Issue Brief

FEDERAL ISSUE BRIEF • JUNE 21, 2017

KEY POINTS

- Changes in low-volume threshold exclusion criteria
- Multiple data submission mechanisms available within a performance category
- Establishment of "virtual groups"
- Future year changes in measurement category weighting

CMS Proposes CY 2018 Updates to the Quality Payment Program

The Centers for Medicare & Medicaid Services has published an extensive and complex proposed 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. This proposal is intended to make changes to the second year of the Quality Payment Program as required by MACRA.

The document is currently on display at the *Federal Register* office. Publication is scheduled for June 30. A comment period ending Aug. 21 is provided. (Note that a CMS fact sheet says the comment period closes Aug. 18). A copy of the 1,058-Page document is available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-13010.pdf. This link will be superseded after publication.

COMMENT

The proposal contains an appendix with more than 200 pages of important tables (beginning on page 819).

CMS estimates that at least 80 percent of clinicians in small practices with 1-15 clinicians will receive a positive or neutral MIPS payment adjustment.

This is not a simple rule to read. CMS says that different types of entities are affected by mutually exclusive sections of this proposal. Therefore, for the purposes of CMS' estimate, CMS assumes that each reviewer will read approximately 50 percent of the proposed rule. CMS estimates that it will take approximately 11.5 hours to review half of this proposed rule. For each commenter that reviews this proposed rule, the estimated cost is $1209.34 (11.5 hours x $105.16). Therefore, CMS estimates that the total cost of reviewing this proposed rule is $4,873,360 ($1209.34 x 4,000 reviewers).

The table of contents is very short and it does not reflect the many components in the rule, making it difficult to locate specific sections.

As noted above, CMS does not expect readers to fully digest the proposal, but rather, concentrate on those areas applicable to their practice. Therefore, the material that follows is not all inclusive.

The entire issue of quality, and its relationship on payment has become complex. Here is a 1,000+ page rule that never really addresses the concept of patient care. Instead it focuses on the collection and scoring of data elements.

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SUMMARY OF THE MAJOR PROVISIONS

Advanced Alternative Payment Models

In the CY 2017 Quality Payment Program final rule, CMS estimated that 70,000 to 120,000 eligible clinicians would be Qualifying APM Participants (QPs) for payment year 2019. With new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus (1+) Model, and the reopening of the application process to new participants for some current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus Model, CMS now estimates that approximately 180,000 to 245,000 eligible clinicians may become QPs for payment year 2020.

To be considered an Advanced APM, an APM must meet all three of the following criteria: (1) The APM must require participants to use CEHRT; (2) The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS and; (3) The APM must either require that participating APM Entities bear risk for monetary losses of a more than nominal amount under the APM, or be a Medical Home Model expanded under Section 1115A(c) of the Act.

CMS is proposing to maintain the generally applicable revenue-based nominal amount standard at 8.0 percent of the estimated average total Parts A and B revenue of eligible clinicians in participating APM Entities for QP Performance Periods 2019 and 2020. QPs are excluded from MIPS for the year, and receive a 5.0 percent APM Incentive Payment for each year they are QPs beginning in 2019 through 2024.

Merit-based Incentive Payment System

For Quality Payment Program Year 2, CMS is proposing the following MIPS policies.

- To maintain the transition year data completeness threshold of 50 percent for data submitted on quality measures using QCDRs, qualified registries, EHR, or Medicare Part B claims to provide an additional year for individual MIPS eligible clinicians and groups to gain experience with the MIPS before increasing the data completeness threshold.
- For the 2020 MIPS payment year, a 60 percent weight for the quality performance category contingent upon its proposal to reweight the cost performance category to zero for the 2020 MIPS payment year.
- To increase the data completeness threshold for the 2021 MIPS payment year to 60 percent for data submitted on quality measures using QCDRs, qualified registries, EHR, or Medicare Part B claims.
- New improvement activities (refer Table F) and improvement activities with changes (refer Table G) for the 2018 MIPS performance period and future years for inclusion in the Improvement Activities Inventory. Activities proposed in this section would apply for the 2018 MIPS performance period and future performance periods unless further modified via notice and comment rulemaking.

