Quality Payment
PROGRAM

Proposed Rule for Quality Payment Program Year 2

The Quality Payment Program, established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), began in 2017, known as the transition year. The Program's main goals are to:

- Improve health outcomes.
- Spend wisely.
- Minimize burden of participation.
- Be fair and transparent.

The Quality Payment Program has 2 tracks: (1) The Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs).

Because the Quality Payment Program brings significant changes to how clinicians are paid within Medicare, the Centers for Medicare & Medicaid Services (CMS) is continuing to go slow and use stakeholder feedback to find ways to streamline and reduce clinician burden, and make it easier for clinicians to participate and put their patients first. CMS has engaged more than 100 stakeholder organizations and over 47,000 people since January 1, 2017 to raise awareness, solicit feedback, and help clinicians prepare to participate. Based on stakeholder feedback, CMS established transition year policies from the clinician perspective, such as:

- Giving clinicians the option to choose how they'll participate. (For the 2017 transition year, MIPS eligible clinicians have the opportunity to "pick their pace" of participation in the performance period by submitting a minimum amount of data, 90-days of data, or a full year of data.)
- Having a low-volume threshold that exempts many clinicians with a low volume of Medicare Part B payments or patients.
- Allowing flexibilities for clinicians who are considered hospital-based or have limited face-to-face encounters with patients (referred to as non-patient facing clinicians).

As the Quality Payment Program moves into the second year, CMS wants to ensure that there is meaningful measurement and the opportunity for improved patient outcomes while minimizing burden, improving coordination of care for patients, and supporting a pathway to participation in Advanced APMs. In the second year of the Quality Payment Program, similar to "pick your pace," CMS is continuing to propose many flexibilities that make it easy for clinicians to participate and that gradually prepare clinicians for full implementation. Please note that CMS refers to the second year of program as "The Quality Payment Program Year 2" rather than "pick your pace."

Quality Payment Program Year 2 Proposals: MIPS

For the Quality Payment Program Year 2, CMS wants to keep what's working and use stakeholder and clinician feedback to improve the policies finalized in the transition year. Some prominent proposals include modestly increasing the performance period requirements to include a full year of data for the Quality and Cost performance categories, though CMS would not use Cost performance scores for final score determination. CMS is also proposing to

increase the performance period to 90-days of data for the Improvement Activities and Advancing Care Information performance categories. In an effort to continue to reduce burden and offer flexibilities to help clinicians to successfully participate, other proposals include:

- Offering the Virtual Groups participation option.
- Increasing the low-volume threshold so that more small practices and eligible clinicians in rural and Health Professional Shortage Areas (HPSAs) are exempt from MIPS participation.
- Continuing to allow the use of 2014 Edition CEHRT (Certified Electronic Health Record Technology), while encouraging the use of 2015 edition CEHRT.
- Adding bonus points in the scoring methodology for:
  - Caring for complex patients.
  - Using 2015 Edition CEHRT exclusively.
- Incorporating MIPS performance improvement in scoring quality performance.
- Incorporating the option to use facility-based scoring for facility-based clinicians.

What are Virtual Groups?

The Year 2 proposed rule offers Virtual Group participation, which is another way clinicians can elect to participate in MIPS.

Virtual Groups would be composed of solo practitioners and groups of 10 or fewer eligible clinicians, eligible to participate in MIPS, who come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year.

Our goal is to make it as easy as possible for Virtual Groups to form no matter where the group members are located or what their medical specialties are. Generally, clinicians in a Virtual Group will report as a Virtual Group across all 4 performance categories and will need to meet the same measure and performance category requirements as non-virtual MIPS groups.

CMS is also proposing more flexibilities for clinicians in small practices that would:

- Add a new hardship exception for clinicians in small practices under the Advancing Care Information performance category.
- Add bonus points to the Final Score of clinicians in small practices.
- Continue to award small practices 3 points for measures in the Quality performance category that don't meet data completeness requirements.

Based on stakeholder and clinician feedback, CMS has proposed policies with respect to the use of Appropriate Use Criteria, and certain policies enacted under the 21st Century Cures Act that affect the Quality Payment Program.

Appropriate Use Criteria (AUC)

The AUC were first introduced in the calendar year (CY) 2016 Physician Fee Schedule Final Rule with Comment Period. More policies were added to the AUC in the CY 2017 Physician Fee Schedule Final Rule. The evidence-based AUC will help clinicians who order and furnish advanced diagnostic imaging services make the most appropriate treatment decisions for specific clinical conditions.

