Quality Payment Program

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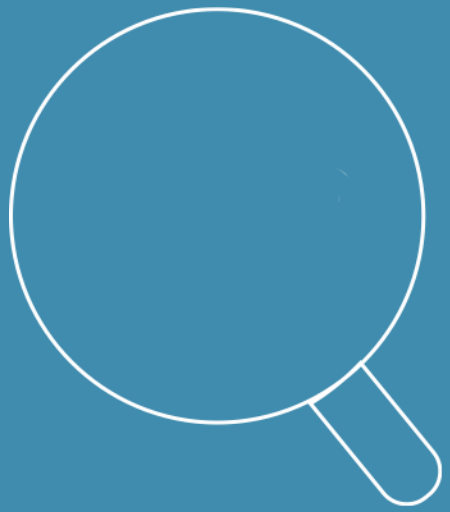
Icebreaker

What is your level of comfort in being able to discuss the Quality Payment Program to someone who may be interested in learning about the program?



What is the Quality Payment Program?

The Quality Payment Program

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

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

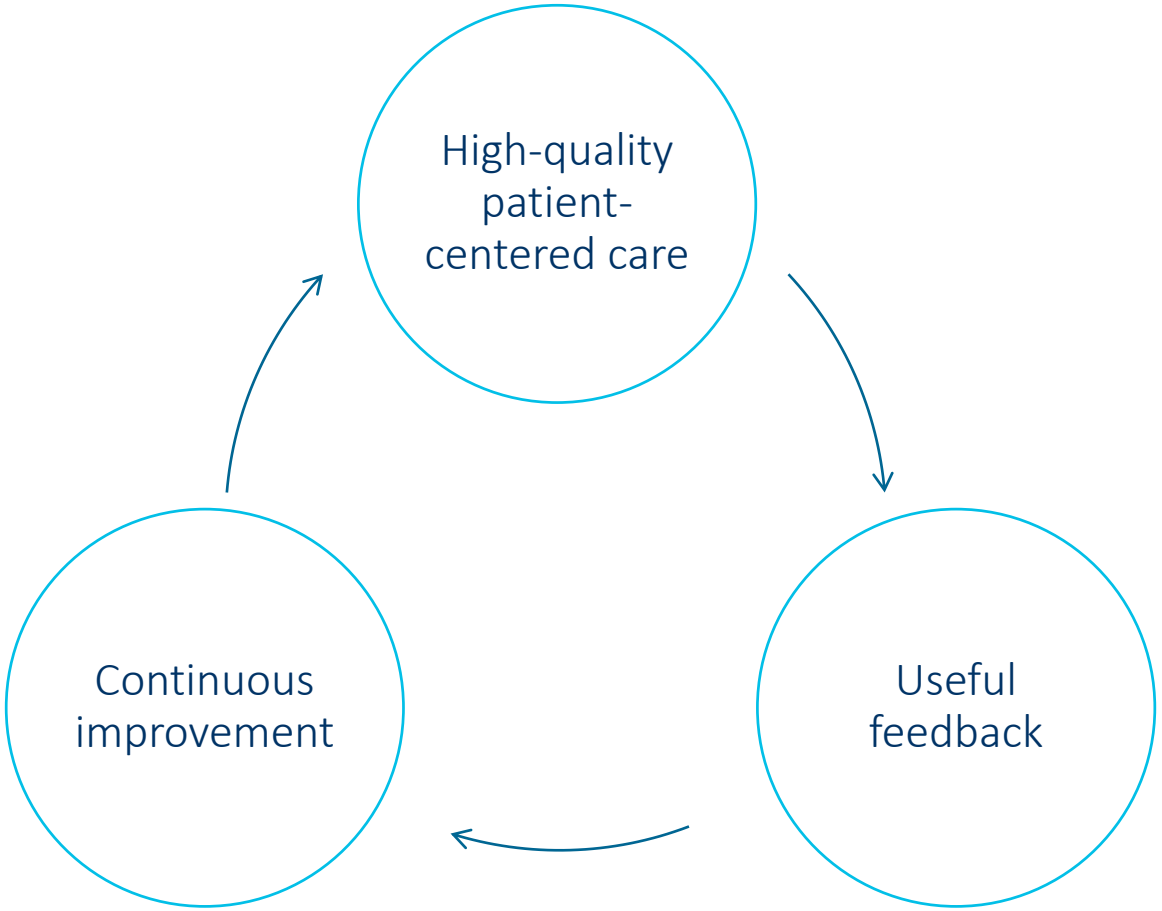
OR

Advanced APMs

Advanced Alternate Payment Models (APMs)

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

Quality Payment Program Bedrock



Quality Payment Program Strategic Goals

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV

Introduction to the Merit-based Incentive Payment System (MIPS)

Lesson Objectives

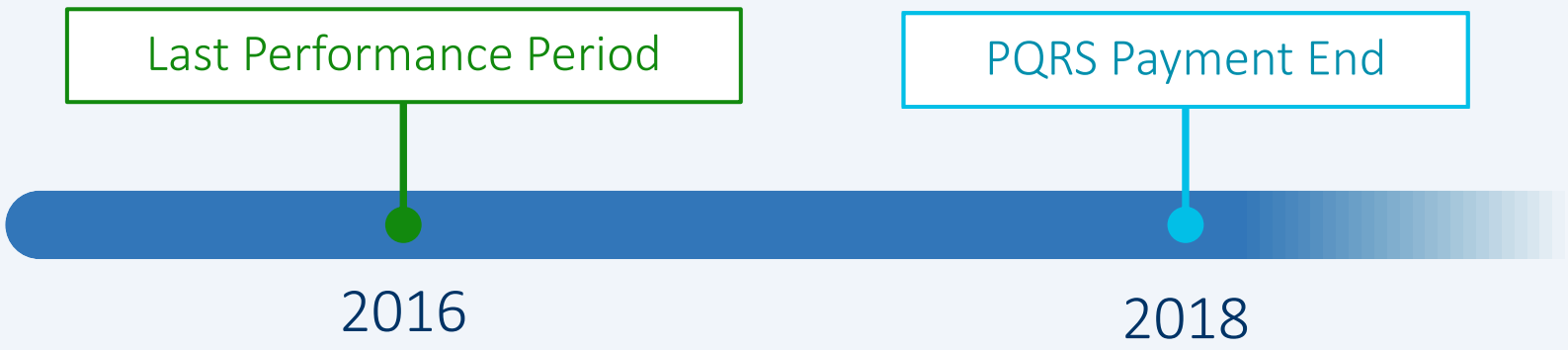
By the end of this lesson, you will be able to:

- Explain the Merit-based Incentive Payment System, including:
  - Structure
  - Eligibility
  - Participation
  - Performance Categories
  - Scoring

What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

Legacy Program Phase Out



What is the Merit-based Incentive Payment System?

