Issue Brief

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KEY POINTS

- The *Medicare Access and CHIP Reauthorization Act of 2015* established the Quality Payment Program for eligible clinicians. MACRA eliminated the physician sustainable growth rate formula. It has replaced payment limits, in part, with a Quality Payment Program.
- CMS says it is continuing many of its transition year policies while introducing modest changes. "As we move towards full implementation of the Quality Payment Program, the policies were finalized to ensure that clinicians are ready for full implementation in year 3."

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CMS Issues Final CY 2018 Updates to the Quality Payment Program

The Centers for Medicare and Medicaid Services published an extensive and complex final rule to update the physician and clinician Quality Payment Program for calendar year 2018.

The ***Medicare Access and CHIP Reauthorization Act of 2015*** established the Quality Payment Program for eligible clinicians. MACRA eliminated the physician sustainable growth rate formula. It has replaced payment limits, in part, with a Quality Payment Program. Eligible clinicians can participate via one of two tracks: Advanced Alternative Payment Models or a Merit-based Incentive Payment System. The final rule implements policies for "Quality Payment Program Year 2," some of which will continue into subsequent years of the Quality Payment Program.

The document is currently on display at the *Federal Register* office. Publication is scheduled for Thursday, Nov. 16. A copy of the 1,653-page document is at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-24067.pdf. This link will be superseded after publication.

COMMENT

While this is another long and complex rule, kudos to CMS. Unlike other 2018 updates and related regulations, this one has clear and detailed "final action" sections throughout. Further, there is a long,—nearly 300 page—but understandable appendix that identifies issues raised, rationales, comments and final actions taken.

However, the material overall is absolutely confusing. It is difficult to understand how all the reporting burdens will improve quality outcomes.

The entire issue of quality and its relationship on payment has become complex to say the least. Here is a 1,600+ page rule that never really addresses the concept of patient care. Instead, it focuses on the collection and scoring of data elements.

CMS says it currently estimates that approximately 185,000 to 250,000 eligible clinicians may become Qualifying APM Participants for payment year 2020 based on Advanced APM participation in performance year 2018. These individuals would become exempt from MIPS and would qualify for lump sum incentive payment based on 5 percent.

CMS estimates that approximately 622,000 MIPS-eligible clinicians will be required to submit data. This represents just over 50 percent of clinicians who meet the statutory requirements of being eligible clinicians and not being newly enrolled (approximately 622,000 out of 1.2 million who are eligible and not newly enrolled).

CMS estimates that this final rule will result in approximately $694 million in collection of information-related burden.

CMS says the provisions included in this final rule will redistribute more than $118 million in budget-neutral payments. In addition, as specified by Section 101 of the MACRA this final rule will increase government outlays for the exceptional performance payment adjustments under MIPS ($500 million) and

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incentive payments to QPs (approximately $675 to $900 million).

CMS says total Medicare expenditures for physician and clinical services in 2015 reached $144.3 billion. Expenditures for physician and clinical services from all sources reached $634.9 billion.

COMMENT

Based on CMS' numbers and the amount of monies involved, the quality program amounts to less than 1 percent. Adding the MIPS $500 million and the upper estimated QP quality incentive amount of $900 million, divided by total Medicare Part B physician and clinical services of $144.3 billion, results in 0.97 percent. Reduce this amount by associated reporting burdens, and the quality add-on is even smaller. One must ask if this effort will result in improved quality.

QUALITY PAYMENT PROGRAM YEAR 2: MIPS HIGHLIGHTS

Items include:

- Raising the performance threshold to 15 points in Year 2 (from three points in the transition year)
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology in Year 2 and giving a bonus for using only 2015 CEHRT
- Giving up to five bonus points on a final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information and Improvement Activities performance categories at zero percent of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters
- Adding five bonus points to the final scores of small practices

ADDING MORE OPTIONS FOR SMALL PRACTICES

CMS says it is continuing to offer tailored flexibilities for groups of 15 or fewer clinicians including:

- Excluding individual MIPS-eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries.
- Adding five bonus points to the final scores of small practices.
- Giving solo practitioners and small practices the choice to form or join a virtual group to participate with other practices.
- Continuing to award small practices three points for measures in the quality performance category that do not meet data completeness requirements.
- Adding a new hardship exception for the Advancing Care Information performance category for small practices.

