

## CY 2018 Quality Payment Program Final Rule Summary

On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released its [final rule](#) outlining the requirements for year two of the Quality Payment Program (QPP). The QPP includes two tracks for participation in 2018: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). There will be a 60-day public comment period that closes on January 1.

CMS finalized the majority of their proposed policies, and modified several others. Some of the key policies finalized include the following:

- Cost will count toward the MIPS composite score in the 2018 performance year unlike in the first year of MIPS
- Improvement scoring in the Quality and Cost performance categories was implemented
- A new bonus point opportunity for clinicians who treat complex patient populations, based on a combination of Hierarchical Condition Categories (HCCs) and the dual eligible population treated
- An increase in the low-volume threshold to less than or equal to \$90,000 in Medicare Part B allowed charges or less than or equal to 200 Part B patients
- Implementation of a virtual group option starting in the 2018 performance year
- Implementation of the “All-Payer Combination Option” for the Advanced APM pathway starting in the 2019 performance year, with Medicare Advantage models applying to the All-Payer option

### **Merit-Based Incentive Payment System**

Below is a summary table of the MIPS performance category requirements for the 2018 performance year.

Category	Reporting and Scoring
Quality	<ul style="list-style-type: none"> <li>• 50% weight in 2018 performance year</li> <li>• 30% weight in 2019 performance year and beyond</li> <li>• Physicians and groups are required to report on 6 quality measures, with at least one outcome measure, or one high-priority measure if no outcome measures are available</li> <li>• Measures must be reported on at least 50% of all patients if submitting via registry or EHR, and 50% of Medicare Part B patients if submitting via claims</li> </ul>

	<ul style="list-style-type: none"> <li>• Data completeness: Increased threshold to 60% for 2019 performance period</li> <li>• Measures that do not meet data completeness criteria will get 1 point instead of 3 points (Small practices will continue to get 3 points)</li> </ul>
Cost	<ul style="list-style-type: none"> <li>• 10% weight in 2018 performance year</li> <li>• 30% weight in 2019 MIPS performance year and beyond</li> <li>• For the 2018 MIPS performance year, CMS will adopt the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period, and will not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period.</li> </ul>
Improvement Activities	<ul style="list-style-type: none"> <li>• 15% weight and measured based on a selection of different medium and high-weighted activities</li> <li>• Physicians practicing in groups of 15 or fewer are still eligible for full credit in the category if they report one high-weighted or two medium-weighted activities</li> <li>• No change in the number of activities that MIPS eligible clinicians have to report to reach a total of 40 points</li> <li>• MIPS eligible clinicians in small practices and practices in rural areas will keep reporting on no more than 2 medium or 1 high-weighted activity to reach the highest score</li> </ul>
Advancing Care Information	<ul style="list-style-type: none"> <li>• 25% weight in 2018 performance year</li> <li>• Composed of a base score and a performance score</li> <li>• 10 percentage point bonus for CY2018 performance period for reporting using CEHRT</li> <li>• Physicians who do not write 100 eligible prescriptions will be excluded from the e-Prescribing measure</li> </ul>

	<ul style="list-style-type: none"> <li>• Those who do not have 100 eligible referrals or transitions of care will be excluded from the health information exchange measures</li> <li>• CMS finalized a re-adjusted bonus structure so physicians who cannot report to immunization registries are not disadvantaged</li> </ul>
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### Low-Volume Threshold

<b>Low-Volume Threshold Qualifications for Exemption</b>	
<b>CY2017 Final Policy</b>	<b>CY2018 Final Policy</b>
≤ \$30,000 in Part B allowed charges, OR ≤ 100 Part B beneficiaries	≤ \$90,000 in Part B allowed charges, OR ≤ 200 Part B beneficiaries

CMS has finalized an increase in the low volume threshold for eligible clinicians. The 2017 threshold excluded eligible clinicians with either a Medicare expenditure threshold of \$30,000 or more in Medicare Part B payments or 100 or more Medicare Part B beneficiaries. The final rule increased the Medicare payment and beneficiary low-volume threshold to \$90,000 or more in Medicare Part B payments or 200 or more Medicare Part B beneficiaries. This excludes more physicians, including radiation oncologists, and groups from MIPS participation. It is estimated only 37 percent of physicians will be MIPS eligible. The agency did not finalize a proposal to allow excluded physicians to opt-in to the program if they exceed one of the two thresholds.

