Quality Payment Program (MACRA)
Proposed Rule CY 2018

July 24, 2017
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Slides on the Proposed Rule Prepared by:

• Gayle Lee, galee@aamc.org
• Ivy Baer, ibaer@aamc.org
Agenda

1. Quality Payment Program (QPP): Background
2. Merit-based Incentive Payment System (MIPS) Overview and Eligibility
3. Performance Categories
4. MIPS Scoring and Performance Thresholds
5. MIPS APMs Scoring
6. Qualified Participants in Advanced APMs
7. Question and Answer
MACRA Legislation

- Repeals the Sustainable Growth Rate (SGR) Formula and sets up 2 payment programs: MIPS and APMs.
- Streamlines multiple quality programs (Meaningful Use, PQRS, Value-based Modifier) under MIPS.
- APM: Bonus payments for participation in advanced APM models.
Strong Bipartisan Support for MACRA

• 92-8 Senate vote in favor of MACRA
• 392-37 House vote in favor of MACRA
• HHS Secretary Price quote:
  “I commit to work closely with the CMS Administrator to make sure we implement MACRA in a way that is easy to understand, minimizes burden, and is fair to all affected providers.” (Senate Finance hearing)
MACRA Crossroads: Quality Payment Programs

**MIPS**

+/- 4% in 2019
+/- 5% in 2020
+/- 9% in 2022

CMS estimates 572,299 clinicians for 2020 payment year

**APMs**

+5% for 2019-2024

Estimates 180,000 to 245,000 clinicians will become QPs for 2020 payment year
MACRA Timeline

- Proposed Rule: Issued June 20, 2017
- Comments due August 21, 2017
- Final Rule Expected Fall 2017
- Performance Year Begins 2018
- 2020 Payment Year based on 2018 Performance
Proposed Rule: Major Highlights

- Hospital-based physicians could report at facility level

- More clinicians exempt from MIPS due to low volume threshold (36% clinicians are eligible but they make up 58% of Part B charges)

- New Virtual reporting groups option for smaller practices

- Improvement is recognized in addition to achievement for cost and quality
Proposed Rule: Major Highlights

- CMS eases up on EHR technology requirements for Advancing Care Information
- Physicians can receive MIPS bonus points for complex patients
- Proposal related to All Payer combination for determining Qualified Participants in APMs
- More eligible clinicians (double) 180,000-245,000 will be qualifying participants in Advanced APMs to receive 5% bonus
Merit Based Incentive Payment System (MIPS) Overview and Eligibility
Composite Performance Score: Four Categories
(2018–same as 2017)

Four Categories
1. Cost (0%)
2. Quality (60%)
3. Improvement Activities (15%)
4. Advancing Care Information (previously Meaningful Use Program) (25%)
# MIPS Performance Categories/Weights

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>MIPS General*</th>
<th>MIPS APM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1 (2019)</td>
<td>Year 2 (2020)</td>
</tr>
<tr>
<td>Quality</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>IA</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>ACI</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

*For MIPS General weights will be adjusted for certain factors, such as non-patient facing clinicians*
Eligible Clinician Identifiers in MIPS: Options for Participation in 2018

<table>
<thead>
<tr>
<th>Individuals</th>
<th>Group Practices</th>
<th>In an APM (Groups)</th>
<th>Virtual Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Defined by Unique TIN/NPI</td>
<td>• Defined by TIN</td>
<td>• APMs recognized by CMS</td>
<td>• 2 or more TINs composed of solo practitioner or group with 10 or fewer eligible clinicians under TIN</td>
</tr>
<tr>
<td>• Similar reporting mechanisms as current programs</td>
<td>• Similar reporting mechanisms as current programs</td>
<td>• Examples are ACOs (all tracks), oncology care model, CPC plus</td>
<td>• Elect to form virtual group with at least one other solo practitioner or group</td>
</tr>
</tbody>
</table>
CMS Seeks Comment on TINs & Group Practices

• CMS acknowledges that multi-specialty groups may want to allow a portion of the group to report as a separate subgroup and states it intends to explore reporting at subgroup level and creation of new identifier.

• CMS seeks comment on ways in which participation as subgroup could be established.
Exceptions to MIPS Participation for Certain Clinicians

Low Patient Volume

- Year 2 CMS proposes to exclude clinicians or groups who bill ≤ $90,000 OR provide care for ≤ 200 Medicare beneficiaries. (up from $30,000 OR 100 or fewer patients in year 1)

Participants in Advanced APMs

- Must meet threshold of Medicare payments or patients through Advanced APM to be qualifying APM participant or partial qualifying APM participant.