Performance Categories

Quality

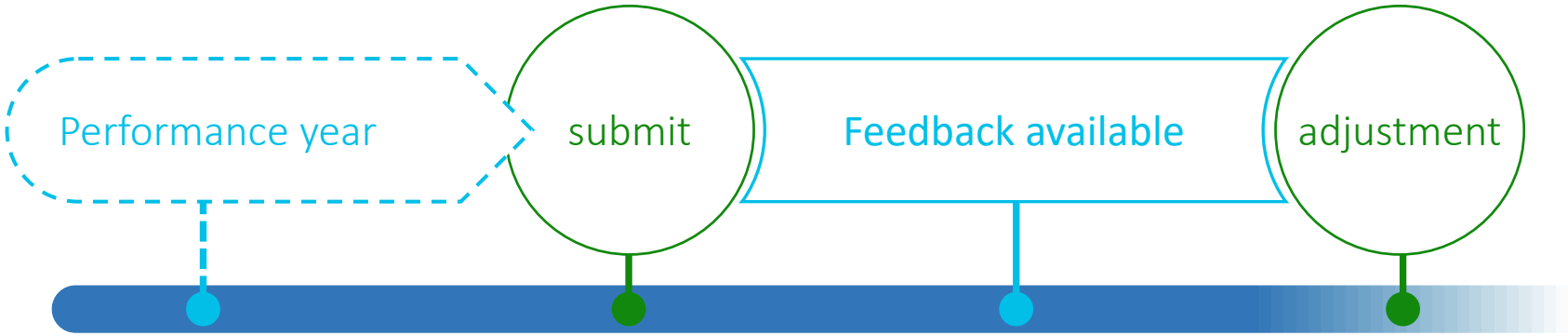
Cost

Improvement Activities

Advancing Care Information

- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible

When Does the Merit-based Incentive Payment System Officially Begin?



2017
Performance Year

Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

March 31, 2018
Data Submission

Send in performance data: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback

Feedback: Medicare gives you feedback about your performance after you send your data.

January 1, 2019
Payment Adjustment

Payment: You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you could earn 5% incentive payment in 2019.

Who Participates in the Merit-based Incentive Payment System?

Eligible Clinicians:

Medicare Part B clinicians billing more than $30,000 a year **AND** providing care for more than 100 Medicare patients a year.

Quick Tip:
Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists

Who is excluded from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

OR

- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of your Medicare payments

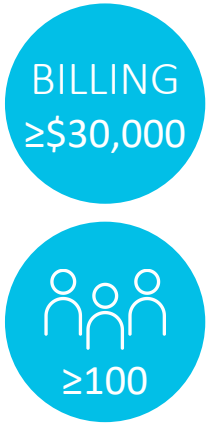
OR

- See 20% of your Medicare patients through an Advanced APM

Eligibility Scenario

You Have Asked: *"I would like to know whether I am exempt from the Merit-based Incentive Payment System if I exceed **EITHER** the Physician-Fee-Schedule charges **or** beneficiary count, but not BOTH."*

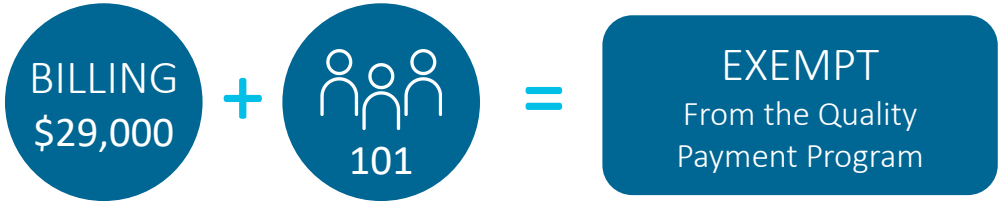
Eligibility Scenario



To be eligible for the Quality Payment Program, a clinician must bill more than $30,000 ***AND*** see more than 100 Medicare beneficiaries.

Quick Tip:
"And" is the key to eligibility

In the example provided in this incident where a clinician billed $29,000 and saw 101 patients, this clinician would be ***EXEMPT*** from the program because the clinician did not bill more than $30,000.



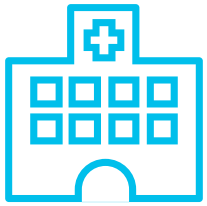
Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is $\leq$ 100 patient facing encounters in a designated period
- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- There are more flexible reporting requirements for non-patient facing clinicians

How do Eligible Clinicians Participate in the Merit-based Incentive Payment System?

