News Updates (11-2-17)

CMS Finalizes Quality Payment Program Rule for Year 2 to Increase Flexibility and Reduce Burdens

Quality Payment Program Year 2 Policies are Gradually Preparing Clinicians for Full Implementation

On November 2nd, the Centers for Medicare & Medicaid Services (CMS) issued the final rule with comment for the second year of the Quality Payment Program (calendar year 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as well as an interim final rule with comment.

CMS listened to feedback from the health care community and used it to inform policy making. As a result, the Year 2 final rule continues many of the flexibilities included in the transition year, while also preparing clinicians for a more robust program in Year 3. CMS wants to ensure that the program consists of meaningful measurement while minimizing burden, improving coordination of care, and supporting a pathway to participation in Advanced Alternative Payment Models (APMs).

Year 2 Final Rule Highlights

We've finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes. Major highlights include:

- Weighting the MIPS Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%.
- Raising the MIPS performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT.
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients.
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters.
- Adding 5 bonus points to the MIPS final scores of small practices.
- Adding Virtual Groups as a participation option for MIPS.
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year

without submitting a hardship exception application (note that Cost has a 0% weight in the transition year) if they were have been affected by Hurricanes Harvey, Irma, and Maria, which occurred during the 2017 MIPS performance period.
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries.
- Providing more detail on how eligible clinicians participating in selected APMs (known as MIPS APMs) will be assessed under the APM scoring standard.
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option. This option will be available beginning in performance year 2019.

The final rule with comment further advances the agency's goals of regulatory relief, program simplification, and state and local flexibility in the creation of innovative approaches to healthcare delivery.

Technical Support

CMS will continue to provide free hands-on support to help individual clinicians and groups participate in the Quality Payment Program.

For More Information

- The Quality Payment Program final rule with comment can be downloaded from the Federal Register at: https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-programs-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme
- For an overview of the final rule with comment, please visit:https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf
- For an executive summary of the rule, visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf
- Register here to join CMS on November 14 for a public webinar on the Quality Payment Program Year 2 Final Rule with comment.

Quality Payment Program Year 2

Final Rule Overview

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Stakeholder feedback is a very important part of the Quality Payment Program. As we go into the second year, referred to as "The Quality Payment Program Year 2," we have been listening to feedback and using it to ensure that:

- The program's measures and activities are meaningful.
- Clinician burden is minimized.
- Care coordination is better.
- Clinicians have a clear way to participate in Advanced APMs.

In Year 2, we are keeping many of the flexibilities from the transition year to help clinicians get ready for Year 3. Since January 1, 2017, we've worked with more than 100 stakeholder organizations and over 47,000 people to get the word out about the Quality Payment Program, get feedback, and help make it easier for you to participate. We've also reviewed over 1,200 stakeholder comments and are finalizing many of the proposed policies from the calendar year (CY) 2018 Quality Payment Program proposed rule. Because we want to continue to receive your feedback, this is a final rule with comment period. The Quality Payment Program makes major changes to how Medicare pays clinicians. We've heard challenges and concerns from stakeholders, so we will keep:

- Going slow while preparing clinicians for full implementation in year 3.
- Providing more flexibility to help reduce your burden.
- Offering new incentives for participation.

Just like in the transition year, we will keep offering our free, hands-on Technical Assistance (TA) to help you and your groups participate in the Quality Payment Program.

Patients Over Paperwork

CMS recently launched the "Patients Over Paperwork" Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The Quality Payment Program final rule with comment period includes the following as part of this initiative:

- 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.
- We address extreme and uncontrollable circumstances, such as hurricanes and other natural disasters, for both the transition year and the 2018 MIPS performance period.
- Including virtual groups as another participation option for year 2.
- Making it easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.

What's new in the Quality Payment Program Year 2?

We're Reducing Your Burden

To help you be successful, we're going to keep looking for ways to reduce your burden and simplify the program. CMS is working to implement the Quality Payment Program in a way to provide flexibility and to reduce burden.