1\textsuperscript{st} year clinician enrolled in Medicare program

- Not treated as MIPS eligible clinician until subsequent year
Expanded Exemptions And Increased APMs Reduce MIPS Participants

Number of MIPS eligible Clinicians in MIPS

- **2017 Proposed Rule**: 836,000
- **2017 final rule**: 712,000
- **2018 proposed rule**: 572,000
MIPS Performance Period

ACI
- 2017 Report 90 days
- 2018 Report 90 days

Quality
- 2017 Report 90 Days
- 2018 Report 12 month calendar year

IA
- 2017 Report 90 days
- 2018 Report 90 days

Cost
- 2017 Automatically calculated based on 12 months
- 2018 Automatically calculated based on 12 months

*Exception: GPRO Web user must report for 12 months calendar year, CAHPS and readmission measures are 12 months.
## Data Submission Mechanisms: Group Reporting 2018 (No change from year 1)

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>QCDR&lt;br&gt;Qualified Registry&lt;br&gt;EHR&lt;br&gt;CMS Web Interface (groups of 25 or more)&lt;br&gt;CMS-approved survey vendor for CAHPS for MIPS (must be reported with another data submission mechanism)&lt;br&gt;Administrative Claims (no submission required)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>Administrative Claims (no submission required)</td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong></td>
<td>Attestation&lt;br&gt;QCDR&lt;br&gt;Qualified registry&lt;br&gt;EHR&lt;br&gt;CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td><strong>Improvement Activities</strong></td>
<td>Attestation&lt;br&gt;QCDR&lt;br&gt;Qualified Registry&lt;br&gt;EHR&lt;br&gt;CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>
## Submission Mechanisms

<table>
<thead>
<tr>
<th>2017 Year</th>
<th>Year 2 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS eligible clinicians required to use only one submission mechanism per performance category</td>
<td>Individual MIPS eligible clinicians and groups could submit measures and activities through multiple submission mechanisms within a performance category as available and applicable to meet requirements of Quality, Improvement Activities or Advancing Information. CMS will pick the highest score</td>
</tr>
</tbody>
</table>
Facility-Based Clinicians: Measurement

- Select Hospital Value based Purchasing (VBP) score in place of MIPS reporting
- For first year limited to quality and cost performance categories.
- Hospital VBP score converted to MIPS score
- Applies to clinicians that furnish 75% or more of their services in inpatient hospital or emergency room. For a group, 75% of Ecs must meet eligibility criteria as individuals
- Participate through opt-in or opt-out
MIPS Performance Categories:
Quality, Cost, Improvement Activities, Advancing Care Information
Quality Measures (60%)

Select from individual measures or a specialty measure set

- Requires reporting 6 measures
- 1 of 6 measures must be outcome measure (if no outcome measure must report high priority measure)

GPRO web-interface users required to report all quality measures for a full year

1 additional population measure will automatically be calculated by CMS

- All-Cause Hospital Readmission (only for groups of 10+, minimum case of 200)
- CMS did not finalize proposal to include chronic admission and acute admission measures in performance score
### Quality Performance: Key Changes 2018

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full year reporting period required</td>
<td></td>
</tr>
<tr>
<td>Reward performance improvement from year to year at performance category level (up to 10 percentage points available)</td>
<td></td>
</tr>
<tr>
<td>New facility-based scoring option</td>
<td></td>
</tr>
<tr>
<td>Topped Out Measures: Starting with 2018 performance period, a cap will be set of 6 points. After 3 years may remove topped out measures (does not apply to Web Interface measures)</td>
<td></td>
</tr>
</tbody>
</table>
Cost (Weight 0%): Key Changes 2018

• Based on current two Value Modifier Program Measures
  – Medicare Spending Per Beneficiary (MSPB)
  – Total Per Capita Cost (includes Medicare Part A and B payments)
• Propose to replace previous 10 episode-based cost measures with measures developed in collaboration with new expert clinicians and stakeholders
• No additional reporting required; calculated from claims data
• Will provide feedback to providers
• Rewards improvement from year to year for significant changes at the measure level.
Improvement Activities (15%)

