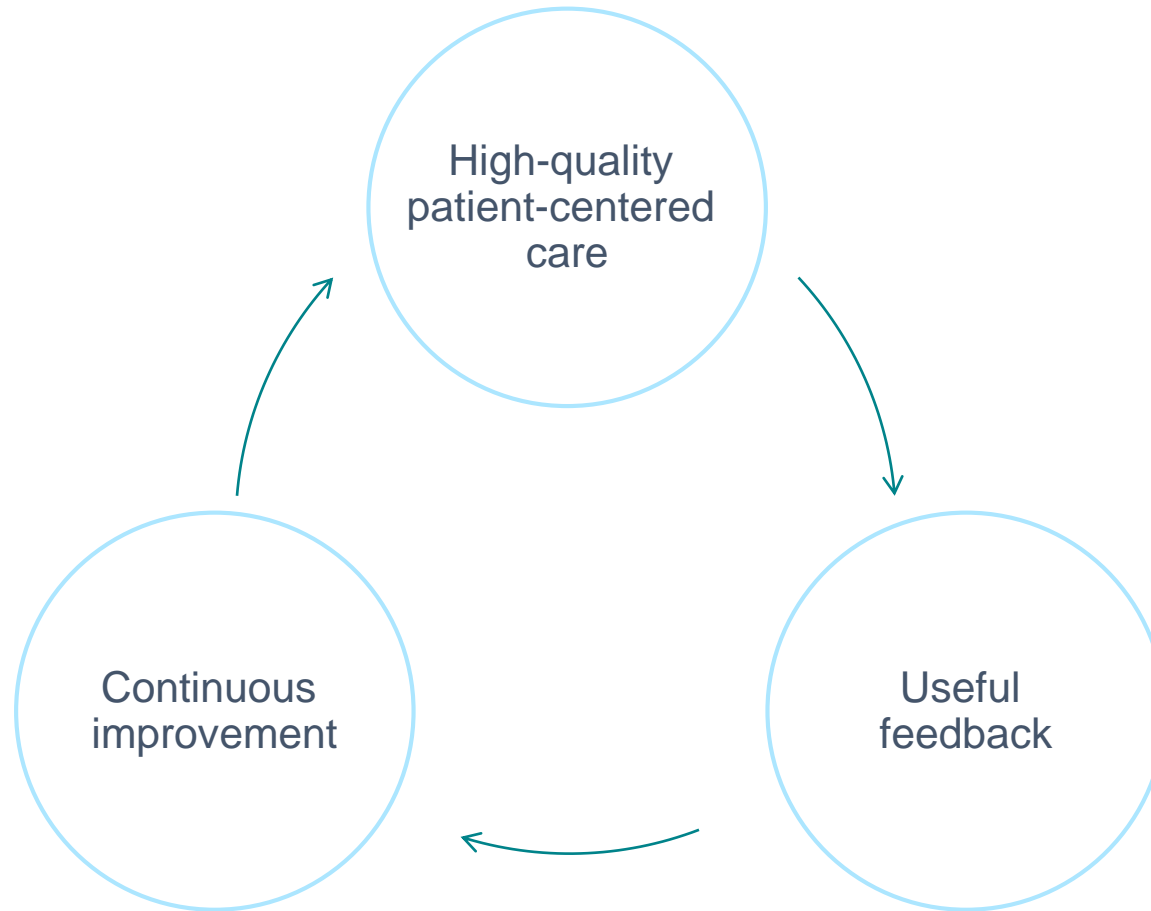
OR



Advanced
APMs

Advanced Alternative Payment
Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.



Quality Payment Program

Considerations

Quality Payment
PROGRAM

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of
Advanced APMs

Maximize participation

Improve data and
information sharing

Ensure operational excellence
in program implementation

Deliver IT systems capabilities
that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

Proposed Rule for Year 2

When and Where to Submit Comments

- The proposed rule includes proposed changes not reviewed in this presentation so please refer to the proposed rule for complete information.
- We will not consider feedback during the presentation as formal comments on the rule so please submit your comments in writing.
- See the proposed rule for information on submitting these comments by the close of the 60-day comment period on **August 21, 2017**. When commenting **refer to file code CMS 5522-P**.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
 - Regulations.gov
 - by regular mail
 - by express or overnight mail
 - by hand or courier
- For additional information, please go to: qpp.cms.gov