GRADUAL IMPLEMENTATION

CMS says it is continuing many of its transition year policies while introducing modest changes. "As we move towards full implementation of the Quality Payment Program, the policies were finalized to ensure that clinicians are ready for full implementation in year 3." These policies include:

- Weighting the MIPS Cost performance category to 10 percent of the physician's total MIPS final score. CMS is including the Medicare Spending per Beneficiary and total per capita cost measures to calculate the cost performance category score for the 2018 MIPS performance period. These two measures carried over from the Value Modifier program and are currently being used to provide

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feedback for the MIPS transition year. CMS will calculate cost measure performance. No action is required from clinicians.

- Increasing the performance threshold to 15 points in Year 2 (from three points in the transition year).
- Continuing a phased approach to public reporting Quality Payment Program performance information on Physician Compare.

CMS has provided a fact sheet to accompany this rule, which is very helpful in identifying major changes. Note that this chart (reproduced below) is not part of the final rule.

Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
MIPS POLICY		
Low-volume threshold	You're excluded if you or your group has ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries.	You're excluded if you or your group has ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries.
Non-patient facing	Individual - If you have ≤100 patient facing encounters. Groups - If your group has > 75% NPIs billing under your group's TIN during a performance period considered as non-patient facing.	Individual and Group policy: No change. Virtual Groups have same definition as groups. Virtual Groups that have > 75% NPIs billing under the Virtual Group's TINs during a performance period who are non-patient facing.
Ways to submit	You use only 1 submission mechanism per performance category.	No change for Year 2. For Year 3, no change for Year 2. Delayed until 2019 MIPS performance period. For Year 3, you'll be able to use multiple submission mechanisms.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Virtual Groups	Not an option for the transition year.	Added Virtual Groups as a way to participate for Year 2. Virtual Groups can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period of a year. Solo practitioners and small groups may only participate in a Virtual Group if you exceed the low-volume threshold. The MIPS payment adjustments will only apply to the MIPS-eligible clinicians in a Virtual Group. If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would have their performance assessed as part of the Virtual Group. Components are finalized for a formal written agreement between each member of the Virtual Group. Election process for 2018 runs from October 11 to December 31, 2017. If certain members of a Virtual Group are in a MIPS APM, CMS will apply the APM Special Scoring Standard instead of the Virtual Group score. Generally, policies that apply to groups would apply to Virtual Groups. Differences include: Definition of non-patient facing MIPS-eligible clinician. Small practice status. Rural area and Health Professional Shortage Area designations.
Facility-based measurement	Not available in current transition year.	Not available in Year 2. Due to operational constraints, the facility-based measurement proposal was delayed until Year 3 of the Quality Payment Program (performance year 2019 and payment year 2021).

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Quality	Weight to final score: 60% in 2019 payment year. 50% in 2020 payment year. 30% in 2021 payment year and beyond.	Weight to final score: Finalized at 50% in 2020 payment year. 30% in 2021 payment year and beyond.
	Data completeness: 50% for submission mechanisms except for Web Interface and CAHPS. Measures that don't meet the data completeness criteria earn 3 points.	Data completeness: 60% for submission mechanisms except for Web Interface and CAHPS. Measures that don't meet the data completeness criteria will earn 1 point, except for a measure submitted by a small practice, which will earn 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. Bonus for additional high priority measures up to 10% of denominator for performance category. Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.	Scoring: No change for Year 2.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Quality/ topped out quality measures	Not applicable for the transition year.	Topped-out measures will be removed and scored on 4 year phasing out timeline. Topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years will earn up to 7 points. The 7-point scoring policy for 6 topped out measures identified for the 2018 performance period is finalized. These 6 topped out measures include the following: Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21) – Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224) – Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23) – Image Confirmation of Successful Excision of Image- Localized Breast Lesion. (Quality Measure ID: 262) – Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359) – Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52) Topped out policies do not apply to CMS Web Interface measures, and we will monitor for differences with other submission options. CAHPS will be addressed in future rulemaking.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Cost	Weight to final score: 0% in 2019 payment year.	Weight to final score: Finalized at 10% in payment year 2020. 30% in MIPS payment year 2021 and beyond.
	Measures: Includes the Medicare Spending per Beneficiary, total per capita cost measures and 10 episode-based cost measures.	Measures: Includes the Medicare Spending per Beneficiary and total per capita cost measures for the Cost performance category for the 2018 MIPS performance period. For the 2018 MIPS performance period, we won't use the 10 episode-based measures adopted for the 2017 MIPS performance period. CMS is developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures fall 2018. CMS expects to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.
	Reporting/Scoring: CMS will calculate individual MIPS-eligible clinician's and group's cost performance using administrative claims data if they meet the case minimum of attributed patients for a measure and if a benchmark has been calculated for a measure. Individual MIPS-eligible clinicians and groups don't have to submit any other information for the cost performance category. CMS compares your performance with the performance of other MIPS-eligible clinicians and groups during the performance period so measure benchmarks aren't based on a previous year. Performance category score is the average of the 2 measures. If only 1 measure can be scored, that score will be the performance category score.	Reporting/Scoring: No change.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Improvement scoring for Quality & Cost	Doesn't apply in the current transition year.	For Quality: CMS will measure improvement at the performance category level. Up to 10 percentage points available in the quality performance category. For Cost: CMS will base improvement scoring on statistically significant changes at the measure level. Up to 1 percentage point available in the cost performance category. For Quality and Cost: If the improvement score can't be calculated because there is not sufficient data, CMS will assign an improvement score of 0 percentage points. CMS will figure an improvement score only when there's sufficient data to measure improvement (e.g., MIPS eligible clinician uses the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods).