For the 2018 MIPS performance period, CMS proposes adding a new improvement activity that MIPS eligible clinicians could choose if they attest they're using AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered.

21st Century Cures Act

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.

Quality Payment Program Year 2 Proposals: APMs

CMS is keeping many of the policies finalized for the transition year, and is proposing changes and updates, including:

- Extending the revenue-based nominal amount standard, which was previously finalized through performance year 2018, for two additional years (through performance year 2020). This standard allows an APM to meet the financial risk criterion to qualify as an Advanced APM if participants are required to bear total risk of at least 8% of their Medicare Parts A and B revenue.
- Changing the nominal amount standard for Medical Home Models so that the minimum required amount of total risk increases more slowly.
- Giving more detail about how the All-Payer Combination Option will be implemented. This option allows clinicians to become Qualifying APM Participants (QPs) through a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs. This option will be available beginning in performance year 2019.
- Giving more detail on how eligible clinicians participating in selected APMs will be assessed under the APM scoring standard. This special standard reduces burden for certain APMs (MIPS APMs) participants who do not qualify as QPs, and are therefore subject to MIPS.

Comparison of current policies to proposed policies:

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
MIPS POLICY		
Low-Volume Threshold	Exclude individual MIPS eligible clinicians or groups with ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries during a low-volume threshold determination period that occurs during the performance period or a prior period.	Increase the threshold to exclude individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries during a low-volume threshold determination period that occurs during the performance period or a prior period. Starting with 2019 MIPS performance period: let clinicians opt-in to MIPS if they exceed 1 or 2 of the low-volume threshold components: • Medicare revenue, or • Number of Medicare patients. Additionally, CMS is proposing that in 2019 the opt-in process would be allowable for 3 items, and is seeking comment on a 3rd potential component: • Number of Part B items and services
Non-Patient Facing	• Individual's ≤100 patient facing encounters. • Groups: > 75% NPIs billing under the group's TIN during a	There is no change in how CMS is defining non-patient facing clinicians, however;

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	performance period are labeled as non-patient facing.	CMS is proposing the same definition for Virtual Groups. • Virtual Groups: > 75% NPIs within a Virtual Group during a performance period are labeled as non-patient facing.
Submission Mechanisms	• MIPS eligible clinicians required to use only 1 submission mechanism per performance category.	• Allow individual MIPS eligible clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category as available and applicable to meet the requirements of the Quality, Improvement Activities, or Advancing Care Information performance categories.
Virtual Groups	Not available in current transition year.	Key Proposals: • Adding Virtual Groups as participation option for year 2, which would be composed of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		• In order for solo practitioners to be eligible to join a Virtual Group, they would need to meet the definition of a MIPS eligible clinician and not be excluded from MIPS based on one of the 4 exclusions (new Medicare-enrolled eligible clinician; Qualifying APM Participant; Partial Qualifying APM Participant who chooses not to report on measures and activities under MIPS; and those who do not exceed the low-volume threshold). In order for groups of 10 or fewer eligible clinicians to be eligible to participate in MIPS as part of a Virtual Group, groups would need to exceed the low-volume threshold at the group level. A group that is part of a Virtual Group may include eligible clinicians who do not meet the definition of a MIPS eligible clinician or may be excluded from MIPS based on one of the four exclusions. • Allow flexibility for solo practitioners and groups of 10 or fewer eligible clinicians to decide if they want to join or form a

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		Virtual Group with other solo practitioners or groups of 10 or fewer eligible clinicians, regardless of location or specialties. • If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would be part of the Virtual Group. • CMS proposes various components that would need to be included in a formal written agreement between each member of the Virtual Group. • Virtual Groups that choose this participation option would need to make an election prior to the 2018 performance period (as outlined in the MACRA legislation). • If/when TIN/NPIs move to an APM, CMS proposes to exercise waiver authority so that CMS can use the APM score instead of the Virtual Group score. • Generally, policies that apply to groups would apply to Virtual Groups, except the following group-related policies: ○ Definition of non-patient facing MIPS eligible clinician.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		○ Small practice status. ○ Rural area and Health Professional Shortage Area designations.
Facility-Based Measurement	Not available in current transition year.	• Implement an optional voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. • Available only for facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital setting or emergency department. • The facility-based measurement option converts a hospital Total Performance Score into a MIPS Quality performance category and Cost performance category score.
Quality	**Weight to final score:** • 60% in 2019 payment year. • 50% in 2020 payment year. • 30% in 2021 payment year and beyond. **Data completeness:** • 50% for submission mechanisms except for Web Interface and CAHPS.	**Weight to final score:** • 60% in 2020 payment year. • 30% in 2021 payment year and beyond. **Data completeness:** • No change, but CMS proposes to increase the data completeness threshold to 60% for the