### Virtual Groups

CMS has finalized a policy defining a virtual group as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians that elect to form a virtual group for a performance year. CMS also finalized its virtual group policies to clearly delineate policies that apply to all groups, including virtual groups” versus those policies that apply only to virtual groups, such as modifying the definition of a non-patient facing MIPS eligible clinician to include a virtual group (provided that more than 75 percent of the NPIs billing under the virtual group’s TINs meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period) and finalizing that a virtual group will be considered a small practice if a virtual group consists of 15 or fewer eligible clinicians.

Virtual groups are required to make an election to participate in MIPS as a virtual group prior to the start of an applicable performance period. The agency is finalizing a two-stage virtual group election process for the applicable 2018 and 2019 performance periods. The first stage is the optional eligibility stage, but for practices that do not choose to participate in stage 1 of the election process, CMS will make an

eligibility determination during stage 2 of the election process. The second stage is the virtual group formation stage. Stage 1 is not required, but serves as a resource for solo practitioners and groups with 10 or fewer eligible clinicians. Solo practitioners and groups that engage in stage 1 and are determined eligible for virtual group participation would proceed to stage 2; otherwise, solo practitioners and groups that do not engage in any activity during stage 1 would begin the election process at stage 2. Engaging in stage 1 would provide solo practitioners and groups with the option to confirm whether or not they are eligible to join or form a virtual group before going to the lengths of executing formal written agreements, submitting a formal election registration, allocating resources for virtual group implementation, and other related activities; whereas, by engaging directly in stage 2 as an initial step, solo practitioners and groups might conduct all such efforts to only have their election registration be rejected with no recourse or remaining time to amend and resubmit.

The agency is also finalizing that virtual groups must have a formal written agreement among each party of a virtual group. The election deadline will be December 31. For Quality Payment Program Year 3, the agency intends to provide an electronic election process, if technically feasible.

To provide support and reduce burden, CMS finalized its proposal to make technical assistance (TA) available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group for the 2018 and 2019 performance years.

Virtual groups are required to meet the requirements for each performance category and responsible for aggregating data for their measures and activities across the virtual group, for example, across their TINs. In future years, CMS intends to examine how we define “group” under MIPS with respect to flexibility in composition and reporting.

### **MIPS Performance Period**

For the quality and cost categories, CMS finalized a full calendar year reporting period for 2018 that occurs two years before the MIPS payment year. The performance period for improvement activities and advancing care information would be a minimum of a continuous 90-day period within the calendar year up to and a full year as a maximum. Bonuses and penalties assessed in 2020 will be determined by data reported in 2018. This is consistent with how CMS has been running its quality reporting programs to date.

### **MIPS Performance Category Measures and Activities**

In the proposed rule, CMS considered allowing individual MIPS eligible clinicians and groups to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category, beginning with the 2018 performance period, for purposes of the 2020 MIPS payment year and future years

CMS finalized this proposal but delayed its implementation until year three of the QPP (2019) due to its inability to aggregate data on the same measure across submission mechanisms. For the 2018 performance period, measures must be submitted using only one mechanism per performance category, the same rule as the 2017 performance period.

### **Quality Performance Category**

As a result of the decision to increase the Cost category weighting to 10 percent, CMS decreased the weight of the Quality category to 50 percent for the 2018 performance year. CMS increased the data completeness threshold from 50 percent to 60 percent for both 2018 and 2019 performance years, with a minimum of 20 cases per measure. Practices that do not meet data completeness requirements in 2017 receive three points toward their Quality score; CMS modified the scoring for 2018 so that practices will only receive one point if they do not achieve data completeness. This policy will not apply to small practices who will continue to earn three points for submitting measures that do not meet these requirements. Beginning with the 2018 performance year, CMS will begin to score achievement as well as performance improvement, if sufficient data is available.

CMS also announced that it is implementing a four-year process for identifying and phasing out topped out measures. Special scoring, featuring a 7-point measure cap, will be applied to measure benchmarks that have been topped out for at least two consecutive years. If during one of the three performance periods, the measure benchmark is not topped out, then the cycle would start again at year one. The agency will consider whether a specialty has other applicable measures when making final determinations about topped out measures.