Quality Payment Program Year 2: MIPS Highlights

In the Quality Payment Program Year 2, here's how we've adopted 2018 policies to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes including:

- Raising the performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2, and giving you a bonus for using only 2015 CEHRT.
- Giving up to 5 bonus points on your final score for treatment of complex patients.
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters.
- Adding 5 bonus points to the final scores of small practices

We're Adding More Options for Small Practices

We realize it can be hard for small practices to participate in the Quality Payment Program, so we're 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 5 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 3 points for measures in the Quality performance category that don't meet data completeness requirements.

- Adding a new hardship exception for the Advancing Care Information performance category for small practices.

Gradual Implementation

CMS 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 below 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% of your total MIPS final score. We're including the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures to calculate your 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 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 3 points in the transition year).
- Continuing a phased approach to public reporting Quality Payment Program performance information on Physician Compare.

Extreme and Uncontrollable Circumstances

Over the past several months, numerous clinicians have been affected in many areas of the country due to Hurricanes Harvey, Irma, and Maria, which occurred during the 2017 MIPS performance period. We address extreme and uncontrollable circumstances for both the transition year and the 2018 MIPS performance period in this final rule with comment.

- For the transition year, if a MIPS eligible clinician's CEHRT is unavailable as a result of extreme and uncontrollable circumstances (e.g., a hurricane, natural disaster, or public health emergency), the clinician may submit a hardship exception application to be considered for reweighting of the Advancing Care Information performance category. This application is due by December 31, 2017.
- This final rule with comment period extends this reweighting policy for the three other performance categories (Quality, Cost, and Improvement Activities) starting with the 2018 MIPS performance period. This hardship exception application deadline is December 31, 2018.
- Because our policies relating to reweighting the Quality, Cost, and Improvement Activities performance categories are not effective until next year, we are issuing an interim final rule for automatic extreme and uncontrollable circumstances where clinicians can be exempt from these categories in the transition year without submitting a hardship exception application (note that cost has a 0% weight in the transition year).

What does that mean for 2017?

- Clinicians in affected areas that do not submit data will not have a negative adjustment. We know that the circumstances have created a significant hardship that has affected the availability and applicability of measures.
- Clinicians that do submit data will be scored on their submitted data. This allows them to be rewarded for their performance in MIPS. Because MIPS is a composite, clinicians have to submit data on two or more performance categories to get a positive payment adjustment.
- The policy applies to individuals (not group submissions), but all individuals in the affected area will be protect for the 2017 MIPS performance period.
- We note that if a MIPS eligible clinician who is eligible for reweighting due to extreme and uncontrollable circumstances, but still chooses to report (as an individual or group), that they will be scored on that performance category based on their results.
- This policy does not apply to APMs.

21st Century Cures Act

Enacted in 2016, the 21st Century Cures Act contains provisions affecting the Advancing Care Information performance category for 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 this final rule with comment period, CMS is implementing these provisions in the 21st Century Cures Act, some of which will apply to the MIPS transition year including:

- Reweighting the Advancing Care Information performance category to 0% of the final score for ambulatory surgical center (ASC)-based MIPS eligible clinicians.
- Using the 21st Century Cures Act authority for significant hardship exceptions and hospital-based MIPS eligible clinicians to reweight the Advancing Care Information performance category to 0% of the final score.

Virtual Groups

Lastly, we are excited to announce the inclusion of Virtual Groups as another participation option for year 2. A Virtual Group is a combination of 2 or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter specialty or location) to participate in MIPS for a performance period of a year. We've developed a Virtual Groups Toolkit with more information including the election process to become a Virtual Group.

Quality Payment Program Year 2: APM Highlights

As a result of the final rule with comment period for the Quality Payment Program Year 2, we've provided more details on how we will incentivize clinicians who participate in APMs offered by payers other than Medicare, starting in 2019. We've also updated our policies to further encourage and reward participation in APMs in Medicare.