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	• Measures that do not meet the data completeness criteria receive 3 points. **Scoring:** • 3-point floor for measures scored against a benchmark. • 3 points for measures that don't have a benchmark or don't meet case minimum requirements. • 3 points for measures that do not meet data completeness. • Bonus for additional high priority measures up to 10%. • Bonus for end-to-end electronic reporting up to 10%.	2019 MIPS performance period. • Measures that do not meet data completeness criteria will get 1 point instead of 3 points, except that small practices will continue to get 3 points. **Scoring:** • Keep 3-point floor for measures scored against a benchmark. • Keep 3 points for measures that don't have a benchmark or don't meet case minimum requirement. • Measures that do not meet data completeness requirements will get 1 point instead of 3 points, except that small practices will continue to get 3 points. • No change to bonuses. • Proposed changes to the CAHPS for MIPS survey collection and scoring.
Quality/ Topped Out Quality Measures	No policies established in the current transition year.	• Starting with the 2018 MIPS performance year, in the second consecutive year, or beyond, CMS proposes to use a cap of 6 points for a select set of 6 topped out measures. • CMS proposes to identify topped out measures, and after 3 years, to consider

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		removal from the program through rulemaking in the 4th year. • This policy on topped out measures wouldn't apply to CMS Web Interface measures.
Cost	**Weight to final score:** • 0% in 2019 payment year. • 10% in 2020 payment year. • 30% in 2021 payment year and beyond. **Measures:** • Will include the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures. • 10 episode-based cost measures. • Measures do not contribute to the score, feedback is provided for these measures.	**Weight to final score:** • CMS proposes 0% in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at 10%. • 30% in 2021 MIPS payment year and beyond. **Measures:** • Include only the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures in calculating Cost performance category score for the 2018 MIPS performance period. However, these measures will not contribute to the 2018 final score if the Cost performance category is finalized to be weighted at 0%. • CMS expects to replace previous episode-based cost measures are developed in collaboration with expert clinicians and other stakeholders.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
Improvement Scoring for Quality and Cost	• Not applicable in the current transition year.	• Rewards improvement in performance (applicable to the Quality and Cost performance categories only) for an individual 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 so that higher improvement results in more points, particularly for those improving from lower performance in the transition year. ○ Improvement is measured at the Quality performance category level. ○ Up to 10 percentage points available in the Quality performance category. **For Cost:** • Improvement scoring will be based on statistically significant changes at the measure level. • CMS proposes an improvement scoring methodology for Cost, but

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		it wouldn't affect the MIPS final score for the 2020 MIPS payment year if the Cost performance category weight is finalized at 0%. CMS will add improvement percentage points to the Quality performance category and Cost performance category scores (beginning in the 2021 payment year for cost), but the performance category scores can't exceed 100%.
Improvement Activities	**Weight to final score:** • 15% and measured based on a selection of different medium and high-weighted activities. **Number of activities:** • No more than 2 activities (2 medium or 1 high-weighted activity) are needed to receive the full score for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians. • No more than 4 activities (4 medium or 2 high-weighted activities, or a combination) for all other MIPS eligible clinicians. • Total of 40 points. • 92 activities were included in the Inventory.	**Weight to final score:** • No change. **Number of activities:** • No change in the number of activities that MIPS eligible clinicians have to report to reach a total of 40 points. • CMS is proposing more activities to choose from and changes to existing activities for the Inventory. • MIPS eligible clinicians in small practices and practices in a rural areas will keep reporting on no more than 2 medium or 1 high-weighted activity to reach the highest score.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	Definition of certified patient-centered medical home: • Includes accreditation as a patient-centered medical home from 1 of 4 nationally-recognized accreditation organizations; a Medicaid Medical Home Model or Medical Home Model; NCQA patient-centered specialty recognition; and certification from other payer, state or regional programs as a patient-centered medical home if the certifying body has 500 or more certified member practices. • Only 1 practice within a TIN has to be recognized as a patient-centered medical home or comparable specialty practice for the TIN to get full credit in the category. **Scoring:** • All APMs get at least 1/2 of the highest score, but CMS will give MIPS APMs an additional score to reach the highest score based on their model. All other APMs must choose other activities to get additional points for the highest score. • Designated specific activities within the performance category that also qualify for Advancing Care Information bonus. • For group reporting, only 1 MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to get credit.	**Definition of certified patient-centered medical home:** • CMS proposes to expand the definition of certified patient-centered medical home to include the CPC+ APM model. • CMS proposes to make it clear that the term "recognized" is the same as the term "certified" as a patient-centered medical home or comparable specialty practice. • CMS proposes a threshold of 50% for 2018 for the number of practices within a TIN that need to be recognized as patient-centered medical homes for the TIN to get the full credit for the Improvement Activities performance category. **Scoring:** • No change to the scoring policy for APMs and MIPS APMs. • Keep designated activities within the performance category that also qualify for an Advancing Care Information bonus. • For group participation, only 1 MIPS eligible