PROPOSED RULE FOR YEAR 2

Merit-based Incentive Payment
System

Proposed Rule for Year 2

Request for Comments: MIPS Proposals

Proposals	Seeking Comments
Raising the low-volume threshold to exclude individual MIPS eligible clinicians or groups who bill \leq \$90,000 Part B billing OR provide care for \leq 200 Part B enrolled beneficiaries	Opt-in option that would begin in 2019
Virtual groups	Definition and composition, election process, agreements, reporting requirements).
Facility-based measurement	Participation through opt-in or opt-out
Quality performance category	Increasing the data completeness threshold, process to cap and then eliminate topped out measures
Cost weight for 2018	Retaining it at 0% as indicated in the transition year final rule

Proposed Rule for Year 2

Request for Comments: MIPS Proposals

Proposals	Seeking Comments
Improvement activities	Future threshold for a group to get credit
Calculation for complex patient bonus	(using the HCC or dual eligible method).
Whether to have a bonus for practices in rural areas	(bonus proposed for small practices).
Whether the performance threshold should be set at a level other than 15 points	(possibly at 6 or 33 points).

Proposed Rule for Year 2

MIPS: Low-Volume Threshold

Transition Year 1 Final

Exclude individual MIPS eligible clinicians or groups who bill \leq \$30,000 in Part B allowed charges OR provide care for \leq 100 Part B enrolled beneficiaries during the performance period or a prior period.

Note: For the 2017 and 2018 MIPS performance periods, individual MIPS eligible clinicians and groups who are excluded may voluntarily participate in MIPS, but would not be subject to the MIPS payment adjustments.

Year 2 Proposed

Exclude MIPS eligible clinicians or groups who bill \leq \$90,000 in Part B allowed charges OR provide care for \leq 200 Part B enrolled beneficiaries during the performance period or a prior period.

Note: Starting with the 2019 performance period, individual MIPS eligible clinicians and groups who are excluded, but exceed one of the low-volume thresholds, would be able to opt-in to MIPS and be subject to the MIPS payment adjustments.

Proposed Rule for Year 2

Who Participates in MIPS?

- No change in the types of clinicians eligible to participate in 2018.
- Other types may be added for the 2019 MIPS performance period.
- The same exclusions will remain in the 2018 MIPS performance period:
 - Eligible clinicians new to Medicare.
 - Clinicians below the low-volume threshold.
 - Clinicians significantly participating in Advanced APMs.

Quick Tip:

Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

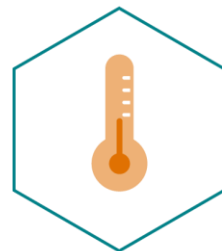
MIPS eligible clinicians include:



Physicians



Physician Assistants



Nurse Practitioners



Clinical Nurse
Specialists



Certified Registered
Nurse Anesthetists

Proposed Rule for Year 2

MIPS: Virtual Groups

- Definition: A combination of two or more Taxpayer Identification Numbers (TINs) composed of a solo practitioner (individual MIPS eligible clinician who bills under a TIN with no other NPIs billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year.
- All MIPS eligible clinicians within a TIN must participate in the virtual group.
- Virtual groups must elect to participate in MIPS as a virtual group prior to the beginning of the performance period and such election cannot be changed once the performance period starts. If TIN/NPIs move to an APM, we propose to use waiver authority to use the APM score over the virtual group score.

Proposed Rule for Year 2

MIPS: Virtual Groups

- Generally, policies that apply to groups would apply to virtual groups with a few exceptions such as the definition of a non-patient facing MIPS eligible clinician; and small practice, rural area, and Health Professional Shortage Area (HPSA) designations.
 - Virtual groups use same submission mechanisms as groups.
- Virtual groups may determine their own composition without restrictions based on geographic area or specialty.
- Initially, there will be no restriction on overall virtual group size.
- CMS will define a “Model Agreement” and will provide a template through additional communications guidance for virtual groups that choose to use it.