#### *Improvement Bonus*

CMS finalized its policy to calculate an improvement bonus using the formula below. Percentage changes in achievement are calculated for the entire Quality category, rather than on a measure-specific basis, during each performance period. The improvement percent score may not total more than 10 percentage points.

Improvement percent score = (increase in quality performance category achievement percent score from prior performance period to current performance period / prior year quality performance category achievement percent score)\*10 percent.

The improvement percent score cannot be negative and would be zero for those who do not have sufficient data or who are not eligible under this proposal for improvement points.

#### *Facility-Based Measurement*

CMS proposed to implement a facility-based scoring option on a limited basis in the 2018 performance year. The agency proposed to incorporate additional facility-based measures under MIPS by using inpatient hospital measures and for the 2020 MIPS payment year, to include all the measures adopted for the FY2019 Hospital Value Based Purchasing (VBP) Program on the MIPS list of quality measures and cost measures.

In its final rule, CMS has delayed implementation of the facility based measurement option in the quality and cost performance categories until year three (2019). The agency says that it plans to use the next year to ensure that clinicians better understand facility-based measurement and ensure “operational readiness.”

#### **Cost Performance Criteria**

For the 2020 MIPS payment year, CMS is finalizing a 10 percent weight for the cost performance category in the final score in order to ease the transition to a 30 percent weight for the cost performance category in the 2021 MIPS payment year. The agency had initially proposed to keep this category's weight at 0. For the 2018 MIPS performance period, the agency is adopting the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period, and will not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period.

CMS is in the process of developing new episode-based measures with significant clinician input and believes it would be more effective to introduce these new measures over time. The agency will continue to offer performance feedback on episode-based measures prior to potential inclusion of those measures in MIPS to increase clinician familiarity with the concept, as well as specific episode-based measures. CMS intends to provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018, as well as feedback on newly developed episode-based cost measures sometime next year.

### **Improvement Activities Performance Criteria**

CMS has finalized its proposal to no longer require self-identifications for non-patient facing MIPS eligible clinicians, small practices, practices located in rural areas or geographic HPSAs, or any combination thereof, beginning with the 2018 MIPS performance period.

It also finalized that for year 2 and future years, MIPS eligible clinicians or groups must submit data on improvement activities in one of the following ways:

- Qualified registries
- EHR submission mechanisms
- Qualified Clinical Data Registries
- CMS Web Interface
- Attestation

For activities that are performed for at least a continuous 90 days during the performance period, MIPS eligible clinicians must submit a yes response for activities within the Improvement Activities Inventory.

CMS is finalizing 21 new improvement activities and changes to 27 previously adopted improvement activities (some with modification and including 1 removal) for year 2 and future years (2018 MIPS performance period and future years) Improvement Activities Inventory. The agency will continue to add new improvement activities.

CMS also finalized several policies related to submission of improvement activities, including formalizing the annual call for activities process for year three and future years. The agency finalized, with modification, for year 3 and future years, that stakeholders should apply one or more of the criteria when submitting improvement activities in response to the Annual Call for Activities. CMS finalized two new criteria rule for nominating new improvement activities:

- 1) Improvement activities that focus on meaningful actions from the person and family's point of view

## 2) Improvement activities that support the patient's family or personal caregiver

These will be added to the list of existing criteria that follow below:

- Relevance to an existing improvement activities subcategory (or a proposed new subcategory)
- Importance of an activity toward achieving improved beneficiary health outcome
- Importance of an activity that could lead to improvement in practice to reduce health care disparities
- Aligned with patient-centered medical homes
- Focus on meaningful actions from the person and family's point of view
- Support the patient's family or personal caregiver
- Activities that may be considered for an advancing care information bonus
- Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care)
- Feasible to implement, recognizing importance in minimizing burden, especially for small practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA
- Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes; or
- CMS is able to validate the activity

CMS finalized the following policies in for this category: there will be an Annual Call for Activities and the agency will accept submissions for prospective improvement activities at any time during the performance period; they will also create an Improvement Activities Under Review (IAUR) list; only prospective activities submitted by March 1 for inclusion in the Improvement Activities Inventory will be considered for following calendar year; and adding new improvement activities and subcategories through notice-and-comment rulemaking in future years of the QPP.