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	• Allow simple attestation of Improvement Activities.	clinician in a TIN has to perform the Improvement Activity for the TIN to get credit. CMS is soliciting comments on alternatives for a future threshold. • Keep allowing simple attestation of Improvement Activities.
Advancing Care Information	• Allow clinicians to use either the 2014 or 2015 CEHRT Edition for the 2017 transition year and require use of 2015 CEHRT edition for 2018. • Performance points awarded for reporting both required and optional measures (up to 10 points each). • Bonus (5%) for reporting to 1 or more additional public health and clinical data registries. • Bonus (10%) for completion of at least 1 of the specified Improvement Activities using CEHRT. • Allowed reweighting of the Advancing Care Information category to 0, if there are insufficient measures applicable and available to MIPS eligible clinicians.	**Key Proposals:** • Allow MIPS eligible clinicians to use either the 2014 or 2015 Edition CEHRT in 2018; grants a bonus for using only 2015 Edition CEHRT. • Add exclusions for the E-Prescribing and Health Information Exchange Measures. • Adds more Improvement Activities that show the use of CEHRT to the list eligible for an Advancing Care Information bonus. • Allow a MIPS eligible clinician to not report on the Immunization Registry Reporting measure and potentially earn 5% each for reporting any of the Public Health and Clinical Data Registry Reporting measures as part of the performance score, up to 10%, and awarding an additional 5% bonus for reporting to an additional

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		registry not reported under the performance score. • Add a decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017. • Change the deadline for the exception application submission for 2017 and future years to be December 31 of the performance year. • For small practices (15 or fewer clinicians), add a new category of hardship exceptions to reweight Advancing Care Information performance category to 0 and reallocate the Advancing Care Information performance category weight of 25% to the Quality performance category. • Proposes 2 policies retroactive to the transition year based on the 21st Century Cures Act, which was passed after publication of the Year 1 Final Rule: ○ Ambulatory surgical center (ASC)-based MIPS eligible clinicians will be automatically reweighted to 0.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		○ Clarifying policies on hardship exceptions for the Advancing Care Information performance category, using the authority of the 21st Century Cures Change time period for the application of the potential modifications to the weight of the Advancing Care Information performance category.
Complex Patients Bonus	• Not available in the current transition year.	• Apply an adjustment of up to 3 bonus points 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 of the patients they see. • Ask for comments on the option of including dual eligibility as a method of adjusting scores as an alternative to the HCC risk score or in addition to the HCC risk score.
Small Practice Bonus	• Not available in current transition year.	• Adjust the final score of any eligible clinician or group who's in a small practice (defined in the regulations as 15 or fewer clinicians) by adding 5