Proposed Rule for Year 2

MIPS: Non-patient Facing

- Non patient-facing:
 - Individuals ≤ 100 patient facing encounters.
 - Groups: $>75\%$ of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing.
 - Virtual Groups: $>75\%$ of NPIs within a virtual group during a performance period are labeled as non-patient facing.
- To reduce burden, non-patient facing MIPS eligible clinicians, groups, and virtual groups would have reduced requirements for two performance categories in the 2018 MIPS performance period.

For **improvement activities**, non-patient facing MIPS eligible clinicians, groups, and virtual groups can report fewer activities (2 medium or 1 high activity) and achieve a maximum improvement activities performance score.

For **advancing care information**, non-patient facing MIPS eligible clinicians, groups, and virtual groups qualify for the reweighting policy, which sets the performance category weight to zero and reallocates the points to other performance categories.

Proposed Rule for Year 2

MIPS: Performance Period

Transition Year 1 Final

- Minimum 90-day performance period for quality, advancing care information, and improvement activities. Exception: measures through CMS Web Interface, CAHPS, and the readmission measures are 12 months.
- Cost (which is not included in Year 1) is based on 12 months of data for feedback purposes only.

Year 2 Proposed

- 12-month calendar year for quality and cost performance categories.
- 90-days for advancing care information and improvement activities.
- Although the cost category will still be weighted at 0% for next year and clinicians don't need to report on this category, we will still provide feedback to clinicians on cost and we believe a 12-month period will provide more reliable measures.

Need to submit MIPS performance data by March 31, 2019

Proposed Rule for Year 2

MIPS: Performance Threshold

Transition Year 1 Final

- 3 points
- Additional performance threshold set at 70 points for exceptional performance.
- Payment adjustment for the 2019 MIPS payment year ranges from -4% to $+(4\% \times 3 \text{ scaling factor})$.

Year 2 Proposed

- 15 points
- Additional performance threshold remains at 70 points for exceptional performance.
- Payment adjustment for the 2020 MIPS payment year ranges from -5% to $+(5\% \times 3 \text{ scaling factor})$.

Some examples of how to achieve 15 points:

- Report all required improvement activities.
- Meet the advancing care information base score and submit 1 quality measure that meets data completeness.
- Meet the advancing care information base score, by reporting the 5 base measures, and submit one medium weighted improvement activity.
- Submit 6 quality measures that meet data completeness criteria.





Proposed Rule for Year 2

MIPS: Performance Threshold

Final Score (Transition Year)	Transition Year Payment Adjustment	Final Score (Year 2)	Year 2 Proposed Payment Adjustment
≥70 points	<ul style="list-style-type: none"> Positive adjustment Eligible for exceptional performance bonus—minimum of additional 0.5% 	≥70 points	<ul style="list-style-type: none"> Positive adjustment Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	<ul style="list-style-type: none"> Positive adjustment Not eligible for exceptional performance bonus 	16-69 points	<ul style="list-style-type: none"> Positive adjustment Not eligible for exceptional performance bonus
3 points	<ul style="list-style-type: none"> Neutral payment adjustment 	15 points	<ul style="list-style-type: none"> Neutral payment adjustment
0 points	<ul style="list-style-type: none"> Negative payment adjustment of -4% 0 points = does not participate 	0 points	<ul style="list-style-type: none"> Negative payment adjustment of -5% 0 points = does not participate

Submission Mechanisms

MIPS

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups
 <p>Quality</p>	<p>Claims</p> <p>QCDR</p> <p>Qualified registry</p> <p>EHR</p>	<p>QCDR</p> <p>Qualified registry EHR</p> <p>CMS Web Interface (groups of 25 or more)</p> <p>CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.)</p> <p>Administrative claims (for readmission measure – no submission required)</p>
 <p>Cost</p>	<p>Administrative claims (no submission required)</p>	<p>Administrative claims (no submission required)</p>
 <p>Advancing Care Information</p>	<p>Attestation</p> <p>QCDR</p> <p>Qualified registry</p> <p>EHR</p>	<p>Attestation</p> <p>QCDR</p> <p>Qualified registry</p> <p>EHR</p> <p>CMS Web Interface (groups of 25 or more)</p>
 <p>Improvement Activities</p>	<p>Attestation</p> <p>QCDR</p> <p>Qualified registry</p> <p>EHR</p>	<p>Attestation</p> <p>QCDR</p> <p>Qualified registry</p> <p>EHR</p> <p>CMS Web Interface (groups of 25 or more)</p>

Proposed Rule for Year 2

MIPS: Submission Mechanisms

Transition Year 1 Final

Only one submission mechanism is allowed per performance category.

