ENDOCRINE SOCIETY
Hormone Science to Health

QUALITY PAYMENT PROGRAM
Changes for Year 2
Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

Merit-Based Incentive Payment System (MIPS)		
Policy	**Year 1 Final Rule**	**Year 2 Final Rule**
Performance Period	Four Pick Your Pace options: Minimum – Submit data for one quality measure, OR one improvement activity, OR the four required ACI measures and avoid a negative payment adjustment. Partial Participation – Submit at least 90 days of data for more than one quality measure, OR more than one improvement activity, OR more than the four required ACI measures and avoid a negative payment adjustment. Partial participation also allows ECs to possibly receive a small positive payment adjustment. Full Participation – Submit at least 90 days of data for all required quality measures, AND all required improvement activities, AND all four required ACI measures to avoid a negative payment adjustment. Full participation also allows ECs to possibly receive a moderate positive payment adjustment. Alternative Payment Model – Eligible clinicians will receive a 5% bonus if they receive 25% of Medicare Part B payments, OR see 20% of patients through an advanced APM.	For the MIPS payment year 2021 and future years: - Full-year reporting period for cost and quality - 90 day performance period for Advancing Care Information and Improvement Activities
Payment Adjustments	+/- 4 percent for the 2019 payment year	+/- 5 percent for the 2020 payment year

		The amount paid by Medicare will be subject to the payment adjustment
Low-Volume Threshold	Providers are excluded if they, or their group, have $30,000 or less in Part B allowed charges OR 100 or less Part B beneficiaries	Providers are excluded if they, or their group, have $90,000 or less in Part B allowed charges or 200 or less Part B beneficiaries
Virtual Groups		**NEW FOR 2018.** Added 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 to participate in MIPS for a performance period of a year. Solo practitioners and small groups may only participate in a Virtual Group if they exceed the low-volume threshold.
Quality Category Requirements	- 60% weight in final composite score - Data completeness: 50% for submission mechanisms except for Web Interface and CAHPS. - Measures that don't meet the data completeness criteria earn 3 points.	- 50% weight in final composite score - 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. **NEW FOR 2018.** - 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. -
Facility-Based Measures	Not available in 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).
Cost	0% weight in final score	- 10% weight in final score - For the 2018 MIPS performance period, CMS won't use the 10 episode-based measures adopted for the 2017 MIPS performance period - It will use two other measures, MSPB and total per capita - The MSPB measure assesses Medicare Part A and B costs incurred during an episode. An episode includes the dates falling between three days prior to an Inpatient Prospective Payment System (IPPS) hospital admission (referred to as an index admission) and 30 days post-hospital discharge. - The total per capita cost measure assesses all Medicare Part A and B costs for each attributed beneficiary - No physician reporting is required
Improvement scoring for Quality & Cost		**NEW FOR 2018** <u>For Quality</u>: - Improvement will be measured at the performance category, not the individual measure, level - Up to 10 percentage points available in the Quality performance category. <u>For Cost</u>: - Improvement scoring will be based on statistically significant changes at the measure level.

		- Up to 1 percentage point available in the Cost performance category. <u>Improvement Scoring</u>: - If the improvement score can't be calculated because there is not sufficient data, CMS will assign an improvement score of 0 percentage points. - CMS will determine an improvement score only when there's sufficient data to measure improvement - When there is insufficient data reported to assign an improvement score, it will be omitted from the calculation of a clinician's composite score
Improvement Activities	Number of activities: 92 activities in the Inventory Definition of certified patient-centered medical home: 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.	Number of activities: 112 activities in the inventory Definition of certified patient-centered medical home: 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.
Advancing Care Information	Can use either 2014 or 2015 Edition CEHRT Scoring: Awarded performance score points if you submit additional measures (up to 10% each).	Providers can continue to use either 2014 or 2015 Edition CEHRT, but only those with 2015 Edition CEHRT are eligible for a 10% bonus. - New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period.

		- Revised 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) - ACI hardship exemption for small practices re-weights the ACI category to zero, shifting an additional 25 percent to the Quality category. - 10 point bonus for eligible clinicians who attest to completing at least one specified improvement activity using CEHRT Scoring: 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
Final Score	- Quality 60% - Cost 0% - Improvement Activities 15% - Advancing Care Information 25%.	- Quality 50% - Cost 10% - Improvement Activities 15% - Advancing Care Information 25%.
Complex Patient Bonus		**NEW FOR 2018.** 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		**NEW IN 2018.** 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.
Performance Threshold	Performance threshold = 3 points	Performance threshold = 15 points

ALTERNATIVE PAYMENT MODELS (APMs)		
Policy	**Year 1 Final Rule**	**Year 2 Final Rule**
Standard for More than Nominal Risk	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 the APM for all performance years	- Extended the 8% revenue-based standard for 2 additional years, through performance year 2020 - The 3% standard was removed for greater clarity
Standard for Medical Home Model Financial Risk	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	50 eligible clinician cap no rescinded for clinicians who are participating in the first round of the Comprehensive Primary Care Plus (CPC+) model
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 - CMS makes 3 QP determinations using data from March 31, through June 30, and through the last day of the QP performance period, respectively	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
Nominal Risk Standard for Other Payer Advanced APMs	Nominal amount of risk must be: - Marginal risk of at least 30% - Minimum Loss Rate of no more than 4% - 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, CMS added a revenue-based nominal risk 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 previously finalized

Payer-Initiated Determination of Other Payer Advanced APMs		**NEW POLICY EFFECTIVE IN 2019.** - 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 CMS make Other Payer Advanced APM determinations before the relevant QP Performance Period. - Option will be offered 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	While QP determinations will be made the same way, if the Medicare threshold score for an eligible clinician is higher when calculated for the APM Entity group than when calculated for the individual eligible clinician, CMS will make the QP determination under the All-Payer Combination Option using a weighted Medicare threshold score that will be factored into 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 CMS with: Payment arrangement information to assess the other payer arrangement on all Other Payer Advanced APM criteria; 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	- If CMS hasn't already made the determination through the Payer-Initiated process, APM Entities or eligible clinicians can submit information about their payment arrangements to the agency and ask it to make Other Payer Advanced APM determinations. - Eliminated the requirement for a payer attestation; APM Entities or eligible clinicians have to certify that the information they submit is accurate.

	number of patients furnished any service through the payer - An attestation from the payer that the submitted information is correct is required.	
Identifying MIPS APM Participants	A clinician on an APM Participation List on at least 1 of the APM participation assessment (Participation List ''snapshot'') date, will be included in the APM Entity group for the APM scoring standard for the applicable performance year. If a clinician isn't on the APM Entity's Participation List on at least one of the snapshot dates (March 31, June 30, or August 31), then they will 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	- CMS 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). - CMS won't use the fourth snapshot date to make QP determinations or extend the QP performance period past August 31.
Virtual Groups & MIPS APMs		**NEW IN 2018.** For MIPS APMs, CMS waived sections of the statute that require all Virtual Group participants to receive their MIPS payment adjustment based on the Virtual Group score. 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.