Pick Your Pace for Participation for the Transition Year

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

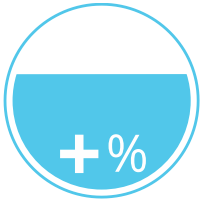
MIPS

Test Pace

Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year



Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MIPS: Choosing to Test for 2017

Submit Something

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: *"What is a minimum amount of data?"*

1 Quality Measure

OR

1 Improvement Activity

OR

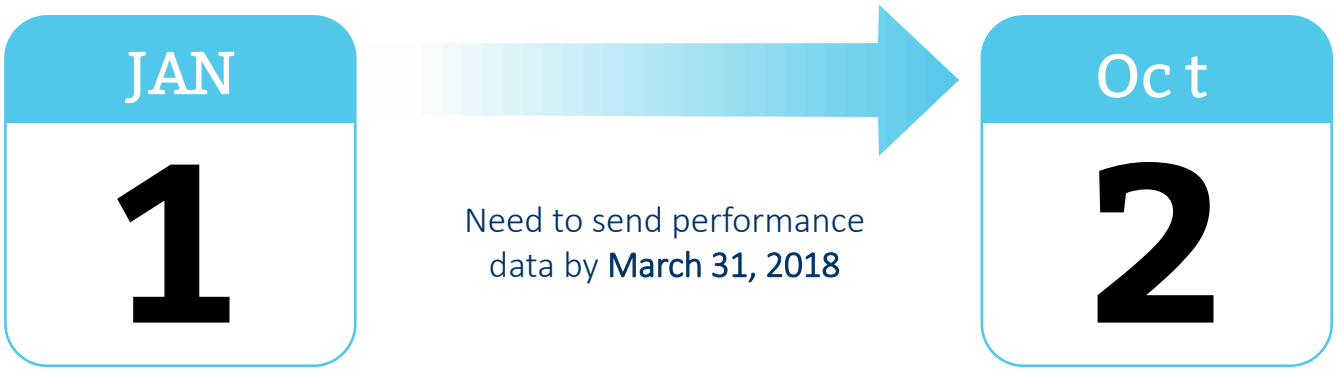
4 or 5 **Required** Advancing Care Information Measures

MIPS: Partial Participation for 2017

Submit a Partial Year

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

"So what?" - If you're not ready on January 1, you can start anytime between January 1 and October 2



MIPS: Full Participation for 2017

Submit a Full Year

- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

Bonus Payments and Reporting Periods

MIPS payment adjustment is based on data submitted. Clinicians should pick what's best for their practice.

Submit a Full Year

Full year participation

- Is the best way to get the max adjustment
- Gives you the most measures to choose from
- Prepares you the most for the future of the program

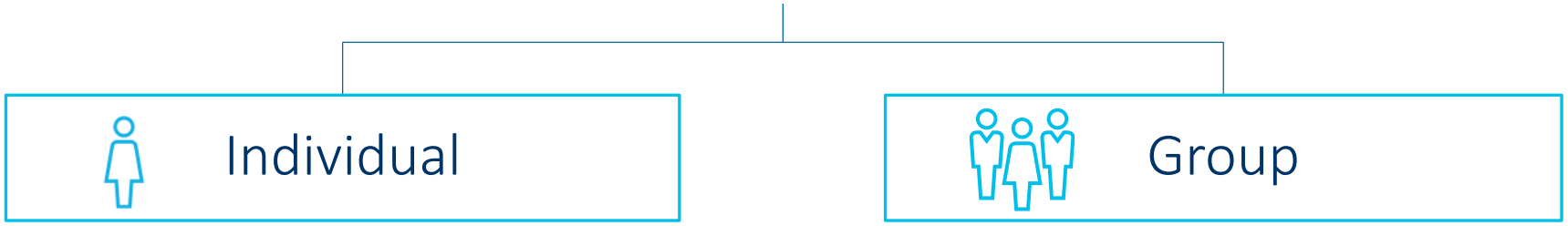
Submit a Partial Year

Partial participation (report for 90 days)

- You can still earn the max adjustment

Individual vs. Group Reporting

OPTIONS



1. **Individual**—under an NPI number and TIN where they reassign benefits

2. **As a Group**
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories

The Merit-based Incentive Payment System Performance Categories

What are the Performance Category Weights?

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

Quality	Cost	Improvement Activities	Advancing Care Information
60%	0%	15%	25%

Note: These are defaults weights; the weights can be adjusted in certain circumstances

MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - *"So what?"*—Provides for an easier transition due to familiarity

60% of final score

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:

- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures

MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- *Keep in mind:*

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)

Only the scoring is different

MIPS Performance Category:
Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- *Clinicians choose* from 90+ activities under 9 subcategories:

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response

MIPS Performance Category:
Improvement Activities

- No clinician or group has to attest to more than 4 activities
- *Special consideration for:*

Practices with 15 or fewer clinicians	Rural or geographic HPSA	Non-patient facing
APM	Certified Medical Home	

- *Keep in mind: This is a new category*

MIPS Performance Category:
Advancing Care Information

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are *2 measure sets for reporting based on EHR* edition:

Advancing Care Information Objectives and Measures	2017 Advancing Care Information Transition Objectives and Measures

MIPS Performance Category:
Advancing Care Information

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

Option 1	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets

For those using 2014 Certified EHR Technology:

Option 1	*Option 2*
2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

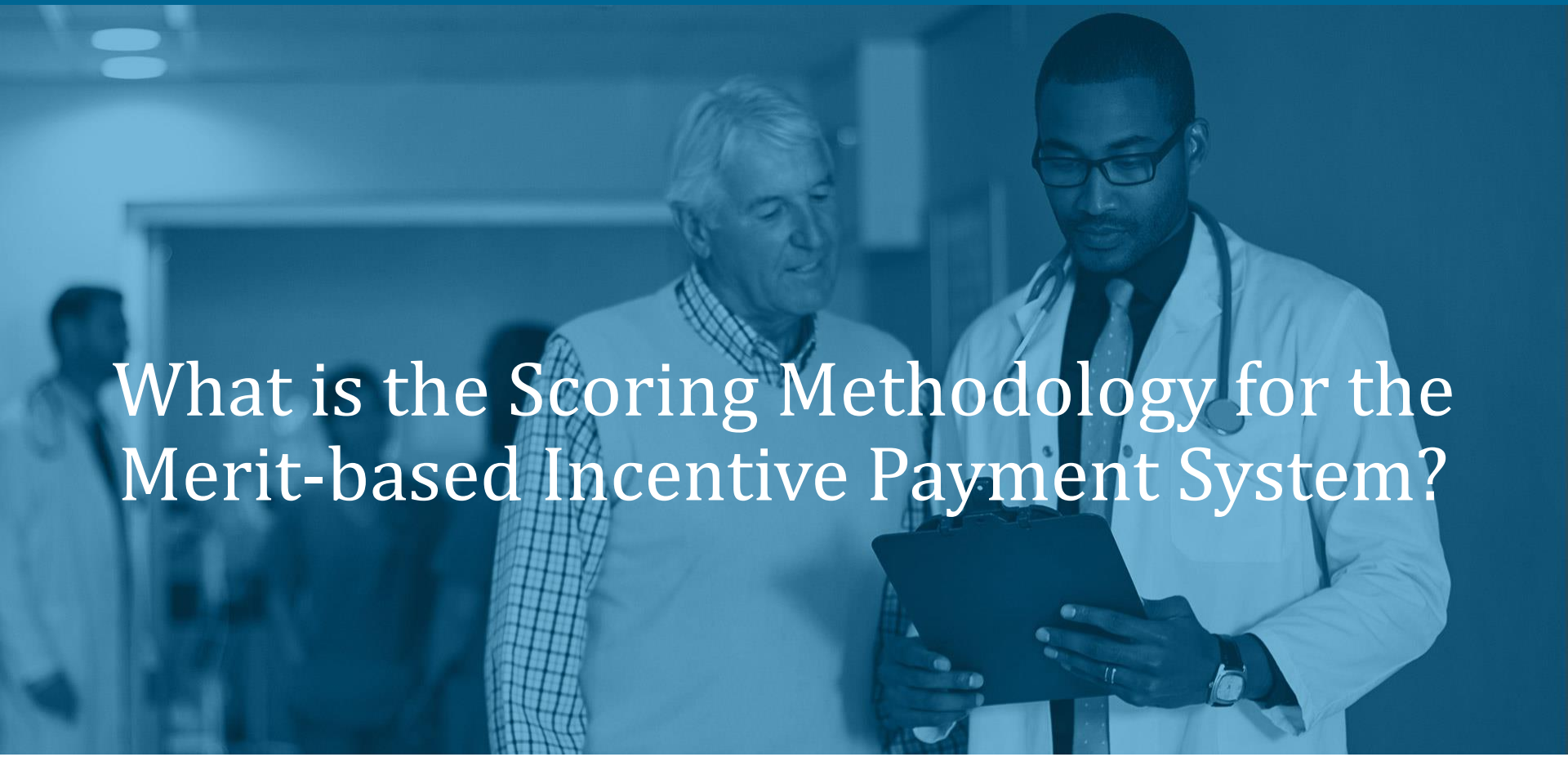
MIPS Performance Category:
Advancing Care Information

Hospital-based MIPS eligible clinicians may choose to report under the **Advancing Care Information** Performance Category

If clinicians face a significant hardship and are unable to report Advancing Care Information measures, **they can apply to have their performance category score weighted to zero**

25%

If objectives and measures are not applicable to a clinician, CMS will reweight the category to zero and assign the 25% to the other performance categories to offset difference in the MIPS final score



What is the Scoring Methodology for the Merit-based Incentive Payment System?

MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)

- Or a specialty set
- Or CMS Web Interface measures

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip:
Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

Bonus points are available

MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Total Quality Performance Category Score =

$$\frac{\{\text{Points earned on required 6 quality measures}\} + \{\text{Any bonus points}\}}{\text{Maximum number of points*}}$$

Quick Tip: Maximum score cannot exceed 100%

*Maximum number of points = # of required measures x 10

MIPS Scoring for Cost
(0% of Final Score in Transition Year)

No submission requirements

Clinicians assessed through claims data

Clinicians earn a **maximum of 10 points** per episode cost measure

MIPS Scoring for Cost
(0% of Final Score in Transition Year)

Cost Performance Category Score = Points assigned for scored measures / (10 × [Number of scored measures])

Quick Tip: No bonus points in cost performance category.

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Total points = 40

Activity Weights

- Medium = 10 points
- High = 20 points

Alternate Activity Weights*

- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Improvement Activities Performance Category Score = { Total number of points scored for completed activities / Total maximum number of points (40) } × 100

Quick Tip: Maximum score cannot exceed 100%

MIPS Performance Category: Advancing Care Information (25% of Final Score in Transition Year)

- Earn up to 155% maximum score, which will be capped at 100%

Advancing Care Information category score includes:

50%	90%	15%
Required Base score (50%)	Performance score (up to 90%)	Bonus score (up to 15%)

Keep in mind: You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category

MIPS Scoring for Advancing Care Information (25% of Final Score in Transition Year)

Calculating the Final Score Under MIPS

Final Score =

[Clinician Quality performance category score x actual Quality performance category weight] + [Clinician Cost performance category score x actual Cost performance category weight] + [Clinician Improvement Activities performance category score x actual Improvement Activities performance category weight] + [Clinician Advancing Care Information performance category score x actual Advancing Care Information performance category weight] × 100

Transition Year 2017

Final Score	Payment Adjustment
≥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
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Additional Adjustment Factors for MIPS

Exceptional Performer

"So what?"
Additional positive payment adjustments of $500,000,000 annually

Final scores of
70 or more qualify for additional payment

You Have Asked:
"Is the amount for top performers split amongst MIPS and APM participants?"

No. You only are eligible for the exceptional performance bonus if you participate in MIPS.

Lesson Summary

In this lesson, you have learned that:

- The Merit-based Incentive Payment System:
  - Streamlines the Legacy Programs
  - Moves Medicare Part B clinicians to a performance-based system
  - Measures clinicians on four Performance Categories:
    - Quality, Cost, Improvement Activities, and Advancing Care Information
  - Calculates a Final Score for clinicians based on their performance in the four Performance Categories
  - Adjusts payments based on the Final Score

Introduction to Advanced Alternative Payment Models (APMs)

Lesson Objectives

By the end of this lesson, you will be able to:

- Discuss Advanced Alternative Payment Models, including:
  - Benefits
  - Criteria
  - Eligible Models for 2017
  - Qualifying APM Participants
  - APM Scoring Standard

What is an Alternative Payment Model (APM)?