For the Quality Payment Program Year 2, the advancing care information performance category comprises 25 percent of the final score. However, if a MIPS-eligible clinician is participating in a MIPS APM the advancing care information performance category may comprise 30 percent or 75 percent of the final score depending on the availability of APM quality data for reporting.

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CMS is proposing to adopt for the cost performance category the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period. For the 2018 MIPS performance period, CMS is not proposing to use the 10 episode-based measures that were adopted for the 2017 MIPS performance period.

CMS is proposing to establish requirements for MIPS participation at a virtual group level. CMS proposes to define a virtual group as a combination of two or more TINs composed of a solo practitioner (a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN) or a group (as defined at §414.1305) 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.

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

Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (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 performance period are labeled as non-patient facing.	There is no change in how CMS is defining non-patient facing clinicians, however; 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.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
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. • 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). • 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 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. – Small practice status. – Rural area and Health Professional Shortage Area designations.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
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. • 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%.	**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 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 removal from the program through rulemaking in the 4th year. • This policy on topped out measures wouldn't apply to CMS Web Interface measures.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
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 is 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.
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. – Definition of non-patient facing MIPS eligible clinician. 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 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%.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
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. **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. • Allow simple attestation of Improvement Activities.	**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 rural areas will keep reporting on no more than 2 medium or 1 high-weighted activity to reach the highest score. **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 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.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
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 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. – 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 Patient 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.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
Small Practice Bonus	Not available in the 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 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. • 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.	• Performance threshold set at 15 points. Comments are solicited on whether it should be higher or lower. • 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 standard), OR 3% of the expected expenditures for an APM Entity is responsible for under the APM for all performance years.	• 8% revenue-based standard is extended for two additional years, through performance year 2020.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
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 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 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.	• Minimum total potential risk for an APM Entity under the Medical Home Model Standard is adjusted to: – 2% 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.
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 QP performance period, respectively.	• 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). • 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.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (Proposed Rule CY 2018)
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
General 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.
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 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.

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Policy Topic	Current Transition Year (Final Rule CY 2017)	Second Year (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 the 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.
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.	• 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%.
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.	
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 improvement activities performance category weight = 30%
Cost Performance Category	• The cost performance category weight = 0%	• The cost performance category weight = 0%

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In the proposal, CMS has provided the following summary of changes being made. [Note this item does not cover all proposed changes.]

"We propose to amend the regulation at §414.1370(e) to identify the four assessment dates that would be used to identify the APM Entity group for purposes of the APM scoring standard, and to specify that the December 31 date will be used only to identify eligible clinicians on the APM Entity's Participation List for a MIPS APM that is a full TIN APM in order to add them to the APM Entity group that is scored under the APM scoring standard. We propose to use this fourth assessment date of December 31 to extend the APM scoring standard to only those MIPS eligible clinicians participating in MIPS APMs that are full TIN APMs, ensuring that an eligible clinician who joins the full TIN APM late in the performance year would be scored under the APM scoring standard.

"We propose to continue to weight the cost performance category under the APM scoring standard for Web Interface reporters at zero percent for the 2020 payment year forward.

"Aligned with our proposal to weight the cost performance category at zero percent, we propose not to take improvement into account for performance scores in the cost performance category for Web Interface reporters beginning with the 2020 MIPS Payment Year.

"We propose to score the CAHPS for ACOs survey, in addition to the CMS Web Interface measures that are used to calculate the MIPS APM quality performance category score for Web Interface reporters including the Shared Savings Program and Next Generation ACO Model), beginning in the 2018 performance year.