Year 2 Proposed

- No change in the types of submission mechanisms available in each performance category.
- Virtual groups would have the same submission mechanisms available to groups.
- Multiple submission mechanisms would be allowed (except for CMS Web Interface) as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories.

Proposed Rule for Year 2

MIPS: Facility Based Measurement

Year 2 Proposed

- Facility-based measurement assesses clinicians in the context of the facilities at which they work to better measure their quality.
- Facility-based scoring will be implemented in a limited fashion in the first year for the quality and cost performance categories.
- This voluntary facility-based scoring mechanism will be aligned with the Hospital Value Based Purchasing Program (Hospital VBP) to help reduce burden for clinicians.
- Eligible as individual: You must have 75% of services in the inpatient hospital or emergency room.

- Eligible as group: 75% of eligible clinicians must meet eligibility criteria as individuals.
- We propose for the 2020 MIPS payment year to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality and cost measures.
- Scores are derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries.
- The facility-based measurement option converts a hospital Total Performance Score into a MIPS quality performance category and cost performance category score.
- Facility-based measurement (participation through opt-in or opt-out).

Proposed Rule for Year 2

MIPS: Quality



Weight to final score:

- Retain 60% in 2020 payment year
- Maintain 30% in 2021 payment year and beyond

Data completeness:

- No change, but we intend to increase the data completeness threshold to 60% for the 2019 MIPS performance period.
- Measures that fail data completeness will receive 1 point instead of 3 points, **except that small practices will continue to receive 3 points**

Scoring:

- Maintain 3-point floor for measures scored against a benchmark.
- Maintain 3 points for measures that do not have a benchmark or do not meet case minimum.
- No change to bonuses.
- Proposed changes to CAHPS survey collection and scoring.

Proposed Rule for Year 2

MIPS: Quality Topped Out Measures



- Starting with the 2018 MIPS performance period, in the second consecutive year, or beyond, we will apply a cap of 6 points for a select set of 6 topped out measures.
- We propose after three years to consider removal of consider removing the topped out measures through notice and comment rulemaking for the fourth year.
- This policy would not apply to CMS Web Interface measures.

Proposed Rule for Year 2

MIPS: Cost



Weight to final score:

- Propose 0% in 2020 MIPS payment year but seek comment on a 10% weight.
- Maintain 30% in 2021 MIPS payment year and beyond.

Measures:

- Even though we are proposing that the cost performance category be weighted at 0, we are proposing to calculate measures for feedback purposes.
- Include only the Medicare Spending Per Beneficiary (MSPB) and total per capita cost measures in calculating cost performance category score.
- Did not include previous episode-based measures as we continue to develop new episode-based measures in collaboration with expert clinicians.
- We'll continue to offer feedback on episode-based measures prior to potential inclusion of these measures in MIPS to increase clinician familiarity with these measures.

Scoring:

- Cost improvement scoring is proposed, but will not contribute to the 2018 final score.

Proposed Rule for Year 2

MIPS: Improvement Activities



Weight to final score:

- No change.
- Remains at 15%.

Number of activities:

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.
- We are proposing additional activities, and changes to existing activities for the Improvement Activities Inventory including credit for using Appropriate Use Criteria (AUC).
- We expand the definition of certified patient centered medical home, to include the CPC+ model, and clarify that the term “recognized” is equivalent to the term “certified” as a patient centered medical home or comparable specialty practice.
- For the number of practice sites within a TIN that need to be recognized as patient-centered medical homes for the TIN to receive the full credit for improvement activities, we propose a threshold of 50% for 2018.

Proposed Rule for Year 2

MIPS: Improvement Activities



Scoring:

- Continue to designate activities within the performance category that also qualify for an advancing care information bonus.
- For group reporting, only one MIPS eligible clinician in a TIN must perform the improvement activity for the TIN to receive credit. We recommend no change to this policy for 2018, but seek comment on a threshold for the future.
- Continue to allow simple attestation of improvement activities.