CMS is also finalizing the policy that for the 2021 MIPS payment year, the performance period for the improvement activities performance category will remain a minimum of a continuous 90-day period within CY 2019, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

The agency is also expanding its definition of how the agency will recognize an individual MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice. At least 50 percent of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice to receive full credit as a certified or recognized patient-centered medical home or comparable specialty practice for the 2020 MIPS payment year and future years. CMS clarified that a practice site is the physical location where services are delivered.

CMS did not finalize its proposal for eligible clinicians in practices that have been randomized to the control group in the CPC+ model would also receive full credit as a Medical Home Model because the Innovation Center has not randomized any practices into a control group in CPC+ Round 2.

### **Advancing Care Information Performance Category**

#### *Performance Score*

CMS finalized its proposed modification of the scoring of the Public Health and Clinical Data Registry Reporting objective beginning in 2018. If a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, he would earn 10 percentage points in the performance score. If he cannot fulfill the Immunization Registry Reporting Measure, the clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports, up to a maximum of 10 percentage points. A clinician who reports to more than one public health agency or clinical data registry may receive credit for this reporting; however, the MIPS eligible clinician would not earn more than a total of 10 percentage points for such reporting.

CMS finalized similar flexibility for clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set. If the clinician fulfills the Immunization Registry Reporting Measure, he would earn 10 percentage points in the performance score. If a clinician cannot do this reporting, he could earn 5 percentage points in the performance score for each public health agency or specialized registry to which the clinician reports, up to a maximum of 10 percentage points. A clinician who chooses to report to more than one specialized registry or public health agency to submit syndromic surveillance data may earn 5 percentage points in the performance score for reporting to each one, up to a maximum of 10 percentage points. CMS believes that this added flexibility will allow additional clinicians to successfully fulfill this objective.

#### *Bonus Score*

CMS is establishing a 5 point bonus for reporting on any one of four Public Health and Clinical Data Registry reporting objectives:

1. Syndromic Surveillance Reporting or Specialized Registry Reporting
2. Electronic Case Reporting
3. Public Health Registry Reporting
4. Clinical Data Registry Reporting

CMS has also established a 10 point bonus for eligible clinicians who attest to completing at least one specified improvement activity using CEHRT. The Agency identified thirty additional improvement activities for the 2018 performance year that qualify for the bonus on Table 6 (pg. 361) of the [final rule](#).

CMS will also be continuing the ACI hardship exemption for the 2018 performance period. The exemption for small practices re-weights the ACI category to zero, shifting an additional 25 percent to the Quality category. CMS had already finalized the deadline for the exemption application as December 31 of the performance year. Additionally, the agency 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, they also receive an exception from the ACI Category.

#### **Complex Patient Bonus**

CMS finalized the addition of up to five bonus points to the overall Composite Performance Score (CPS) for complex patients based on a combination of the dual eligibility ratio and the average Hierarchical Conditions Category (HCC) risk score, for next year. CMS will average the HCC risk scores for



beneficiaries cared for by the MIPS eligible clinician during the 12-month segment of the eligibility period, which spans from the last four months of a calendar year one year prior to the performance period, followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018, for the 2018 performance period).

The dual eligibility ratio will be calculated based on the proportion of unique patients who have dual eligible status seen by the MIPS eligible clinician among all unique patients seen during the second 12-month segment of the eligibility period, the same period as the HCC score. CMS also finalized that MIPS eligible clinicians must submit data on at least one measure or activity in a performance category in order to receive the complex patient bonus.

## **MIPS APMs**

### *APM Scoring Standard for Clinicians in MIPS APMs*

CMS finalized the following: add an APM participant assessment date for full TIN APMs; add the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey to the Shared Savings Program and Next Generation ACO quality measures included for scoring under the MIPS APM quality performance category;; and add scoring for quality improvement to the MIPS APM quality performance category for MIPS APMs beginning in 2018. The agency also finalized a Quality Payment Program 2018 performance year quality scoring methodology for Other MIPS APMs, and to describe the scoring methodology for quality improvement for Other MIPS APMs as applicable.