Alternative Payment Models (APMs) are new approaches to paying for medical care through Medicare that incentivize quality and value. The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations that CMS conducts.

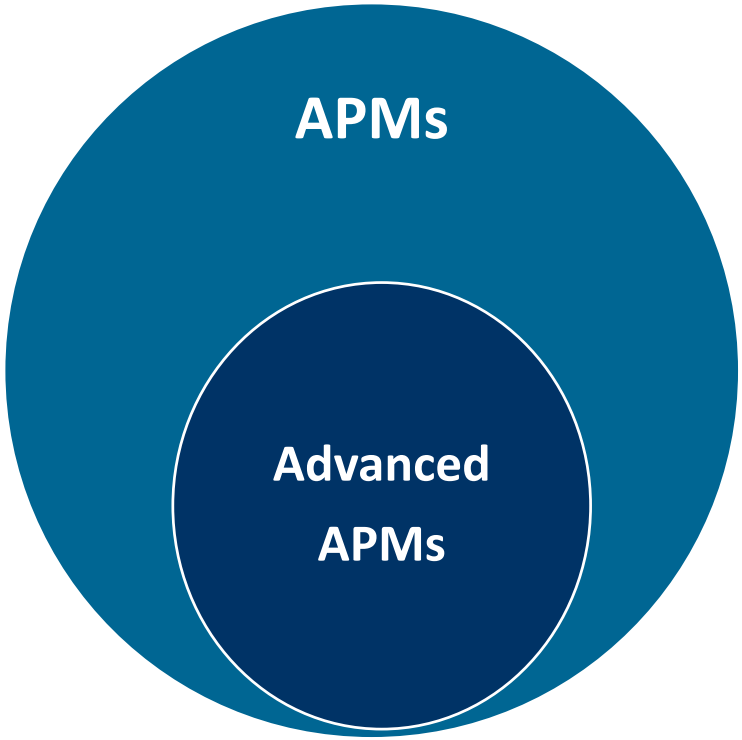
As defined by MACRA, **APMs include:**

- ✓ CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- ✓ MSSP (Medicare Shared Savings Program)
- ✓ Demonstration under the Health Care Quality Demonstration Program
- ✓ Demonstration required by federal law

Alternative Payment Models (APMs)

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- Can apply to a specific condition, care episode or population.
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of APMs



Advanced Alternative Payment Models

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

Advanced APMs → +

Advanced APM-specific rewards

5% lump sum incentive

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates extra incentives for a sufficient degree of participation in Advanced APMs.

What are the Benefits of Participating in an Advanced APM as a Qualifying APM Participant (QP)?

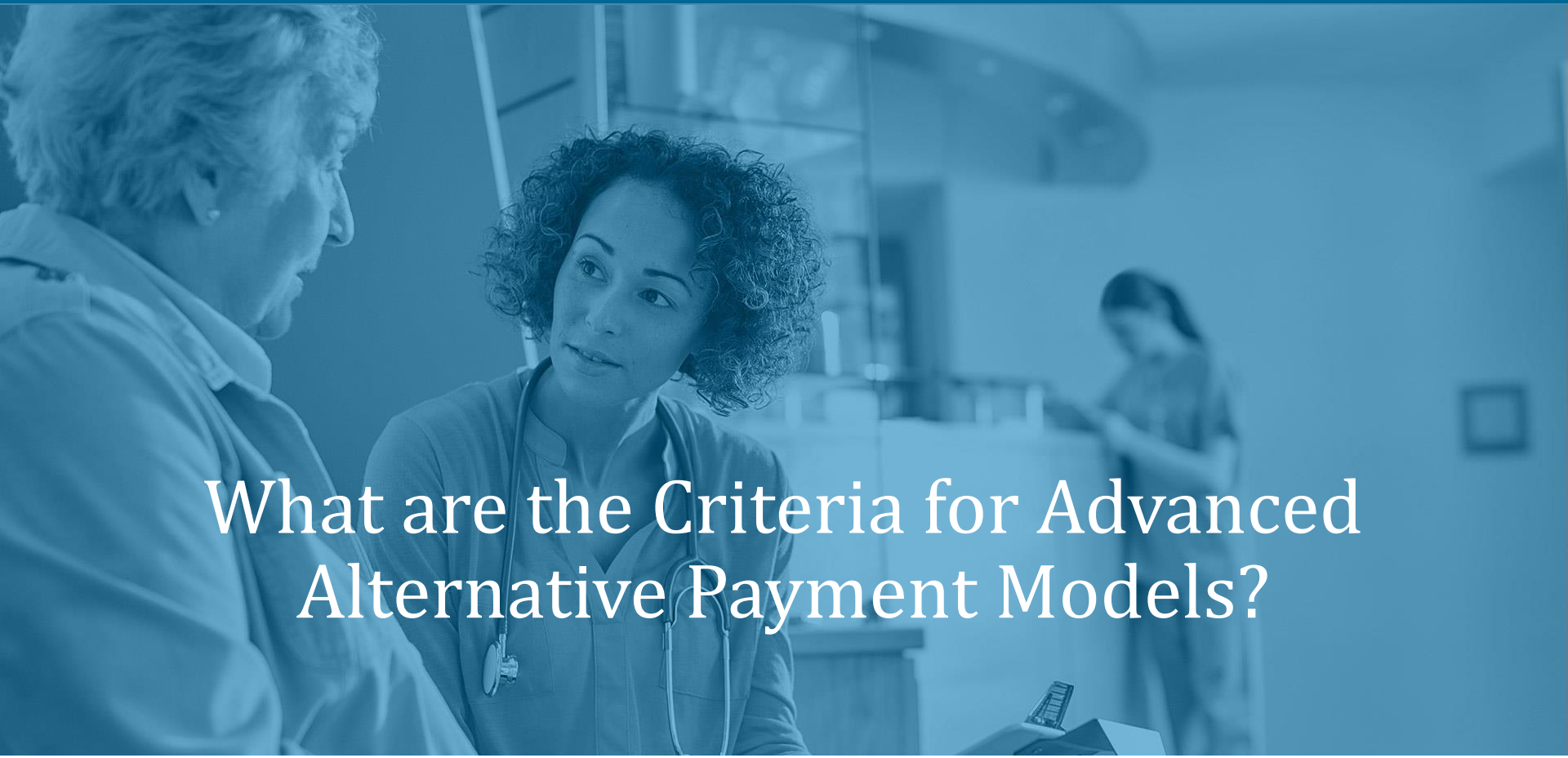
QPs:

- Are excluded from MIPS
- Receive a 5% lump sum bonus
- Receive a higher Physician Fee Schedule update starting in 2026

The Quality Payment Program provides **additional** rewards for participating in APMs.