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Improvement Activities	Weight to final score: 15% and CMS measures it based on a selection of different medium and high-weighted activities.	Weight to final score: No change for the 2020 payment year.
	Number of activities: CMS included 92 activities in the inventory. Small practices; practices in rural areas, geographic health professional shortage areas; and non-patient facing MIPS-eligible clinicians don't need more than 2 activities (2 medium or 1 high-weighted activity) to earn the full score. All other MIPS-eligible clinicians don't need more than 4 activities (4 medium or 2 high-weighted activities, or a combination).	Number of activities: Finalized more activities and changes to existing activities for a total of approximately 112 activities in the inventory. Requirements for small practices, practices in rural areas, geographic HPSAs and non-patient facing MIPS eligible clinicians: no change. No change in the number of activities that you need to report to reach a maximum of 40 points.
	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 a patient-centered medical home or comparable specialty practice for the TIN to get full credit in the category.	Definition of certified patient-centered medical home: CMS has finalized the term "recognized" to mean the same as "certified" as a patient-centered medical home or comparable specialty practice. CMS has finalized a 50% threshold for 2018 for the number of practice sites within a TIN that need to be patient-centered medical homes for that TIN to get full credit for the Improvement Activities performance category.
	Scoring: All APMs get at least 1/2 of the highest score, but CMS will give MIPS APMs an additional score, which may be higher than one half of the highest potential score based on their model. All other APMs must choose other activities to get additional points for the highest score. Some activities qualify for Advancing Care Information bonus. For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit.	Scoring: No change to the scoring policy for APMs and MIPS APMs. CMS kept some activities in the performance category that also qualify for an Advancing Care Information bonus. For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit. CMS allows simple attestation of Improvement Activities.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Advancing Care Information	Weight to final score: 25%, made up of a base score, performance score, and bonus points for data submission on certain measures and activities.	Weight to final score: No change for the 2020 payment year.
	CEHRT requirements: Can use either 2014 or 2015 Edition CEHRT for the 2017 transition year.	CEHRT requirements: No change for 2018. A 10% bonus is available if you only use the 2015 Edition CEHRT.
	Scoring: Award a base score of 50% if you submit the numerator (of at least "1") and denominator, or "yes" for the yes/no measure, for each required measure. If the base score isn't met, you'll get a 0 for the Advancing Care Information category. Awarded performance score points if you submit additional measures (up to 10% each). Give a bonus score (5%) for submitting to 1 or more additional public health agencies or clinical data registries. Give bonus points (10%) when you use CEHRT to complete at least 1 of the specified Improvement Activities.	Scoring: No change to the base score requirements for the 2020 payment year. For the performance score, you or your group may earn 10% in the performance score for reporting to any single public health agency or clinical data registry. A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score. Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if you use CEHRT to complete at least 1 of the specified Improvement Activities. A 10% bonus score for using 2015 Edition exclusively.
	Exceptions: CMS reweighted the Advancing Care Information performance category to 0% of the final score and reallocate the weight to the Quality performance category if there are not sufficient measures applicable and available for a clinician.	Exceptions: Based on authority from the 21st Century Cures Act, CMS will reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality performance category for: – A significant hardship exception—we won't apply a 5-year limit to this exception; – A new significant hardship exception for MIPS-eligible clinicians in small practices (15 or fewer clinicians); – An exception for hospital-based MIPS-eligible clinicians; – A new exception for Ambulatory Surgical Center-based MIPS-eligible clinicians, finalized to apply beginning with the transition year; and – A new exception for MIPS-eligible clinicians whose EHR was decertified.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Advancing Care Information (continued)		New deadline of Dec. 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period. CMS has revised the definition of hospital-based MIPS-eligible clinicians to include covered professional services furnished by MIPS-eligible clinicians in an off-campus-outpatient hospital (POS 19). Measures and Objectives: CMS has finalized exclusions for the E-Prescribing and Health Information Exchange Measures for the transition year.
Complex patients bonus	Not available in the current transition year.	Clinicians can earn up to 5 bonus points for the treatment of complex patients (based on a combination of the Hierarchical Condition Categories and the number of dually eligible patients treated).
Small practice bonus	Not available in current transition year.	Added 5 points to any MIPS-eligible clinician or small group who's in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS-eligible clinician or group submits data on at least 1 performance category in an applicable performance period.
Final score	2017 MIPS performance period final score: Performance category weight: Quality 60%, Cost 0%, Improvement Activities 15% and Advancing Care Information 25%.	2018 MIPS performance year final score: Performance category weight: Quality 50%, Cost 10%, Improvement Activities 15% and Advancing Care Information 25%.
Performance threshold/ Payment adjustment	Performance threshold is set at 3 points. Additional performance threshold set at 70 points for exceptional performance. Payment adjustment for the 2019 payment year ranges from - 4% to + (4% x scaling factor not to exceed 3) as required by law. (CMS will figure the scaling factor to get to budget neutrality). Additional payment adjustment for exceptional performance starts at 0.5% and goes up to 10% x scaling factor not to exceed 1.	CMS sets the performance threshold at 15 points. 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 not to exceed 3) as required by law. (The scaling factor is determined in a way so that budget neutrality is achieved). Additional payment adjustment calculation is the same as in 2017. CMS will apply the payment adjustment to the amount Medicare pays.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