CMS finalized its proposal to define the term "Other MIPS APM" as a MIPS APM that does not require reporting through the CMS web interface. In the 2018 MIPS performance period, Other MIPS APMs will include the Comprehensive ESRD Care Model, the Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model.

For the quality performance category, MIPS APMs are not required to report additional quality information other than what is reported through the APM.

### *Assessment Dates for Inclusion of MIPS Eligible Clinicians in APM Entity Groups under the APM Scoring Standard*

CMS will continue to use the three assessment dates of March 31, June 30, and August 31 to identify MIPS eligible clinicians who are on an APM Entity's Participation List and determine the APM Entity group that is used for purposes of the APM scoring standard. Beginning in the 2018 performance year, CMS finalized the addition of a fourth assessment date of December 31 to identify those MIPS eligible clinicians who have assigned their billing rights to the TIN and participate in a MIPS APM; this date will not be used for Qualifying APM Participant (QP) determinations.

### *MIPS APM Cost Performance Category*

CMS finalized weighting the cost performance category at zero percent for MIPS eligible clinicians scored under the MIPS APM scoring standard because many MIPS APMs incorporate cost measurement in other ways.

### *MIPS APM Quality Performance Category*

CMS finalized its proposal to score the CAHPS for ACOs survey, in addition to the CMS Web Interface measures that are used to calculate the MIPS APM quality performance category score for the Shared Savings Program and Next Generation ACO Model, beginning in the 2018 performance year. In the first year of the QPP, CMS did not score any quality data that was not reported through the CMS Web Interface (i.e. the CAHPS for ACOs survey and claims-based measures). The agency will not subject MIPS APM Web Interface reporters to a 3 point floor when calculating quality scores because the agency does not believe it is necessary to apply this transition year policy to eligible clinicians participating in previously established MIPS APMs.

#### *Performance Category Weighting*

CMS finalized weighting the quality performance category score at 50 percent, the improvement activities performance category at 20 percent, and the advancing care information performance category at 30 percent of the final score for all APM Entities in Other MIPS APMs.

There could be instances where an Other MIPS APM has no measures available to score for the quality performance category for a MIPS performance period. In such instances, under the APM scoring standard, CMS proposes to reweight the affected performance category to zero.

#### **Advanced Alternative Payment Models**

##### *Nominal Risk*

CMS finalized its proposal to retain nominal risk for Advanced APMs at 8 percent of estimated average total Medicare Parts A and B revenues through performance year 2020. CMS will not finalize a policy reducing the nominal risk standard for small and rural practices, but will monitor the impact of the policy and potentially reconsider it in future rulemaking.

##### *Medical Home Model Financial Risk Standard*

CMS finalized its proposal to exempt Round 1 participants in the Comprehensive Primary Care Plus Model (CPC+) from the requirement that there be fewer than 50 clinicians in their parent organization.

##### *Medical Home Model Nominal Amount Standard*

For performance year 2018, CMS proposed adjusting the minimum total potential risk for an APM Entity under the Medical Home Model Standard to 2 percent of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in the participating APM entities. For the 2019 performance year, the minimum would increase to 3 percent of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities. For the 2020 performance period, it would increase to 4 percent; and for 2021 and beyond, it would increase to 5 percent.

After considering the comments received, the agency does not believe it would be appropriate to lower the Medical Home Model nominal amount standard to 2 percent for the 2018 performance period after the standard has been set at 2.5 percent for 2017. Instead, it will maintain the Medical Home Model nominal amount standard at 2.5 percent for the 2018 performance period as well. The 2019, 2020, and 2021 minimum total potential risk will be finalized as proposed.

### *Qualifying APM Participant (QP) Performance Period and QP and Partial QP Determination*

CMS finalized the proposal that for Advanced APMs that start or end during the QP Performance Period, and operate continuously for a minimum of 60 days during the performance year, they will make QP determinations using payment or patient data only for the dates that APM Entities were eligible to participate in the Advanced APM, not for the full QP Performance Period.

Eligible clinicians who participate in Advanced APMs but do not meet the QP or Partial QP thresholds are subject to MIPS reporting requirements and payment adjustments unless they are otherwise excluded from MIPS.