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
<th>Patient Safety &amp; Practice Assessment</th>
<th>Participation in an APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day appointments for urgent needs</td>
<td>Monitoring health conditions &amp; providing timely intervention</td>
<td>Timely communication of test results</td>
<td>Establishing care for complex patients</td>
<td>Use of clinical or surgical checklists</td>
<td>As defined in prior slide</td>
</tr>
<tr>
<td>After hours clinician advice</td>
<td>Participation in a QCDR</td>
<td>Timely exchange of clinical information with patients AND providers</td>
<td>Patient self management &amp; training</td>
<td>Practice assessments related to maintain certification</td>
<td>At a minimum receive ½ CPIA score for APM participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of remote monitoring and Telehealth</td>
<td>Employing shared decision making</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS proposes about 20 more improvement activities to choose from (Table F in rule). Adds research and teaching to list.
<table>
<thead>
<tr>
<th>New Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Leadership in Clinical trials, research alliances or community-based participate research (CPBR) focusing on minimizing disparities in healthcare access, care quality, affordability, or outcomes.</td>
</tr>
<tr>
<td>Acting as preceptor for clinicians-in-training and accepting such clinicians for clinical rotations in community practices in small, underserved or rural areas.</td>
</tr>
<tr>
<td>Completion of an Accredited Safety or Quality Improvement Program (must be a continuing medical education program that meets certain criteria)</td>
</tr>
</tbody>
</table>
Improvement Activities and Patient Centered Medical Home

• Patient centered medical home receives full credit for improvement activities
• Expand definition of patient centered medical home to include CPC+ model
• To receive full credit for improvement activities, proposes that 50% of the practice sites within a TIN need to be recognized as patient centered medical home (in 2017 entire TIN got credit)
## Improvement Activities and Group Reporting

<table>
<thead>
<tr>
<th>2017</th>
<th>2018 Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2017, for MIPS group reporting, all clinicians in the group will receive credit if at least one clinicians in the group (TIN) has performed the Improvement Activity for 90 days.</td>
<td>CMS seeks comments on whether there should be a minimum threshold (e.g. 50%) for clinicians must perform activity or different thresholds based on group size.</td>
</tr>
</tbody>
</table>
## Advancing Care Information (weighted 25%)

- Can report as individuals or groups
- Scoring in two categories: Base and Performance; in 2017 & 2018 must report for minimum of 90 days
- Failure to meet requirement to protect patient health information in EHR = 0 score
- More flexibility in choosing measures to report for Performance Score
- Removed Reporting Requirement for Clinical Provider Order Entry and Clinical Decision Support Objectives
- Optional reporting for: NPs, PAs, CNS, CRNAs
Advancing Care Information: Key Changes for 2018

• Allow Clinicians to use either the 2014 or 2015 CEHRT Edition in 2018
• Provide 10 point bonus for use of 2015 CEHRT edition
• Add a decertification hardship for eligible clinicians whose EHR was decertified
• Add new exception for MIPS eligible clinicians in small practices and HPSAs to reweight this category to zero.
• Reweights ACI category to 0% of final score for ambulatory surgical center (ASC) based physicians
MIPS Scoring and Performance Thresholds
MIPS Scoring: Bonus for Groups with Complex Patients

• Proposes to award small bonus for caring for complex patients
• Would add HCC risk score to final MIPS score and could receive bonus of 1-3 points
• CMS seeks comment on alternative method: ratio of dual eligible patients as proxy for bonus
MIPS Scoring: Bonus for Small Practices

- Adjusts final score of MIPS eligible clinician or group who is small practice (15 or fewer clinicians) by adding 5 points.
- Seek comment on expansion of bonus to rural areas.
Accounting for Social Risk Factors

- CMS seeks comments on whether they should take approaches such as stratifying scores based on proportion of dual eligible patients and public reporting of stratified measure results and risk adjustment of particular measures.
- Seeks comment on which social risk factors might be appropriate.
MIPS Scoring: 2018 Summary

- Same weights as 2017 for the 4 performance categories
- Continue to allow reweighting of ACI to 0% for specified situations
- Add 5 bonus points to final score for small practices
- Add 1-3 bonus points to final score for complex patients
- Add 10 point bonus for clinicians who use 2015 CEHRT in ACI category
## Performance Threshold and Payment Adjustment

<table>
<thead>
<tr>
<th>Year 1 (2017)</th>
<th>Year 2 (2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 points (to avoid penalty and get neutral score)</td>
<td>15 points (to avoid penalty and get neutral score)</td>
</tr>
<tr>
<td>70 points (qualifies for exceptional performance bonus)</td>
<td>70 points (qualified for exceptional performance bonus)</td>
</tr>
<tr>
<td>Payment adjustment for 2019 MIPS payment year ranges from -4% to + (4% x scaling factor)</td>
<td>Payment adjustment for 2019 MIPS payment year ranges from -5% to + (5% x scaling factor)</td>
</tr>
</tbody>
</table>

