Quality Payment
PROGRAM

PROPOSED RULE FOR QUALITY PAYMENT PROGRAM YEAR 2

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Quality Payment Program

Topics

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

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

MIPS and Advanced APMs

Quality Payment PROGRAM

The Quality Payment Program:

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

Clinicians have two tracks to choose from:

The Merit-based Incentive Payment System (MIPS)

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

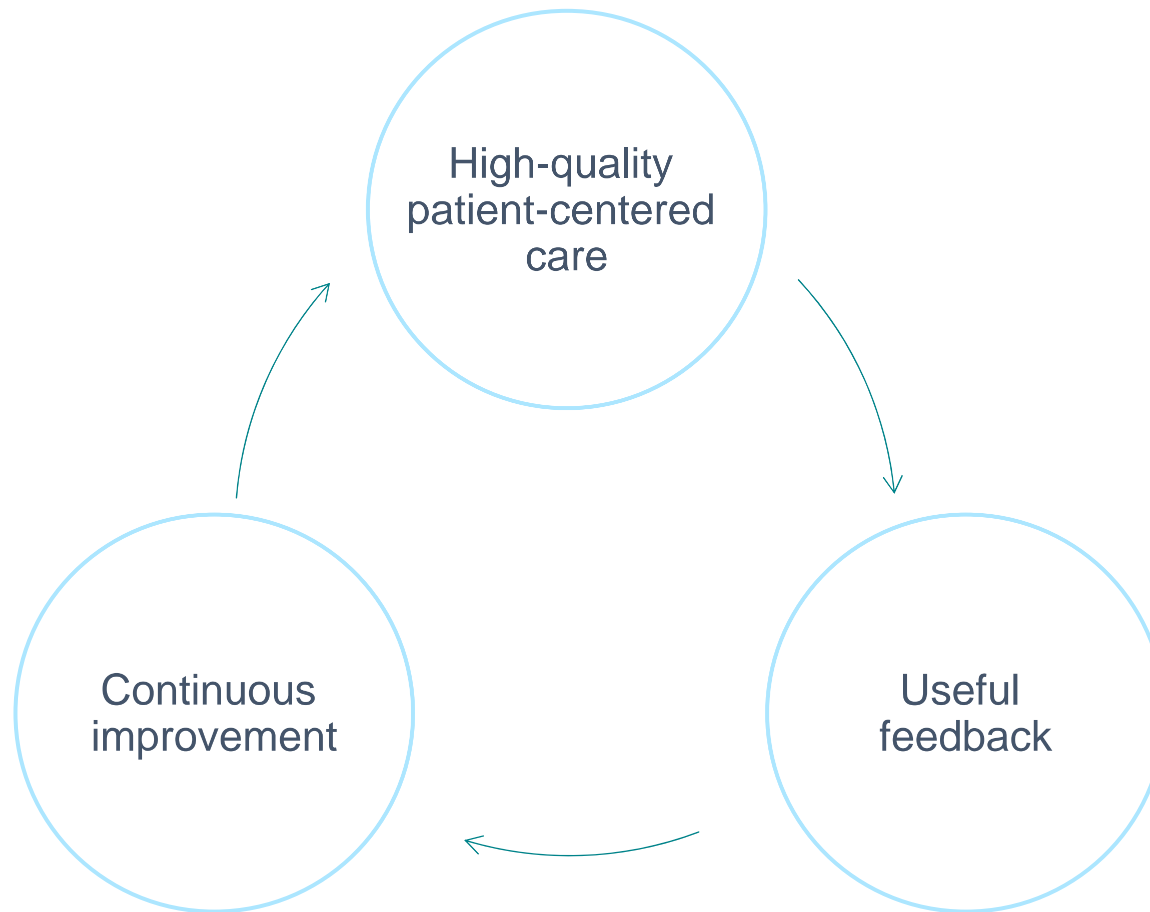
OR

Advanced Alternative Payment Models (Advanced APMs)

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

Quality Payment Program

Bedrock



Quality Payment Program

Considerations

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

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

PROPOSED RULE FOR YEAR 2

Merit-based Incentive Payment System

Proposed Rule for Year 2

Request for Comments: MIPS Proposals

- Some examples of areas where we are seeking comments on are shown in parentheses:
  - Raising the low-volume threshold to exclude individual MIPS eligible clinicians or groups who bill ≤ $90,000 Part B billing **OR** provide care for ≤ 200 Part B enrolled beneficiaries (opt-in option).
  - Virtual groups (definition and composition, election process, agreements, reporting requirements).
  - Facility-based measurement (participation through opt-in or opt-out).
  - Quality performance category (increasing the data completeness threshold, process to cap and then eliminate topped out measures).
  - Cost weight for 2018 (retaining it at 10% as indicated in the transition year final rule).
  - Improvement activities (future threshold for a group to get credit).
  - Calculation for complex patient bonus (using the HCC or dual eligible method).
  - Whether to have a bonus for practices in rural areas (bonus proposed for small practices).
  - Whether the performance threshold should be set at a level other than 15 points (possibly at 6 or 33 points).