Potential financial rewards

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
	If you are a **Qualifying APM Participant (QP)** =	5% lump sum bonus



What are the Criteria for Advanced Alternative Payment Models?

Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;
2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
3. **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.**

Advanced APM Criterion 1: Requires use of Certified EHR Technology

1. Requires participants to use certified EHR technology
   - Requires that at least 50% of the clinicians in each APM Entity use certified EHR technology to document and communicate clinical care information with patients and other health care professionals.
   - Shared Savings Program requires that clinicians report at the group TIN level according to MIPS rules.

Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

2. Bases payments on quality measures that are comparable to those used in the MIPS quality performance category.

- Ties payment to quality measures that are evidence-based, reliable, and valid.
- At least one of these measures must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.

Advanced APM Criterion 3: Bear a More than Nominal Amount of Financial Risk

3. 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.**

Financial Risk

Bearing financial risk means that the Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to CMS

Total Amount of Risk

The total amount of that risk must be equal to at least either:

- 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities; OR
- 3% of the expected expenditures for which an APM Entity is responsible under the APM.

Advanced APM Criterion 3: Medical Home Expanded Under CMS Authority

3. 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.

Medical Home Model Financial Risk Standard

Bearing financial risk means that the Medical Home Model may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to CMS, or
- Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

Medical Home Model Nominal Risk Standard

To be an Advanced APM, the amount of risk under a Medical Home Model must be at least the following amounts:

- 2.5% of estimated average total Medicare Parts A and B revenue (2017)
- 3% of estimated average total Medicare Parts A and B revenue (2018)
- 4% of estimated average total Medicare Parts A and B revenue (2019)
- 5% of estimated average total Medicare Parts A and B revenue (2020 and later)

Advanced APMs in 2017

For the 2017 performance year, the following models are Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements as needed.

Future Advanced APM Opportunities

In future performance years, we anticipate that the following models will be Advanced APMs:

- Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
- New Voluntary Bundled Payment Model
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- ACO Track 1+

Keep in mind: The Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review and assess proposals for Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

What is a Qualifying APM Participant?

Qualifying APM Participant (QP)

Qualifying APM Participants (QPs) are clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.

Beginning in 2021, this threshold % may be reached through a combination of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

How do Eligible Clinicians become Qualifying APM Participants?—Step 1

1

- ✓ Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - ✓ individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - ✓ eligible clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model will be assessed individually.

How do Eligible Clinicians become Qualifying APM Participants?—Step 2

2

- ✓ CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).
- ✓ Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM
- ✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

These definitions are used for calculating Threshold Scores under both methods.

Attributed (beneficiaries for whose cost and quality of care the APM Entity is responsible)

Attribution-eligible (all beneficiaries who could potentially be attributed)

How do Eligible Clinicians become Qualifying APM Participants?—Step 2

2

✓ The two methods for calculation are Payment Amount Method and Patient Count Method.

Payment Amount Method

$$$ for Part B professional services to **attributed beneficiaries**

$$$ for Part B professional services to **attribution-eligible beneficiaries**

= Threshold Score %

Patient Count Method

of **attributed beneficiaries** given Part B professional services

of **attribution-eligible beneficiaries** given Part B professional services

= Threshold Score %

How do Eligible Clinicians become Qualifying APM Participants?—Step 3

3

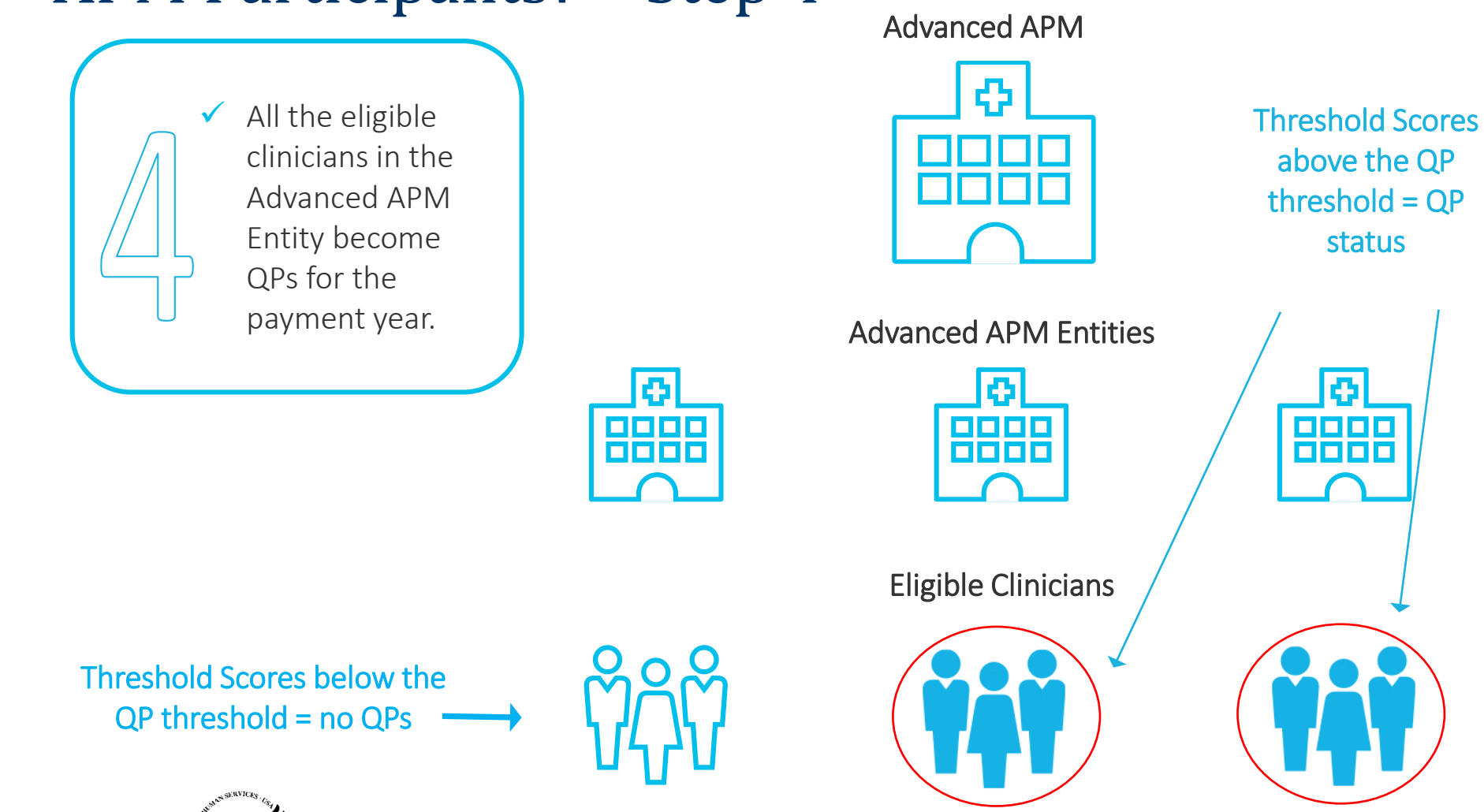
✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