"We propose that, beginning for the 2018 performance year, eligible clinicians in MIPS APMs that are Web Interface reporters may receive bonus points under the APM scoring standard for submitting the CAHPS for ACOs survey.

"We propose to calculate the quality improvement score for MIPS eligible clinicians submitting quality measures via the CMS Web Interface using the methodology described in section II.C.7.a.(1)(i).

"We propose to calculate the total quality percent score for MIPS eligible clinicians using the CMS Web Interface according to the methodology described in section II.C.7.a.(1)(h)(2) of this proposed rule.

"We propose to establish a separate MIPS final list of quality measures for each Other MIPS APM that would be the quality measure list used for purposes of the APM scoring standard.

"We propose to calculate the MIPS quality performance category score for Other MIPS APMs using MIPS APM-specific quality measures. For purposes of the APM scoring standard, we would score only measures that: (1) are tied to payment as described under the terms of the APM, (2) are available for scoring near the close of the MIPS submission period, (3) have a minimum of 20 cases available for reporting, and (4) have an available benchmark.

"We propose to only use the MIPS APM quality measure data that are submitted by the close of the MIPS submission period and are available for scoring in time for inclusion to calculate a MIPS quality performance category score.

"We propose that, for the APM scoring standard, the benchmark score used for

continued

a quality measure would be the benchmark used in the MIPS APM for calculation of the performance based payments, where such a benchmark is available. If the APM does not produce a benchmark score for a reportable measure that is included on the APM measures list, we would use the benchmark score for the measure that is used for the MIPS quality performance category generally (outside of the APM scoring standard) for that performance year, provided the measure specifications for the measure are the same under both the MIPS final list and the APM measures list.

"We propose that the minimum number of quality measures required to be reported for the APM scoring standard would be the minimum number of quality measures that are required within the MIPS APM and are collected and available in time to be included in the calculation for the APM Entity score under the APM scoring standard. We propose that if an APM Entity submits some, but not all of the measures required by the MIPS APM by the close of the MIPS submission period, the APM Entity would receive points for the measures that were submitted, but would receive a score of zero for each remaining measure between the number of measures reported and the number of measures required by the APM that were available for scoring.

"We propose that the benchmark score used for a quality measure would be the benchmark used by the MIPS APM for calculation of the performance based payments within the APM, if possible, in order to best align the measure performance outcomes between the two programs. We are proposing that for measures that are pay for reporting or which do not measure performance on a continuum of performance, we will consider these measures to be lacking a benchmark and they will be treated as such.

"We propose to score quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories, as described in the finalized MIPS quality scoring methodology. We propose to use a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile.

"We propose that each APM Entity that reports on quality measures would receive between 1 and 10 achievement points for each measure reported that can be reliably scored against a benchmark, up to the number of measures that are required to be reported by the APM.

"We propose that APM Entities in MIPS APMs, like other MIPS eligible clinicians, would be eligible to receive bonus points for the MIPS quality performance category for reporting on high priority measures or measures submitted via CEHRT. For each Other MIPS APM, we propose to identify whether any of their available measures meets the criteria to receive a bonus, and add the bonus points to the quality achievement points.

"Beginning in the 2018 performance year, we propose to score improvement as well as achievement in the quality performance category. For the APM scoring standard, we propose that the improvement percentage points would be awarded based on the following formula:

- Quality Improvement Score = (Absolute Improvement/Previous Year Quality Performance Category Percent Score Prior to Bonus Points) / 10.

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"We propose that the APM Entity's total quality performance category score would be equal to [(achievement points + bonus points)/ total available achievement points] + quality improvement score.

"Under the APM scoring standard, we propose that if a MIPS eligible clinician who qualifies for a zero percent weighting of the advancing care information performance category in the final score is part of a TIN that includes one or more MIPS eligible clinicians who do not qualify for a zero percent weighting , we would not apply the zero percent weighting to the qualifying MIPS eligible clinician, and the TIN would still be required to report on behalf of the group, although the TIN would not need to report data for the qualifying MIPS eligible clinician.