Proposed Rule for Year 2

MIPS: Advancing Care Information



- Allow clinicians to use either the 2014 or 2015 CEHRT Edition in 2018 and provide a bonus for use of 2015 CEHRT edition.
 - Add more improvement activities to the list eligible for an advancing care information bonus.
 - Expand options beyond the one immunization registry reporting measure for 10% toward the performance score and allow reporting on a combination of other public health registry measures that may be more readily available for 5% each toward the performance score (up to 10%).
 - For the 5% bonus, must report to a different public health agency or registry than those used to earn the performance score.
- Add a decertification hardship for eligible clinicians whose EHR was decertified.
 - Change the deadline for the significant hardship application for 2017 and going forward to be December 31 of the performance period.
 - Add new category of exception, for MIPS eligible clinicians in small practices and those practicing in HPSAs to reweight advancing care information category to zero and reallocating the 25% to the quality performance category.

Proposed Rule for Year 2

MIPS: Advancing Care Information



- Enacted in 2016, the 21st Century Cures Act contains provisions affecting how CEHRT impacts the Quality Payment Program's current transition year and future years.
- The 21st Century Cures Act was enacted after the publication of the Quality Payment Program Year 1 Final Rule. In the Year 2 proposed rule, CMS is proposing to implement the provisions in the 21st Century Cures Act, some of which will apply to the MIPS transition year:
 - Reweighting the Advancing Care Information performance category to 0% of the final score for ambulatory surgical center (ASC)-based MIPS eligible clinicians.
 - Using the authority for significant hardship exceptions and hospital-based MIPS eligible clinicians for the Advancing Care Information performance category the 21st Century Cures Act grants CMS.

Proposed Rule for Year 2

MIPS Scoring: Scoring Improvements

Rewards improvement in performance for a MIPS eligible clinician or group for a current performance period compared to the prior performance period

- **For quality:**
 - Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well.
 - Improvement is measured at the performance category level.
 - Up to 10 percentage points available in the performance category.
- **For cost:**
 - Improvement scoring will be based on statistically significant changes at the measure level.
 - Although, we propose an improvement scoring methodology for cost, it would not affect the MIPS final score for the 2020 MIPS payment year.
 - No improvement percentage points available for the cost category for the 2020 payment year. (The weight for the cost category is proposed to be 0 in 2020.)

In 2020, Improvement percentage points will be added to the quality performance category, but the performance category scores cannot exceed 100%.

Proposed Rule for Year 2

MIPS Scoring: Complex Patient Bonus

- Apply an adjustment of 1 to 3 bonus points to the final score by adding the average Hierarchical Conditions Category (HCC) risk score to the final score.
- Generally, this will award between 1 to 3 points to clinicians based on the medical complexity for the patients treated.

Proposed Rule for Year 2

MIPS Scoring: Small Practice Bonus

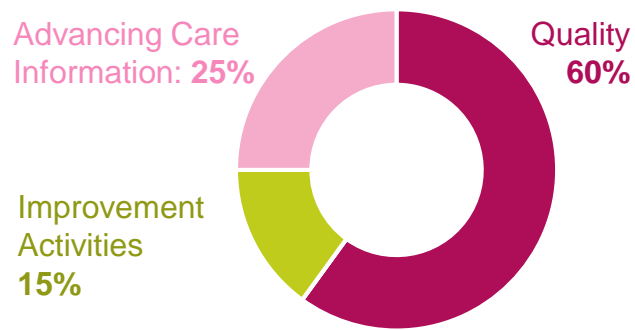
- Adjust the final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians) by adding 5 points, so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.
- Seek comment on whether the small practice bonus should be extended to those who practice in rural areas as well.
- Add **5 additional points** for small practices to the final score.

We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements to incentivize their participation.

Proposed Rule for Year 2

MIPS Scoring: 2018 MIPS Performance Year Final Score

- Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%.



- Continue to allow reweighting of the advancing care information performance category to the quality performance category (for hardships, and other specified situations).
- Proposed Propose new extenuating circumstances for quality, cost, and improvement activities performance categories.

- Add 5 bonus points for small practices.
- Add 1 to 3 points to the final score for caring for complex patients.
- Add a 10-point bonus for those clinicians who use 2015 CEHRT.
- Seek comment on adding bonus points for practices in rural areas.