How do Eligible Clinicians become Qualifying APM Participants?—Step 4

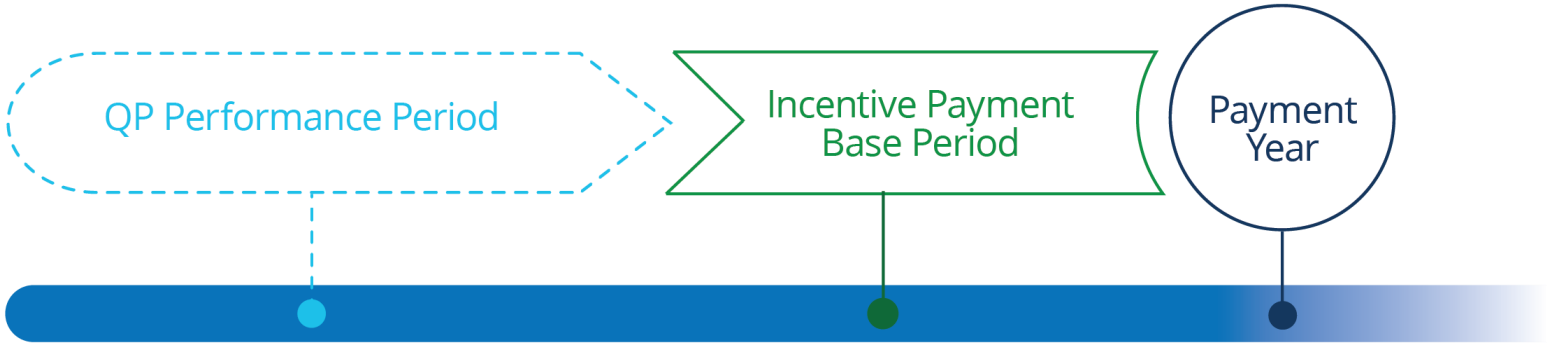
4

- ✓ All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.



What is the Performance Period for QPs?

- The QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for the payment year.
- The QP Performance Period for each payment year will be from **January 1—August 31st** of the calendar year that is **two years prior** to the **payment year**.



Performance Period:
QP status based on Advanced APM participation

Incentive Determination:
Add up payments for Part B professional services furnished by QP

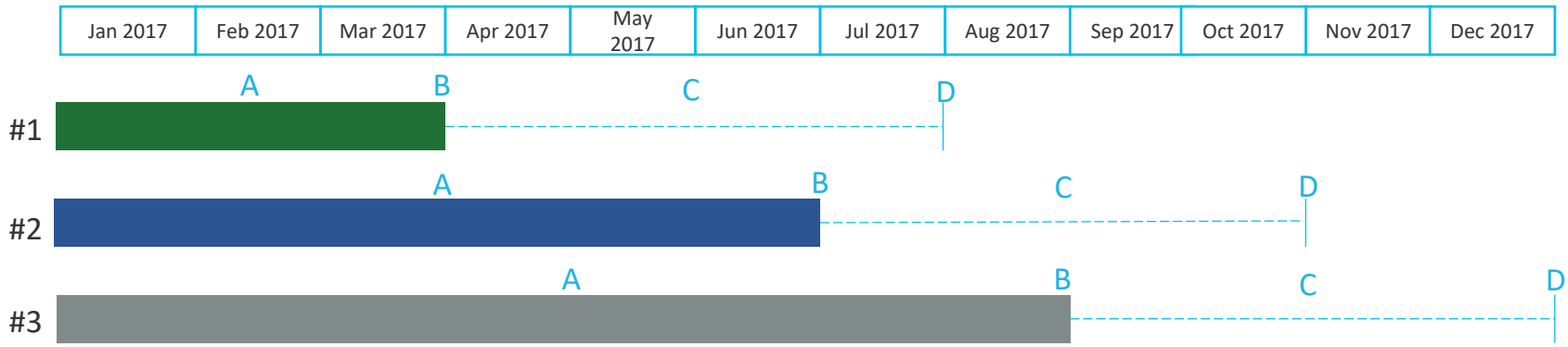
Payment:
+5% lump sum payment made (excluded from MIPS adjustment)

What are the three "Snapshots" for QPs during the Performance Period?

- During the QP Performance Period (January—August), CMS will take three "snapshots" (March 31, June 30, August 31) to determine which eligible clinicians are participating in an Advanced APM and whether they meet the thresholds to become Qualifying APM Participants.