CMS seeks comments on whether 15 point threshold is good. In 2019, threshold will be based on median or mean...
MIPS Payment Adjustment for 2020

Performance threshold at 15 points if meet test pace submission

Composite Score

0 15 100

Sliding Scale Positive Adjustment to Fee Schedule Rate

70 points and above get exceptional performance bonus (.5%)

Automatically receive a -5% payment adjustment when nothing is submitted
MIPS APM Scoring
Determination of APM Participants

• MIPS eligible clinicians who participate in certain APM models receive specials scoring as APM (examples: shared savings program, Next Generation, oncology care model, CPC plus)

• Must be participant in the APM at one of the following dates:
  - MAR 31
  - JUN 30
  - AUG 31
2018: Fourth Snapshot Date Added

- CMS proposes to add a fourth snapshot date of December 31 for full TIN APMs (only applies to ACOs) for determining which eligible clinicians are participants for purposes of scoring standard.
- Allows participants who joined certain APMs between September 1-December 31 opportunity to benefit from APM scoring standard.
Key Changes: APM MIPS Scoring

In 2017, there are different scoring weights for ACO models and all other APMs. Other APMs had quality weight set at zero.

CMS proposes to assess all APMs on quality in 2018 and align the weights.

Participants in the “Other MIPS APMs (e.g. oncology care, CPC plus) will be scored under MIPS using quality measures they are required to report as condition of their APM model.
# MIPS APM Scoring for Eligible Clinicians: Weights

## Transition Year: 2017

<table>
<thead>
<tr>
<th>MIPS Performance Category</th>
<th>Shared Savings Program and Next Generation ACOs</th>
<th>Other MIPS APMs</th>
<th>All MIPS APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>IA</td>
<td>20%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>ACI</td>
<td>30%</td>
<td>75%</td>
<td>30%</td>
</tr>
</tbody>
</table>

## 2018 proposed
REMEMBER—it is possible that parts of your TIN may be in different programs!

TIN XYZ

Eligible Clinicians in MIPS

Eligible Clinicians in MIPS/APMs

Report under General MIPS

Report with different performance category weights
# Hierarchy for Final Score

<table>
<thead>
<tr>
<th>Example</th>
<th>Final score used to determine payment adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIN/NPI has more than one APM Entity Final Score</td>
<td>The highest of the APM Entity final scores</td>
</tr>
<tr>
<td>TIN/NPI has an APM final score and also has a group final score</td>
<td>APM entity final score</td>
</tr>
<tr>
<td>TIN/NPI has a group final score and an individual final score, but no APM Entity final score</td>
<td>The highest of the group or individual final score</td>
</tr>
</tbody>
</table>
Qualified Participants in Advanced APMs
What does it take to be an Advanced APM?

• Use of certified EHR technology (CEHRT)
• Payment based on quality measures comparable to MIPS quality measures
• Bear financial risk for monetary losses in excess of a nominal amount, or APM is a Medical Home Model expanded under §1115A(c)
2017 Advanced APMs

- Comprehensive End Stage Renal Disease Care Model (2-sided risk)
- Oncology Care Model (2-sided risk)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
- Shared Savings Program Track 2
- Next Generation ACO Model
- Comprehensive Primary Care Plus (CPC+)
2018 Anticipated Advanced APMs (In addition to 2017 list)

- Surgical Hip/Knee Fracture Treatment (SHHFT) Model (Track I) (CEHRT)
- Advancing Care Coordination through EPMs Track 1 (CEHRT)
- ACO Track 1+
- Vermont Medicare ACO Initiative (part of All-Payer ACO Model)

*Physician-Focused Payment Model Technical Advisory Committee (PTAC) will continue to review and assess future models.*
Proposed Changes to Advanced APM Criteria

• If enrolled in Round 1 of CPC+: exempt from 50 Eligible Clinician or fewer requirement
  – Future CPC+ enrollees will not be exempt

• Nominal risk amount: general
  – Revenue-based amount: 8% of average estimated total Parts A & B revenue for 2019-2020
    • Comment: should amount be lower or higher?
Nominal Risk Amount: In General

• In general (from final 2017 rule)
  – 8% of average estimate total Medicare Parts A & B revenue of providers and suppliers participating in APM entities

• CMS proposes retaining 8% for 2019 & 2020

• Asks for comment: should amount be higher or lower 2019 & 2020
## Nominal Risk: Medical Home