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		points to the final score, as long as the eligible clinician or group submits data on at least 1 performance category in an applicable performance period. • Ask for comments on whether the small practice bonus should be given to those who practice in rural areas as well.
Final Score	• If no Advancing Care Information performance category, then reassign to the Quality performance category. • If no Quality performance category, then reassign 50% to Improvement Activities and 50% to Advancing Care Information. • The Quality performance category weight isn't lowered if there are only 1 or 2 scored measures.	**2018 MIPS performance year final score:** • Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%. • Keep reweighting the Advancing Care Information performance category to the Quality performance category for participants who meet exclusions. • Make new extenuating circumstances for all performance categories. • Add up to 5 bonus points for small practice bonus. • Add up to 3 bonus points to the final score for caring for complex patients.
Performance Threshold/ **Payment Adjustment**	• Performance threshold is set at 3 points. • Additional performance threshold set at 70 points for exceptional performance bonus.	• Performance threshold set at 15 points. Comments are solicited on whether it should be higher or lower.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	• Payment adjustment for the 2019 payment year ranges from - 4% to + (4% x scaling factor not to exceed 3) as required by law. (The scaling factor is determined in a way so that budget neutrality is achieved.) • Additional performance threshold starts at 0.5 and goes up to 10% x scaling factor not to exceed 1.	• Additional performance threshold stays at 70 points for exceptional performance. • Payment adjustment for the 2020 payment year ranges from - 5% to + (5% x scaling factor) as required by law. (The scaling factor is determined in a way so that budget neutrality is achieved.) • Additional performance threshold range doesn't change. • The payment adjustment is applied to the amount Medicare paid for Part B claims.
Performance Period	• Minimum 90-day performance period for Quality, Advancing Care Information, and Improvement Activities. Exception: measures through CMS Web Interface, CAHPS, and the readmission measure are for 12 months. Cost is measured for 12 months.	• Quality and Cost: 12-month calendar year performance period. • Advancing Care Information and Improvement Activities: 90 days minimum performance period.
ADVANCED APM POLICY		
Generally Applicable Nominal Amount Standard	• 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 (the revenue-based	• 8% revenue-based standard is extended for two additional years, through performance year 2020.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	standard), OR 3% of the expected expenditures for an APM Entity is responsible for under the APM for all performance years.	
Medical Home Model Financial Risk Standard	• In order for an APM to meet the medical home standard, the APM Entity must, if actual expenditures exceed expected expenditures or performance on specified performance measures doesn't meet or exceed expected performance, be subject to: ○ Withheld payment for services to the APM Entity and/or the APM Entity's eligible clinicians; ○ Lower payment rates to the APM Entity and/or the APM Entity's eligible clinicians; ○ Repayments to CMS; or ○ Loss of the right to all or part of an otherwise guaranteed payment or payments. • Starting in the 2018 QP performance period, the Medical Home Model Advanced APM financial risk standard wouldn't apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians.	• Exempt Round 1 participants in the Comprehensive Primary Care Plus Model (CPC+) from the requirement that the medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization.
Medical Home Model Nominal Amount Standard	• The total potential risk for an APM Entity under the Medical Home Model Standard must be equal to at least: ○ 2.5% of the estimated average total Parts A and B revenue of	• Minimum total potential risk for an APM Entity under the Medical Home Model Standard is adjusted to: ○ 2% of the estimated average total Medicare

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	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.	Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2018. ○ 3% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for the QP performance period in 2019. ○ 4% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2020. ○ 5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance years 2021 and after.
Qualifying APM Participant (QP) Performance Period and QP and Partial QP Determination	• Beginning in 2017, the QP performance period will be January 1 – August 31 each year. • CMS will make 3 QP determinations using data available through March 31, through June 30, and through the last day of the	• The QP performance period stays the same but will be called the Medicare QP performance period (creating a term for the All-Payer QP performance period).

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	QP performance period, respectively.	• The period the payment/patient threshold calculations are based on is modified for certain Advanced APMs. For Advanced APMs that start or end during the QP performance period, QP Threshold Scores would be calculated using only the dates that APM Entities were able to participate in the Advanced APM, as long as they were able to participate for at least 60 continuous days during the QP performance period. •
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
Generally Applicable Nominal Amount Standard	• 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.	• In addition to the existing Total Risk standard, an additional revenue-based nominal amount standard of 8% is added. This standard would only apply to models in which risk for APM Entities is expressly defined in terms of revenue. It would be an additional option, and would not replace or supersede the expenditure-based standard previously finalized.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
All-Payer Combination Option QP Performance Period	• Beginning in 2019, the QP performance period will be January 1 – August 31 each year. • CMS will make 3 QP determinations (Q1, Q2, and Q3) using data available through March 31, through June 30, and through the last day of the QP performance period, respectively.	• A separate All-Payer QP Determination Period is created, and would last from January 1 – June 30 of the performance year. • All-Payer Combination Option QP determinations would be made based on 2 periods: January 1 – March 31 or January 1 – June 30.
Payer-Initiated Determination of Other Payer Advanced APMs	• Not addressed in the CY 2017 Final Rule.	• Starting in performance year 2019, payers would be able to submit payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models before the relevant All-Payer QP performance period. • This option would be offered to other payer types in future years.
All-Payer Combination Option QP Determinations	• 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.	• QP determinations under the All-Payer Combination Option would be calculated at the individual eligible clinician level only. • If the Medicare Threshold Score for an eligible clinician is higher when calculated for the APM Entity group than when calculated for the