When Will Clinicians Learn their QP Status?

- Reaching the QP threshold at any one of the three QP determinations will result in QP status for the eligible clinicians in the Advanced APM Entity
- Eligible clinicians will be notified of their QP status after each QP determination is complete (point D).



What if Clinicians do not meet the QP Payment or Patient Thresholds?

- Clinicians who participate in Advanced APMs, but do not meet the QP threshold, may become "Partial" Qualifying APM Participants (Partial QPs).
- Partial QPs choose whether to participate in MIPS.

Medicare-Only Partial QP Thresholds in Advanced APMs						
Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments	20%	20%	40%	40%	50%	50%
Percentage of Patients	10%	10%	25%	25%	35%	35%

What is the APM Scoring Standard?

What are MIPS APMs?

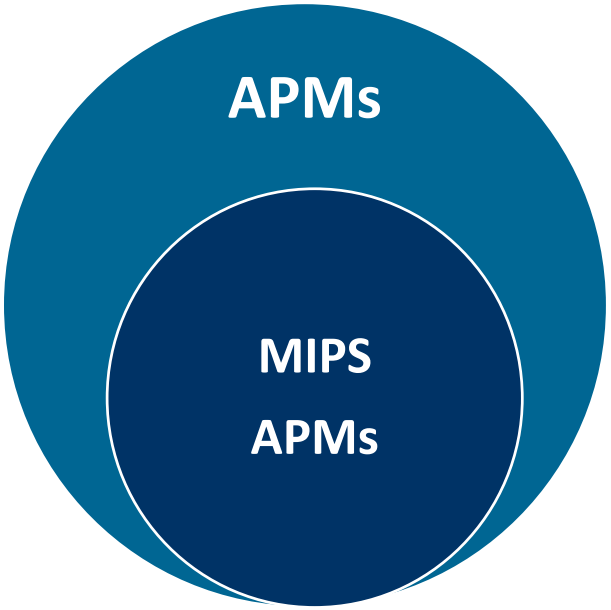
Goals

- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

How does it work?

- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

MIPS APMs are a Subset of APMs



What are the Requirements to be Considered a MIPS APM?

The APM scoring standard **applies to APMs that meet these criteria**:

- ✓ APM Entities participate in the APM under an **agreement with CMS**;
- ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
- ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization** and **quality**.

What are key dates for the APM scoring standard?

- To be considered part of the APM Entity for the APM scoring standard, an eligible clinician **must be on an APM Participation List on at least one of the following three snapshot dates (March 31, June 30 or August 31)** of the performance period.

- Otherwise an eligible clinician must report to MIPS under the standard MIPS methods.

To which APMs does the APM Scoring Standard apply in 2017?

For the **2017 performance year**, the following models are considered MIPS APMs:

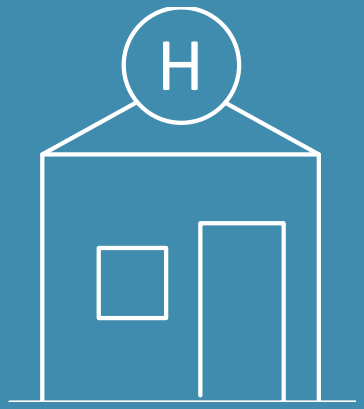
- Comprehensive ESRD Care (CEC) Model (All Arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
- Shared Savings Program Tracks 1, 2, and 3
- Next Generation ACO Model
- Oncology Care Model (OCM) (All Arrangements)

The list of MIPS APMs is posted at QPP.CMS.GOV and will be updated on an ad hoc basis.

Lesson Summary

In this lesson, you have learned that:

- Advanced Alternative Payment Models:
  - Must meet three specific requirements to be considered Advanced APMs
  - Have several eligible models for 2017
  - Are comprised of Qualifying APM Participants
- APM Scoring Standard:
  - Applies to certain APM Entities



What is Being Done for Small/Rural Practices and Health Professional Shortage Areas (HPSAs)?

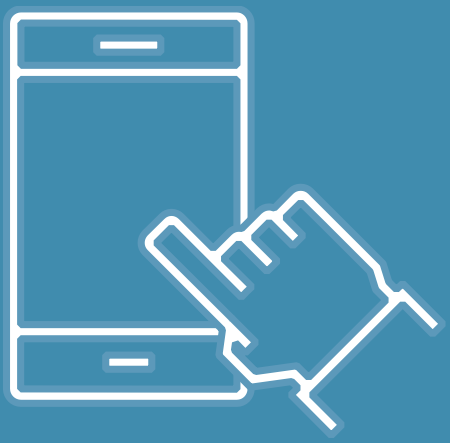
Small, Rural, and Health Professional Shortage Areas (HPSAs)

You Have Asked: *"Based on the requirements, can small or rural practices succeed in the Quality Payment Program?"*

- Increasing the availability of Advanced APMs to small practices
- Increasing ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant
- Providing funding for direct technical assistance

We have heard these concerns and are taking additional steps to aid small, rural, and HPSAs, including:

- Reducing the time and cost to participate in the program
- Excluding more small practices through the low-volume threshold
- Allowing practices to pick their pace of participation



Where can I go to learn more?

Technical Assistance

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

Quality Payment Program Portal

- Learn about the Quality Payment Program, explore the measures, and find educational tools and resources.

Transforming Clinical Practice Initiative (TCPI):

- Designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):

- Includes 14 QIN-QIOs
- Promotes data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

The Innovation Center's Learning Systems provides specialized information on:

- Successful Advanced APM participation
- The benefits of APM participation under MIPS

When and where do I submit comments?

- Submit comments referring to file code **CMS-5517-FC** by **December 19, 2016**
- Comments must be submitted in one of the following ways:
  - Electronically through Regulations.gov
  - By regular mail
  - By express or overnight mail
  - By hand or courier
- ***Note:*** *Final Rule with comment includes changes not reviewed in this presentation. Presentation feedback not considered formal comments on the rule.*

For additional information, please go to: QPP.CMS.GOV

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