### *All-Payer Advanced APM Arrangements*

CMS finalized the proposal to allow eligible clinicians to participate in All-Payer Advanced APM arrangements, starting with the 2019 performance period.

### *All-Payer Combination Option QP Performance Period*

In the proposed rule, CMS proposed creating a separate All-Payer QP Determination Period that would last from January 1 – June 30 of the performance year. All-Payer Combination Option QP determinations would be made based on 2 periods: January 1 – March 31 or January 1 – June 30.

After considering public comments, CMS did not finalize the proposal to create a separate All-Payer QP Performance Period. The agency will continue to align the QP Performance Period for the All-Payer Combination Option with the Medicare Option, so that the QP Performance Period for both options will begin on January 1 and end on August 31 of the calendar year that is 2 years prior to the payment year.

CMS will continue to use the term “QP Performance Period” to refer to the performance period under both the Medicare Option and the All-Payer Combination Option, and the separate terms “All-Payer QP Performance Period” and “Medicare QP Performance Period” and the corresponding revisions to regulations are no longer necessary.

### *All-Payer Combination Option/Other Payer Advanced APM Policy*

In last year’s final rule, CMS set the total risk standard as at least 3 percent of the expected expenditures the APM Entity is responsible for. In addition to this finalized standard, CMS proposed an additional revenue-based nominal amount standard of 8 percent, similar to the standard for Medicare-only advanced APMs. This standard would only apply to models in which risk for APM Entities is expressly defined in terms of revenue. It would be an additional option, and would not replace or supersede the expenditure-based standard previously finalized.

CMS finalized this proposal with one clarification. For the revenue based nominal amount standard under the All-Payer Combination Option, the agency will review the total combined revenues of the providers or other entities under the payment arrangement to determine that an other payer arrangement would meet the total risk component of the nominal standard. This would only apply if, under the terms of the other payer arrangement, the total amount that an APM Entity potentially owes the payer, or foregoes, is equal to at least 8 percent of the total combined revenues from the payer to

providers and other entities under the payment arrangement. This would apply for both the 2019 and 2020 QP Performance Periods.

For Advanced APMs, CMS may determine that an APM still meets the generally applicable revenue-based nominal amount standard, even if risk is not explicitly defined in terms of revenue, by comparing model downside risk to the estimated average Medicare revenue of model participants.

#### *Payer-Initiated Determination of Other Payer Advanced APMs*

CMS finalized the proposals allowing certain other payers, including payers with payment arrangements authorized under Title XIX (i.e. Medicaid); Medicare Health Plan payment arrangements (i.e. Medicare Advantage Plans, Medicare Cost Plans); and payers with payment arrangements aligned with a CMS Multi-Payer Model, to request that the agency determine whether their other payer arrangements are Other Payer Advanced APMs starting prior to the 2019 QP Performance Period and following years. CMS will refer to this process as the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process). The Payer Initiated Process will be voluntary for all payers.

#### *All-Payer Combination Option QP Determinations*

CMS will make QP determinations based on three snapshot dates: March 31, June 30, and August 31. The agency finalized its 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.

In the event that an eligible clinician or APM Entity submits only information for either of the first two snapshots, CMS will make QP determinations on that basis.

#### *Eligible Clinician Initiated Submission of Information and Data for Assessing Other Payer Advanced APMs*

CMS finalized its proposal that through the Eligible Clinician Initiated Process, APM Entities and eligible clinicians participating in other payer arrangements would have an opportunity to request that the agency determine for the year whether those other payer arrangements are Other Payer Advanced APMs.

In the final rule, CMS seeks additional comment regarding the current duration of payment arrangements and whether creating a multi-year determination process would encourage the creation of more multiyear payment arrangements as opposed to payment arrangements that are one year. The agency also seeks comment on what kind of information should be submitted annually after the first year to update an Other Payer Advanced APM determination. CMS will consider in future rulemaking whether to introduce an option where Other Payer Advanced APM determinations could last for more than one year a time.

#### **Physician-Focused Payment Model Technical Advisory Committee**

In its proposed rule, CMS sought comments on potentially expanding PTAC's review process to also include Medicaid models. After receiving comments from stakeholders, CMS decided to maintain the current definition of a PFPM to include only payment arrangements with Medicare as a payer.