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. CMS will measure Cost for 12 months.	No change for Advancing Care Information, Improvement Activities and Cost performance periods. Minimum 12-month performance period for Quality. No change to the exception.
ADVANCED APM POLICIES		
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 standard) OR 3% of the expected expenditures that an APM Entity is responsible for under the APM for all performance years.	CMS extended the 8% revenue-based standard for 2 additional years, through performance year 2020.
Medical Home Model financial risk standard	Starting in the 2018 QP performance period, the Medical Home Model financial risk standard wouldn't apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians.	CMS is keeping the "50 eligible clinician cap" in place except for clinicians who are participating in the first round of the Comprehensive Primary Care Plus model.
Medical Home Model nominal amount standard	The total potential risk for an APM Entity under the Medical Home Model standard has to 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.	CMS is finalizing that the minimum total potential risk for an APM Entity under the Medical Home Model standard is adjusted to: 2.5% of the estimated average total Medicare 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.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Qualifying APM participant performance period & QP & partial QP determination	Beginning in 2017, the QP performance period will be Jan. 1 to Aug. 31 each year. CMS will make 3 QP determinations using data from March 31 through June 30 and through the last day of the QP performance period, respectively.	The QP performance period stays the same. The timeframe on which the payment/patient threshold calculations is based is modified for certain Advanced APMs. For Advanced APMs that start or end during the QP performance period, QP Threshold Scores are 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 for Other Payer Advanced APMs	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.	For performance years 2019 and 2020, CMS added a revenue-based nominal amount standard of 8% that only applies to payer arrangements where the risk for APM Entities is expressly defined in terms of revenue. This is an additional option and wouldn't replace or supersede the expenditure-based standard CMS previously finalized.
All-Payer Combination Option QP performance period	Beginning in 2019, the QP performance period will be Jan. 1 to Aug. 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.	As CMS does for the Medicare Option, CMS will make QP determinations based on three snapshot dates: March 31, June 30 and Aug. 31. CMS is finalizing its proposal that an eligible clinician would need to meet the relevant QP or Partial QP threshold under the All-Payer Combination Option as of one of these three dates, and to use data for the same time periods for Medicare and other payer payments or patients in making QP determinations.
Payer-initiated determination of Other Payer Advanced APMs	CMS didn't address this in the CY 2017 Final Rule.	Starting in performance year 2019, payers can submit payment arrangements authorized under Title XIX (Medicaid), Medicare Health Plan payment arrangements (including Medicare Advantage), and payment arrangements aligned with a CMS Multi-Payer Model and request that CMS make Other Payer Advanced APM determinations before the relevant QP Performance Period. CMS intends to offer this option to other remaining payers, including commercial and other private payers in future years.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
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.	For purposes of QP determinations under the All-Payer Combination Option, eligible clinicians will have the option to either be assessed at the individual level or at the APM Entity level. If the Medicare threshold score for an eligible clinician is higher when calculated for the APM Entity group than when calculated for the 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 All-Payer Combination Option threshold score calculated at the individual eligible clinician level.
Eligible Clinician Initiated Submission of Information and Data as Part of the All-Payer Combination Option	To be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians would be required to provide us with this information: – Payment arrangement information CMS needs to assess the other payer arrangement on all Other Payer Advanced APM criteria. – For each other payment arrangement, the amount of revenues for services given through that arrangement, the total revenues from the payer, the number of patients furnished any service through the arrangement and the total number of patients furnished any service through the payer. – An attestation from the payer that the submitted information is correct.	If CMS hasn't already made the determination through the Payer-Initiated process, APM Entities or eligible clinicians can submit information about their payment arrangements to CMS and ask CMS to make Other Payer Advanced APM determinations. CMS has eliminated the requirement for a payer attestation; APM Entities or eligible clinicians have to certify that the information they submit is accurate.
MIPS APM/APM SCORING STANDARD POLICY		
Identifying MIPS APM participants	A clinician on an APM Participation List on at least 1 of the APM participation assessment (Participation List ''snapshot'') date will be included in the APM Entity group for the APM scoring standard for the applicable performance year. If you aren't on the APM Entity's Participation List on at least one of the snapshot dates (March 31, June 30 or Aug. 31), then you'll need to submit data to MIPS using the MIPS individual or group participation option and meet all generally applicable MIPS data submission requirements in order to avoid a negative payment adjustment.	CMS is adding Dec. 31 as a fourth snapshot date to determine participation in Full TIN MIPS APMs (currently applies to participation in the Medicare Shared Savings Program only). CMS won't use the fourth snapshot date to make QP determinations or extend the QP performance period past Aug. 31.
Virtual Groups & MIPS APMs	Not applicable for the transition year.	For MIPS APMs, CMS is waiving sections of the statute that require all Virtual Group participants to receive their MIPS payment adjustment based on the Virtual Group score. This means that participants in APM Entities in MIPS APMs who are also participating in a Virtual Group would receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.