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		individual eligible clinician, CMS will make the QP determination under the All-Payer Combination Option using a weighted Medicare Threshold Score that will be factored into an All-Payer Combination Option Threshold Score calculated at the individual eligible clinician level.
Eligible Clinician Initiated Submission of Information and Data for Assessing Other Payer Advanced APMs and Making All-Payer Combination Option QP Determinations	• To be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians would be required to provide CMS with the following information: ○ Payment arrangement information needed to assess the other payer arrangement on all Other Payer Advanced APM criteria. ○ For each other payment arrangement, the amount of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement, and the total numbers of patients furnished any service through the payer. ○ An attestation from the payer that the submitted information is correct.	• APM Entities or eligible clinicians may submit information regarding their payment arrangement to and request that CMS make Other Payer Advanced APM determinations, when the determination had not already been made through the Payer-Initiated process. ○ The requirement for attestation from the payer is eliminated; APM Entities or eligible clinicians would need to certify information they submit.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
MIPS APM/APM SCORING STANDARD POLICY		
Identifying MIPS APM Participants	• If a MIPS eligible clinician is on an APM Participation List on at least one of the APM participation assessment (Participation List ''snapshot'') dates, the MIPS eligible clinician will be included in the APM Entity group for purposes of the APM scoring standard for the applicable performance year. If the MIPS eligible clinician is not on the APM Entity's Participation List on at least one of the snapshots dates (March 31, June 30, or August 31), then the MIPS eligible clinician will need to submit data to MIPS using the MIPS individual or group reporting option and adhere to all generally applicable MIPS data submission requirements to avoid a negative payment adjustment.	• A fourth snapshot date of December 31 will be added for the purpose of determining participation in full TIN MIPS APMs. • This fourth snapshot date will not be used to make QP determinations and will not extend the QP performance period beyond August 31.
Virtual Groups and MIPS APMs	• No previously finalized policy.	• CMS is proposing to waive sections of the statute that would require that all participants in a Virtual Group receive their MIPS payment adjustment based on the Virtual Group score, so that participants in APM Entities in MIPS APMs may receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
Quality performance category	• Use quality measure data reported through APM. • 50% weight for MSSP, Next Generation ACO Model in the first year. • 0% weight for other MIPS APMs in the first year.	• Use quality data reported through the APM. • Performance Category weight = 50%. • Quality Improvement points will be available beginning in the 2018 performance year for any APM Entity for which 2017 quality performance data are available.
Improvement Activities performance category	• 20% weight for MSSP, Next Generation ACO Model. • 25% weight for other MIPS APMs for first year. • Automatic assignment of Improvement Activity scores based on APM design (no reporting activity required). CMS will review each MIPS APM on a case-by-case basis, identify activities inherent to the design of those APMs that correlate to Improvement Activities, and assign the correlating Improvement Activity score to the APM Entity group.	• CPC+ practices that are assigned to a control group will receive full credit in the Improvement Activities performance category. • The improvement activities performance category weight = 20%.
Advancing Care Information performance category	• The Advancing Care Information performance category for the 2017 performance period is weighted at 30% for the Medicare Shared Savings Program and the Next Generation ACO model MIPS APMs. • For all other MIPS APMs this performance category is weighted at 75% for the 2017 performance period.	• The Advancing Care Information performance category weight = 30%

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
Cost performance category	• The cost performance category weight = 0%	• The cost performance category weight = 0%

Continuing the dialogue

Continuing our user-centered approach, CMS wants to hear from the health care community on the proposed policy and the implications for clinicians in Year 2, as well as on our message and education delivery. To give feedback or host a listening session, please contact us at QPP@cms.hhs.gov.

How to comment on the proposed rule

Please see the proposed rule for how to submit 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 are in the proposed rule; FAX transmissions won't be accepted. Use 1 of the following ways to officially submit comments:

- Electronically through Regulations.gov
- Regular mail
- Express or overnight mail
- Hand or courier

For more information, go to: qpp.cms.gov

Contact us

The Quality Payment Program can be reached at 1-866-288-8292 (TTY 1-877-715- 6222), Monday through Friday, 8:00 AM-8:00 PM Eastern time or by email at: QPP@cms.hhs.gov.