Proposed Rule for Year 2

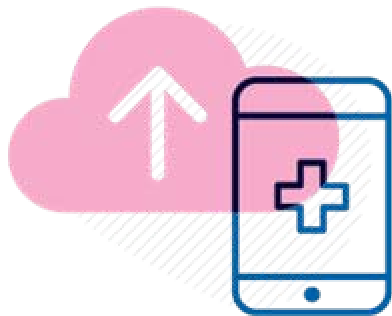
MIPS: Performance Threshold

Quality Payment PROGRAM

Final Score (Transition Year)	Transition Year Payment Adjustment	Final Score (Year 2)	Year 2 Proposed Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%	≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus	16-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment	15 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate	0 points	• Negative payment adjustment of -5% • 0 points = does not participate

Proposed Rule for Year 2

MIPS: Advancing Care Information



- Allow clinicians to use either the 2014 or 2015 CEHRT Edition in 2018 and provide a bonus for use of 2015 CEHRT edition.
- Add more improvement activities to the list eligible for an advancing care information bonus.
- Expand options beyond the one immunization registry reporting measure for 10% toward the performance score and allow reporting on a combination of other public health registry measures that may be more readily available for 5% each toward the performance score (up to 10%).
- For the 5% bonus, must report to a different public health agency or registry than those used to earn the performance score.

- Add a decertification hardship for eligible clinicians whose EHR was decertified.
- Change the deadline for the significant hardship application for 2017 and going forward to be December 31 of the performance period.
- Add new category of exception, for MIPS eligible clinicians in small practices and those practicing in HPSAs to reweight advancing care information category to zero and reallocating the 25% to the quality performance category.

Proposed Rule for Year 2

MIPS: Advancing Care Information

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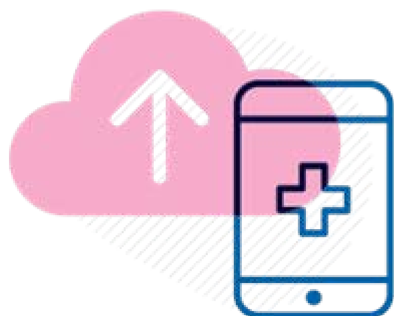

- Enacted in 2016, the 21st Century Cures Act contains provisions affecting how CEHRT impacts the Quality Payment Program's current transition year and future years.
- The 21st Century Cures Act was enacted after the publication of the Quality Payment Program Year 1 Final Rule. In the Year 2 proposed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

Proposed Rule for Year 2

MIPS Scoring: Small Practice Bonus

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

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

Proposed Rule for Year 2

MIPS Scoring: 2018 MIPS Performance Year Final Score

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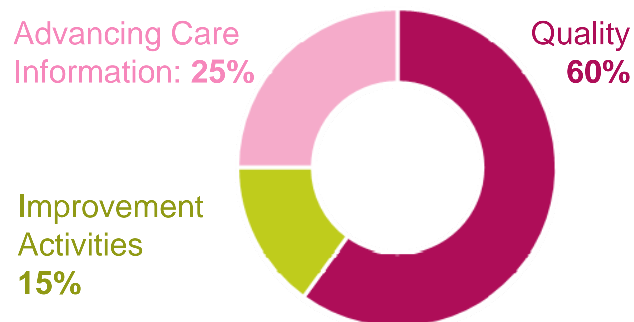
- Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%.



- Continue to allow reweighting of the advancing care information performance category to the quality performance category (for hardships, and other specified situations).
- Proposed Propose new extenuating circumstances for quality, cost, and improvement activities performance categories.
- Add 5 bonus points for small practices.
- Add 1 to 3 points to the final score for caring for complex patients.
- Add a 10-point bonus for those clinicians who use 2015 CEHRT.
- Seek comment on adding bonus points for practices in rural areas.

PROPOSED RULE FOR YEAR 2

Alternative Payment Models (APMs)

What are Alternative Payment Models (APMs)?

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

Proposed Rule for Year 2

Request for Comments: APM Proposals

Quality Payment PROGRAM

- Examples of where comments are requested regarding APMs are shown in the parentheses:
  - Advanced APM nominal amount standard (appropriate level for the revenue-based standard).
  - Medical Home Model Nominal Amount Standard (whether to change the nominal amount standard for Medical Home Models so that the minimum required amount of total risk increases more slowly).
  - QP Determinations under the All-Payer Combination Option (whether to make QP determinations at the eligible clinician level only).
  - Other Payer Advanced Determination Process (seek comment on our proposed Payer Initiated and Eligible Clinician Initiated Processes).
  - Other Payer Advanced APM nominal amount standard (whether to add a revenue-based nominal amount standard of 8 percent for total risk, in addition to the existing expenditure-based nominal amount standard).
  - APM scoring standard (how eligible clinicians participating in selected MIPS APMs will be assessed).

Proposed Rule for Year 2

Quality Payment PROGRAM

Advanced APMs: Generally Applicable Nominal Amount Standard

Transition Year 1 Final

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

Year 2 Proposed

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

Proposed Rule for Year 2

Advanced APMs: Medical Home Model 50 Clinician Cap

Transition Year 1 Final

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

Year 2 Proposed

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

Proposed Rule for Year 2

Quality Payment PROGRAM

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

Transition Year 1 Final

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

Year 2 Proposed

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

APM SCORING STANDARD

Proposed Rule for Year 2

Category Weighting for MIPS APMs

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

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

Proposed Rule for Year 2

MIPS APMs: Additional Changes for Year 2

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

QUALITY PAYMENT PROGRAM

Resources

Technical Assistance

Available Resources

Quality Payment PROGRAM

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

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

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

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

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

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

LARGE PRACTICES

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

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

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

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

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

Proposed Rule: Comments Due 8/21/2017

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

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