PROPOSED RULE FOR YEAR 2

Alternative Payment Models (APMs)

What are Alternative Payment Models (APMs)?

- APMs are approaches to paying for health care that incentivize quality and value.
- As defined by MACRA, APMs include CMS Innovation Center models (under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- To be an Advanced APM, a model must meet the following three requirements:
 - Requires participants to use **certified EHR technology**;
 - Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
 - Either: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk**.
- In order to qualify for a 5% APM incentive payment, model participants must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance year.

Proposed Rule for Year 2

Advanced APMs: Generally Applicable Nominal Amount Standard

Transition Year 1 Final

- Total potential risk under the APM must be equal to at least either:
 - 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018, or
 - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 Proposed

- The 8% revenue-based standard is extended for two additional years, through performance year 2020.

A Medical Home Model is an APM that has the following features:



Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.



Empanelment of each patient to a primary clinician; and



At least four of the following additional elements:

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- 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.

Medical Home models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Advanced APM.

Proposed Rule for Year 2

Advanced APMs: Medical Home Model 50 Clinician Cap

Transition Year 1 Final

- For performance year 2018 and thereafter, the medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization.

Year 2 Proposed

- Exempts Round 1 participants in the Comprehensive Primary Care Plus Model (CPC+) from the requirement that medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization

Proposed Rule for Year 2

Advanced APMs: Medical Home Model Nominal Amount Standard

Transition Year 1 Final

- Total potential risk for an APM Entity must be equal to at least:
 - 2.5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2017.
 - 3% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2018.
 - 4% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2019.
 - 5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2020.

Year 2 Proposed

- Total potential risk for an APM Entity is adjusted, so that it must be equal to at least:
 - 2% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2018.
 - 3% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2019.
 - 4% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2020.
 - 5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2021 and after.

Proposed Rule for Year 2

All-Payer Combination Option: Summary

- The All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP or Partial QP.
- QP Determinations under the All-Payer Combination Option will be based on an eligible clinicians' participation in a combination of both Advanced (Medicare) APMs and Other Payer Advanced APMs.
- QP Determinations are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option. Only clinicians who fail to become QPs under the Medicare Option will need to participate in the All-Payer Combination Option.
- The All-Payer Combination Option is available beginning in the 2019 QP Performance Period.

- The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used within Medicare:
 - Requires at least 50 percent of eligible clinicians to use **certified EHR technology** to document and communicate clinical care information.
 - Base payments for covered professional services on **quality measures** that are comparable to those used in the MIPS quality performance category.
 - Either: (1) is a **Medicaid Medical Home Model** that meets criteria that is comparable to a **Medical Home Model expanded** under CMS Innovation Center authority, OR (2) Require **participants to bear a more than nominal amount of financial risk**.

Proposed Rule for Year 2

All-Payer Combination Option: Generally Applicable Nominal Amount Standard

Transition Year 1 Final

- Nominal amount of risk must be:
 - Marginal Risk of at least 30%;
 - Minimum Loss Rate of no more than 4%; and
 - Total Risk of at least 3% of the expected expenditures the APM Entity is responsible for under the APM.

Year 2 Proposed

- Maintain the Marginal Risk and Minimum Loss Rate requirements.
- Add a revenue-based nominal amount standard for total risk of 8%. This standard would be an additional option (in addition to the previously finalized expenditure-based standard) and would only apply to models in which risk for APM Entities is expressly defined in terms of revenue.

Proposed Rule for Year 2

All-Payer Combination Option: QP Determinations

Transition Year 1 Final

- QP determinations under the All-Payer Combination Option would be made at either the APM Entity or individual eligible clinician level, depending on the circumstances.

Year 2 Proposed

- QP determinations would be made at the individual eligible clinician level only.

We are proposing to calculate QP determinations under the All-Payer Combination Option at the individual eligible clinician level only. This proposal aims to account for the fact that participation in APMs will vary across payer; the eligible clinicians participating in an APM in Medicare may not be identical to eligible clinicians who participate in an APM in a commercial payer or Medicaid.

Proposed Rule for Year 2

All-Payer Combination Option: Determination of Other Payer Advanced APMs

Transition Year 1 Final

- Eligible Clinicians (or APM entities on their behalf) would report information about the payment arrangements they participate in after the 2019 QP Performance Period.