Better Coordination and Promoting Alignment

The final rule more closely aligns the standards that apply to Medicare and Other Payer Advanced APMs. Specific policies include:

- Establishing a generally applicable revenue-based nominal amount standard for Other Payer Advanced APMs. This standard allows a non-Medicare payment arrangement to meet the financial risk criterion to qualify as an Other Payer Advanced APM if participants are required to bear total risk of at least 8% of their revenues from a given payer.

Increasing APM Participation: We are Taking Steps to Increase APM Participation

This year's rule includes provisions to make it easier for eligible clinicians to participate in select APMs (known as Advanced APMs), which may allow them to qualify for incentive payments. Specific policies include:

- Extending the 8% generally applicable revenue based nominal amount standard that allows APMs to qualify as Advanced APM for two additional years, through performance year 2020.
- Exempting Round 1 Comprehensive Primary Care Plus participants certain currently participating clinicians from the 50 clinician limit on organizations that can earn incentive payments by participating in medical home models.
- Changing the requirement for Medical Home Models so that the minimum required amount of total financial risk increases more slowly.
- Making it easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.

Reducing Complexity

We are continuing to establish policies through this year's rule that will further reduce burden and simplify the program. We worked to provide clarity and additional details on many aspects of the program including the APM scoring standard and the All-Payer Combination Option. Specific polices include:

- We provided more detail on how eligible clinicians participating in selected APMs (known as MIPS APMs) will be assessed under the APM scoring standard. This special standard reduces burden for MIPS APM participants who do not qualify as Qualifying APM Participants (QPs), and are therefore subject to MIPS.
- We elaborated on how the All-Payer Combination Option will be implemented. This option allows clinicians to become QPs through a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs. Where possible, we have created additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option. This option will be available beginning in performance year 2019.

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.
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.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)

		• 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 – December 31, 2017.
		• If certain members of a Virtual Group are in a MIPS APM, we'll 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:
		  o Definition of non-patient facing MIPS eligible clinician.
		  o Small practice status.
		  o 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 (2019 performance year and 2021 payment year).

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.

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: o Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21) o Melanoma: Overutilization of Imaging Studies in Melanoma.(Quality Measure ID: 224) o Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23) o Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262) o Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359) o Chronic Obstructive Pulmonary Disease (COPD): Inhaled

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		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.
Cost	**Weight to final score:** • 0% in 2019 payment year.	**Weight to final score:** • Finalized at 10% in 2020 payment year. • 30% in 2021 MIPS payment year and beyond.
	Measures: • Includes the Medicare Spending per Beneficiary (MSPB), total per capita cost measures, and 10 episode-based cost measures.	**Measures:** • Includes the Medicare Spending per Beneficiary (MSPB) 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. • We are developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures fall 2018. • We expect to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.
	Reporting/Scoring: • We'll calculate individual MIPS eligible	**Reporting/Scoring:** • No change.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	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. • We compare 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.	
Improvement scoring for Quality & Cost	• Doesn't apply in the current transition year.	**For Quality:** • We'll measure improvement at the performance category level. • Up to 10 percentage points available in the Quality performance category. **For Cost:**

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		• We'll 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, we'll 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).
Improvement Activities	**Weight to final score:** • 15% and we measure 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: • We included 92 activities in the Inventory. • Small practices; practices in rural areas, geographic health professional shortage areas (HPSAs); and non-patient facing MIPS eligible clinicians don't	**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.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	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).	• 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:** • We've finalized the term "recognized" to mean the same as "certified" as a patient-centered medical home or comparable specialty practice. • We've 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.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	Scoring: • All APMs get at least 1/2 of the highest score, but we'll 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. • We've 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. • We allow simple attestation of Improvement Activities.
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.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	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: • We reweighted the Advancing Care Information performance category to 0% of the final score and reallocate the weight to the Quality performance category if	**Exceptions:** • Based on authority from the 21st Century Cures Act, we'll reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25%