"We propose to maintain the cost performance category weight of zero for Other MIPS APMs under the APM scoring standard for the 2020 MIPS payment year and subsequent MIPS payment years. Because the cost performance category would be reweighted to zero that weight would need to be redistributed to other performance categories. We propose to align the Other MIPS APM performance category weights with those proposed for Web Interface reporters and weight the quality performance category to 50 percent, the improvement activities performance category to 20 percent, and the advancing care information performance category to 30 percent of the APM Entity final score.

"It is possible that none of the Other MIPS APM's measures would be available for calculating a quality performance category score by or shortly after the close of the MIPS submission period, for example, due to changes in clinical practice guidelines. In addition, the MIPS eligible clinicians in an APM Entity may qualify for a zero percent weighting for the advancing care information performance category. In such instances, under the APM scoring standard, we propose to reweight the affected performance category to zero.

"Beginning with the 2018 performance year, we propose that MIPS eligible clinicians whose MIPS payment adjustment is based on their score under the APM scoring standard will receive performance feedback as specified under section 1848(q)(12) of the Act for the quality, advancing care information, and improvement activities performance categories to the extent data are available for the MIPS performance year. Further, we propose that in cases where the MIPS APM performance category has been weighted to zero for that performance year, we would not provide performance feedback on that MIPS performance category.

COMMENT

This proposal is table intensive. There are some 91 tables not including those in the proposal's appendix. Below are some with their (display copy) page numbers.

TABLE 2: Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually (TIN/NPI) (page 93)

TABLE 3: Data Submission Mechanisms for MIPS Eligible Clinicians Reporting as Groups (TIN) (page 93)

TABLE 5: Summary of Proposed Quality Data Submission Criteria for MIPS Payment Year 2020 via Part B Claims, QCDR, Qualified Registry, EHR, CMS Web Interface, and the CAHPS for MIPS Survey (page 118)

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Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

TABLE 6: Proposed New Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus Beginning with the 2018 Performance Period (page 178)

TABLE 7: 2018 Performance Period Advancing Care Information Performance Category Scoring Methodology Advancing Care Information Objectives and Measures (page 190)

TABLE 8: Advancing Care Information Objectives and Measures and Certification Criteria for 2014 and 2015 Editions (page 199)

TABLE 9: Advancing Care Information Performance Category Scoring Methodology for 2018 Advancing Care Information Transition Objectives and Measures (page 201)

TABLE 10: Web Interface Reporters: Shared Savings Program and Next Generation ACO Model New Measure (page 244)

TABLE 12: APM Scoring Standard Performance Category Weights– Beginning for the 2018 Performance Period (page 261)

TABLE 13: APM Scoring Standard Performance Category Weights for Other MIPS APMs with Performance Categories Weighted to 0– beginning for the 2018 Performance Period (page 263)

TABLE 33: FY 2019 Hospital VBP Program Measures (page 385)

The rule's appendix contains the following tables.

TABLE Group A: New Quality Measures Proposed for Inclusion in MIPS for the 2018 Performance Period (page 819)
TABLE Group B: Proposed New and Modified MIPS Specialty Measure Sets for the 2018 Performance Period (page 829)

TABLE C.1: Proposed MIPS Measures Removed Only from Specialty Sets for the 2018 Performance Period (page 1013)

TABLE C.2: Proposed Quality Measures Removed from Merit-Based Incentive Payment System Program for the 2018 Performance Period (page 1020)

TABLE D: 2018 Proposed Cross-Cutting Measures (page 1024)

TABLE E: Measures with Substantive Changes Proposed for MIPS Reporting in 2018 (page 1026)

TABLE F: Proposed New Improvement Activities for the Quality Payment Program Year 2 and Future Years (page 1037)

TABLE G: Proposed Improvement Activities with Changes for the Quality Payment Program Year 2 and Future Years (page 1044)

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