Year 2 Proposed

- Would establish:
 - A voluntary Payer-Initiated Process that would allow payers to report payment arrangements and request that CMS can determine whether they qualify as Other Payer Advanced APMs.
 - An Eligible Clinician-Initiated Process in which eligible clinicians would report payment arrangements that had not previously been reported by payers.

Proposed Rule for Year 2

All-Payer Combination Option: Determination of Other Payer Advanced APMs

- Prior to each All-Payer QP Performance Period, CMS would make Other Payer Advanced APM determinations based on information voluntarily submitted by payers.
- This payer-initiated process would be available for Medicaid, Medicare Advantage, and CMMI multi-payer models for performance year 2019. We intend to add remaining payer types in future years.
- APM Entities and eligible clinicians would also have the opportunity to submit information regarding the payment arrangements in which they were participating in the event that the payer had not already done so.
- Guidance and submission forms for both payers and clinicians would be made available for each other payer type early in the calendar year prior to each All-Payer QP Performance Period.
- Note, that the specific deadlines and processes for submitting payment arrangements will vary by payer type (Medicaid, Medicare Advantage, etc.) in order to align with pre-existing processes and meet statutory requirements.

APM SCORING STANDARD

What is the APM scoring standard?

The APM scoring standard offers a special, minimally-burdensome way of participating in MIPS for eligible clinicians in APMs who do not meet the requirements to become QPs and are therefore subject to MIPS, or eligible clinicians who meet the requirements to become a Partial QP and therefore able to choose whether to participate in MIPS . The APM scoring standard **applies to APMs that meet the following criteria:**

- ✓ APM Entities participate in the APM under an **agreement with CMS;**
- ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
- ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization** and **quality**.

Proposed Rule for Year 2

Category Weighting for MIPS APMs

- In the 2017 rule, we finalized different scoring weights for ACO models (including the Medicare Shared Savings Program and the Next Generation ACO model) which were assessed on quality, and other MIPS APMs, which had quality weighted to zero. For 2018 we are proposing to align weighting across all MIPS APMs, and assess all MIPS APMs on quality

Domain	Transition Year		Year 2 Proposed
	SSP & Next Generation ACOs	Other MIPS APMs	All MIPS APMs
Quality	50%	0%	50%
Cost	0%	0%	0%
Improvement Activities	20%	25%	20%
Advancing Care Information	30%	75%	30%

Proposed Rule for Year 2

MIPS APMs: Additional Changes for Year 2

- We are proposing additional details on how the quality performance category will be scored under the APM scoring standard for non-ACO models, who had quality weighted to zero in 2017. In 2018, participants in these models will be scored under MIPS using the quality measures that they are already required to report on as a condition of their participation in their APM.
- A fourth snapshot date of **December 31st** would be added for full TIN APMs for determining which eligible clinicians are participating in a MIPS APM for purposes of the APM scoring standard. This would allow participants who joined certain APMs between September 1st and December 31st of the performance year to benefit from the APM scoring standard.

QUALITY PAYMENT PROGRAM

Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.



Locate the PTN(s) and SAN(s) in your state

LARGE PRACTICES

Quality Innovation Networks- Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.



Locate the QIN-QIO that serves your state

Quality Innovation Network
(QIN) Directory

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.



TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:



Quality Payment Program Website: qpp.cms.gov

Serves as a starting point for information on the Quality Payment Program.



Quality Payment Program Service Center

Assists with all Quality Payment Program questions.

1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov



Center for Medicare & Medicaid Innovation (CMMI) Learning Systems

Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide:
<https://qpp.cms.gov/resources/education>

- See the proposed rule for information on submitting these comments by the close of the 60-day comment period on **August 21, 2017**. When commenting **refer to file code CMS 5522-P**.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
 - Regulations.gov
 - by regular mail
 - by express or overnight mail
 - by hand or courier
- For additional information, please go to: qpp.cms.gov

- CMS must protect the rulemaking process and comply with the Administrative Procedure Act.
- Participants are invited to share initial comments or questions, but only comments formally submitted through the process outlined by the Federal Register will be taken into consideration by CMS.
- See the [proposed rule](#) for information on how to submit a comment.