<table>
<thead>
<tr>
<th>Year</th>
<th>Finalized in FY 2017 Rule</th>
<th>Proposed Changes in FY 2018 Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2.5% total Part A&amp;B Revenue</td>
<td>n/a</td>
</tr>
<tr>
<td>2018</td>
<td>3%</td>
<td>2% average estimated total Part A&amp;B revenue</td>
</tr>
<tr>
<td>2019</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>2020</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>2021 and later</td>
<td>n/a</td>
<td>5%</td>
</tr>
</tbody>
</table>
Length of Advanced APM during Performance Period

- Must be at least **60 continuous days of active testing** during QP performance period for payment amount or patient count
  - Asking for comment: should it be **90 continuous days**?
Participation in Multiple Advanced APMs

- Will make QP determination using full Medicare QP Performance Period even if EC participates in one or more Advanced APMs that start or end during the QP Performance Period
## All-Payer Combination Option

<table>
<thead>
<tr>
<th></th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Amount Method</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QP Payment Amt Threshold</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>75%</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Partial QP Payment Amt Threshold</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>50%</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Patient Count Thresholds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QP Pt Threshold</td>
<td>20%</td>
<td>35%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>50%</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial QP Pt Threshold</td>
<td>10%</td>
<td>25%</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>35%</td>
<td>10%</td>
<td>35%</td>
</tr>
</tbody>
</table>
Decision Tree

FIGURE 1: QP Determination Tree, Payment Years 2021-2022

- **QP**
  - Is Medicare Threshold Score ≥ 50%?
    - Yes
    - Is Medicare Threshold Score ≥ 25%?
      - Yes
      - Is All-Payer Threshold Score ≥ 50%?
        - No
        - Partial QP
      - No
      - Is Medicare Threshold Score ≥ 20%?
        - Yes
        - Is All-Payer Threshold Score ≥ 40% OR is Medicare Threshold Score ≥ 40%?
          - No
          - MIPS eligible clinician
        - No
        - MIPS eligible clinician
    - No
  - No
  - MIPS eligible clinician

82 Fed Reg 30179, June 30, 2017
Other Payer Advanced APMs

Finalized in 2017

- Any payer other than traditional Medicare
- 50% or more of ECs in each APM entity to use CEHRT
- Payment based on quality measures comparable to MIPS
- Must bear more than nominal financial risk or is Medicaid Medical Home Model
- Asking for comments on definition of Other Payer Medical Home Model
Other Payer Advanced APMs Risk

• No changes proposed in marginal risk and minimum loss rate that were finalized in 2017
  – Marginal risk: least 30%
  – Minimum Loss Rate: no more than 4%
  – Total Risk: at least 3% of expected expenditures for which APM entity is responsible
Proposed Revenue Based Risk for All-Payer Advanced APMs

• 2019 and 2020: 8% of total combined revenues from the payer and providers and suppliers in participating APM entities
  – Limited to arrangements in which risk is explicitly defined in terms of revenue in the agreement covering other payer arrangement
Determination of Other Payer Advanced APMs

• Process can be initiated by payer or eligible clinician

• Determination effective for 1 year; new information to be submitted each year
Medicare Advantage

• Medicare Health Plans—includes Medicare Advantage, Medicare-Medicaid Plans—cannot be included in QP determination calculation under Medicare Option.

• These plans can request a determination of whether they are Other Payer Advanced APMs
CMS Multi-Payer Models

• Examples of CMS Multi-Payer models that are Advanced APMs
  – CPC+
  – Oncology Care Model (2-sided risk)
  – Vermont All-Payer ACO Model

• A request can be made to CMS by payer or EC to determine whether other arrangements qualify as Other Payer Advanced-APMs
All-Payer Performance Period

• Separate performance period for all-payer:
  January 1 through June 30 of calendar year 2 years prior to payment year
  – Performance period for Medicare option: January 1 through August 31
QP Determinations

• Transition year 1 determination at either APM entity or individual Eligible Clinician level

• Year 2 (proposed): determination at individual Eligible Clinician level ONLY
Feedback on QP Status

• Eligible Clinicians to be informed of their QP status “as soon as practicable after the All-Payer Information Submission deadline”
References

The proposed rule’s link:

List of New Improvement activities for 2018:
*Table F in the rule*

Proposed Quality Measures for MIPS reporting in 2018:
*Table A and B in rule*
Questions

Please use the Q&A panel located on the right hand side of your screen to submit your questions. Send to All Panelists.