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	there are not sufficient measures applicable and available for a clinician.	to the Quality performance category for: o A significant hardship exception—We won't apply a 5-year limit to this exception; o A new significant hardship exception for MIPS eligible clinicians in small practices (15 or fewer clinicians); o An exception for hospital-based MIPS eligible clinicians; o A new exception for Ambulatory Surgical Center (ASC)-based MIPS eligible clinicians, finalized to apply beginning with the transition year; and o A new exception for MIPS eligible clinicians whose EHR was decertified. • New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period. • We've revised the definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19). **Measures and Objectives:** • We have finalized exclusions for the E-Prescribing and Health Information Exchange Measures, for the transition year.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
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 (HCCs) 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. (We'll figure the	• We've set 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.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	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.	• We'll apply the payment adjustment to the amount Medicare pays.
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. • We'll 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	• We've extended the 8% revenue-based standard for 2 additional years, through performance year 2020.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	the APM for all performance years.	
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.	• We are keeping the "50 eligible clinician cap" in place except for clinicians who are participating in the first round of the Comprehensive Primary Care Plus (CPC+) 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	We are 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.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	participating APM Entities for performance year 2020.	
Qualifying APM participant (QP) performance period & QP & partial QP determination	• Beginning in 2017, the QP performance period will be January 1 – August 31 each year. • We'll 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: o Marginal risk of at least 30%; o Minimum Loss Rate of no more than 4%; and o 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, we've 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 we previously finalized.
All-Payer Combination	• Beginning in 2019, the QP performance period	• As we do for the Medicare Option, we will make QP determinations based

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
Option QP performance period	will be January 1 – August 31 each year. • We'll 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.	on three snapshot dates: March 31, June 30, and August 31. We are finalizing our 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	• We 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 we make Other Payer Advanced APM determinations before the relevant QP Performance Period. • We intend to offer this option to remaining other payers including commercial and other private payers 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.	• 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, we'll make the QP determination under the All-

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		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: o Payment arrangement information we need to assess the other payer arrangement on all Other Payer Advanced APM criteria. o 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	• If we haven't already made the determination through the Payer-Initiated process, APM Entities or eligible clinicians can submit information about their payment arrangements to us and ask us to make Other Payer Advanced APM determinations. • We've eliminated the requirement for a payer attestation; APM Entities or eligible clinicians have to certify that the information they submit is accurate.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	furnished any service through the payer. o An attestation from the payer that the submitted information is correct.	
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, you’ll 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 August 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.	• We are adding December 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). • We won’t use the fourth snapshot date to make QP determinations or extend the QP performance period past August 31.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
Virtual Groups & MIPS APMs	• Not applicable for the transition year.	• For MIPS APMs, we're 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.
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. • We'll automatically assign Improvement Activity scores based on APM design (no data submission required). We'll review each MIPS	• The Improvement Activities performance category weight = 20%.

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	APM on a case-by-case basis, identify activities that are part of the design of the APMs that go with Improvement Activities, and assign the correlating Improvement Activity score to the APM Entity group.	
Advancing Care Information performance category	• We've 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%.

Continuing the Dialogue

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

How to Comment on the Final Rule with Comment Period (and Interim Final Rule (CMS-5522-IFC))

Please refer to file code CMS–5522–FC when commenting on issues in the final rule with comment period, and CMS-5522-IFC when commenting on issues in the interim final rule with comment period. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):

1. **Electronically**. You may submit electronic comments on this regulation to http://www.regulations.gov/. Follow the ‘‘Submit a comment’’ instructions.

2. **By regular mail**. You may mail written comments to the following address ONLY:
   Centers for Medicare &Medicaid Services,
   Department of Health and Human Services,
   Attention: CMS–5522–FC or CMS-5522-IFC (as appropriate),
   P.O. Box 8016,
   Baltimore, MD 21244–8016.

3. **By express or overnight mail**.

4. **By hand or courier**.

Contact us

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

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