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Quality Payment Program: Final Policies Compared-Years 1 & 2		
POLICY TOPIC	**TRANSITION YEAR 1 (Final Rule CY 2017)**	**YEAR 2 (Final Rule CY 2018)**
Quality performance category	Use quality measure data reported through the APM. 50% weight for Medicare Shared Savings Program ACOs, Next Generation ACO Model in the first year. 0% weight for other MIPS APMs in the first year.	Use quality measure 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 Medicare Shared Savings Program ACOs, Next Generation ACO model. 25% weight for other MIPS APMs for first year. CMS will automatically assign Improvement Activity scores based on APM design (no data submission required). CMS reviews each MIPS APM on a case-by-case basis, identifies activities that are part of the design of the APMs that go with Improvement Activities and assigns the correlating Improvement Activity score to the APM Entity group.	The Improvement Activities performance category weight = 20%.
Advancing Care Information performance category	CMS weighted the Advancing Care Information performance category for the 2017 performance period at 30% for the Medicare Shared Savings Program and the Next Generation ACO Model MIPS APMs. For all other MIPS APMs, we've weighted this performance category at 75% for the 2017 performance period.	The Advancing Care Information performance category weight = 30%.
Cost performance category	The Cost performance category weight = 0%.	The Cost performance category weight = 0%.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting