CY 2018 Quality Payment Program
Proposed Rule Summary

On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) released its proposed rule updating 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 August 21.

CMS is proposing various new policies with the aim of increasing flexibility and reducing burdens, particularly for solo practitioners and rural and small practice groups. Some of the key proposed changes to the program include the following:

- A Virtual Group participation option proposal
- A low-volume threshold increase to $90,000 in allowed Medicare Part B charges or 200 patients
- The continued use of 2014 Edition CEHRT is also being proposed along with the addition of bonus points in the scoring methodology for caring for complex patients and using 2015 Edition CEHRT exclusively
- Providing facility-based clinicians the option to use facility-based measures.
- Continuing to weight the MIPS Cost category at 0

For APMs, CMS is proposing changes and updates, including the extension of the revenue-based nominal amount standard for two more years through the 2020 performance year. CMS also proposes changing the nominal amount standard for Medical Home Models so that the minimum required amount of total risk increases more slowly. More detail was provided on the implementation of the All-Payer Combination Option, which will be available beginning in the 2019 performance year.

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	• 60% weight in 2018 performance year • 30% weight in 2019 performance year and beyond • 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 • 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 • Data completeness: Proposal to increase threshold to 60% for 2019 performance period • Measures that do not meet data completeness criteria will get 1 point instead of 3 points (Small practices will continue to get 3 points)
Cost	• 0% weight in 2018 performance year, but CMS is soliciting feedback on keeping the weight at 10% • 30% weight in 2019 MIPS performance year and beyond • Include only the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures in calculating Cost performance category score for the 2018 MIPS performance period (but will not be counted toward 2018 score)
Improvement Activities	• 15% weight and measured based on a selection of different medium and high-weighted activities • 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 • No change in the number of activities that MIPS eligible clinicians have to report to reach a total of 40 points • CMS is proposing more activities to choose from and changes to existing activities for the Inventory • 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
Advancing Care Information	• 25% weight in 2018 performance year • Composed of a base score and a performance score

	• 10 percentage point bonus for CY2018 performance period for reporting using only 2015 edition CEHRT • Physicians who do not write 100 eligible prescriptions will be excluded from the e-Prescribing measure • Those who do not have 100 eligible referrals or transitions of care will be excluded from the health information exchange measures • CMS is also proposing to readjust the bonus structure so physicians who cannot report to immunization registries are not disadvantaged

Low-Volume Threshold

Low-Volume Threshold Qualifications for Exemption	
CY 2017 Final Policy	**CY2018 Proposed Policy**
≤ $30,000 in Part B allowed charges, OR ≤ 100 Part Be beneficiaries	≤ $90,000 in Part B allowed charges, OR ≤ 200 Part B beneficiaries

Beginning with the 2018 performance period, CMS proposes to increase the low-volume threshold exempting more providers from the QPP. Under this revised threshold, CMS proposes to exempt clinicians or groups who have Medicare Part B allowed charges less than or equal to $90,000 or provide care for 200 or fewer Part B enrolled Medicare beneficiaries during the low volume threshold determination period. Clinicians who do not exceed the low-volume threshold are excluded for a single performance period. Based on this proposed change, CMS estimates that 647,219 clinicians will be excluded in 2018.

CMS is proposing to modify the low-volume threshold determination period as well. The 12-month period would span from the last 4 months of a calendar year 2 years prior to the performance period, followed by the first 8 months of the next calendar year and include a 30-day claims run out. For example, the low volume threshold determination period for the 2018 performance year would run from September 1, 2016 through August 31, 2017 with a 30-day claims run out period beginning September 1, 2017.

CMS will assess which clinicians and groups exceed the low volume threshold annually. Please note if CMS determines an individual clinician is excluded from the 2018 performance period, but then determines that he is eligible for the 2019 performance period, this will not impact the 2018 exclusion

under the low volume threshold. CMS notes that low-volume threshold determinations are made at the individual and group level, and not at the virtual group level.

CMS is considering adding another criterion for the low-volume threshold exception that would be based on the number of items and services a MIPS-eligible clinician providers to Part B beneficiaries. The agency is proposing to define items and services by using the number of patient encounters or procedures associated with a clinician. CMS is soliciting comments on methods to define items and services provided by a clinician and a process for clinicians that meet the low-volume threshold to opt-in to MIPS.

Virtual Groups

CMS includes a proposal to create virtual groups, which are defined as a combination of two or more tax identification numbers (TIN) composed of a solo practitioner (a MIPS eligible clinician who bills under a TIN with no other national provider identifiers (NPI) billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. The formation of virtual groups to participate in of MIPS does not change the application of the physician self-referral laws. While entire TINs participate in a virtual group, including each NPI under a TIN, and are assessed and scored collectively as a virtual group, only NPIs that meet the definition of a MIPS eligible clinician would be subject to a MIPS payment adjustment.

CMS believes it is important for virtual groups to have the flexibility to determine their own composition and as a result, is not proposing to establish any classifications regarding virtual group composition or any limit to the number of TINs that may form a virtual group. The agency will monitor the ways in which solo practitioners and groups with 10 or fewer eligible clinicians form virtual groups and may propose to establish appropriate classifications regarding virtual group composition or a limit on the number of TINs that may form a virtual group in future rulemaking.

CMS proposes that each MIPS eligible clinician who is part of a virtual group would be identified by a unique virtual group participant identifier. The unique identifier would be a combination of three identifiers: (1) Virtual group identifier (established by CMS); (2) TIN (9 numeric characters); and (3) NPI (10 numeric characters). The agency is seeking public comment on this proposal.

CMS proposes to apply CMS' previously finalized and proposed group policies to virtual groups, unless otherwise specified. The agency proposes that a virtual group would be identified as having a small practice status if the virtual group does not have 16 or more members of a virtual group (NPIs). For performance periods beginning in 2018, CMS proposes that a group with 75 percent or more of the TIN's practice sites designated as rural or HPSA practices would be designated as rural or HPSA at the group level. The same standard would be applied to virtual groups.

CMS proposes to codify that a solo practitioner or a group of 10 or fewer eligible clinicians must make their virtual group election prior to the start of the applicable performance period; this election cannot be changed during the performance period. Virtual group participants may elect to be in only one virtual group for a performance period and, in the case of a group, the election applies to all MIPS eligible clinicians in the group.

CMS proposes to establish a virtual group election period. Beginning with performance periods occurring in 2018, a solo practitioner, or group of 10 or fewer eligible clinicians electing to be in a virtual group must make their election by December 1 of the calendar year preceding the applicable performance period. CMS intends to publish the start date of the virtual group election period applicable to the 2018 performance period and subsequent years in subregulatory guidance.

Technical assistance (TA) will be available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group. CMS will establish an electronic election process for virtual groups for the 2019 performance year, if technically feasible.

CMS proposes that each virtual group member must execute formal written agreements with each member of the virtual group to ensure that requirements and expectations of participation in MIPS are clearly articulated, understood, and agreed upon. A designated virtual group representative would be required to confirm through acknowledgement that an agreement is in place between each member. An agreement would be executed for at least one performance period. If an NPI joins or leaves a TIN, or a change is made to a TIN that impacts the agreement itself (i.e. a legal business name change) during the applicable performance year, a virtual group would be required to update the agreement to reflect such changes and submit changes to CMS via the Quality Payment Program Service Center. An agreement template that could be used by virtual groups will be made available via subregulatory guidance.

Eligible clinicians electing to be a virtual group will:

1. Have their performance assessed for the quality and cost performance categories in a manner that applies the combined performance of all eligible clinicians in the virtual group to each MIPS eligible clinician (except for those participating in a MIPS APM or an Advanced APM under the MIPS APM scoring standard) in the virtual group for a performance period of a year
2. Be scored based on the assessment of the combined performance described above regarding the quality and cost performance categories for a performance period.

CMS proposes that virtual groups would be assessed and scored across all four MIPS performance categories at the virtual group level for a performance period of a year.

MIPS Performance Period

For the quality and cost categories, CMS is proposing that the performance period during which reporting be required for the full calendar year 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. This means that 2020 bonuses and penalties 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

Beginning with the 2018 performance period, for purposes of the 2020 MIPS payment year and future years, CMS will allow 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.

Under this proposal, individual MIPS eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission mechanism (e.g. claims or registries) would be required to submit data on additional measures and activities via one or more additional submission mechanisms, as necessary, provided that such measures and activities are applicable and available to them to receive the maximum number of points under a performance category.

If an individual MIPS eligible clinician or group submits the same measure through two different mechanisms, each submission would be calculated and scored separately. CMS would only count the submission that gives the clinician the higher score, thereby avoiding double counting. With this proposed modification, clinicians could meet the requirement to report six quality measures by submitting data on two additional quality measure via another submission mechanism, such as claims or qualified registry. This would enable him to receive the maximum number of points available under the quality performance category. The requirements for the performance categories remain the same, regardless of the number of submission mechanisms used.

CMS is proposing that virtual groups would be able to use a different submission mechanism for each performance category. However, virtual groups would be required to utilize the same submission mechanism for the improvement activities and the advancing care information performance categories.

Quality Performance Category

For the first year of the MIPS program, CMS finalized the weight of the quality performance category as 60 percent of the final score. If the proposal to reweight the cost performance category to zero for MIPS payment year 2020 is finalized, performance in the quality performance category will remain 60 percent of a MIPS eligible clinician's final score for that payment year.

CMS addressed topped out quality measures in this proposal. These measures have a high and unvarying performance level that meaningful distinctions and improvements in performance can no longer be made. The agency believes these measures could have a disproportionate impact on a clinician's score. CMS is proposing a 3-year timeline for identifying and removing topped out measures. Once a measure is identified as topped out for three consecutive years, CMS may propose to remove the measure for the 4th year. Based on these criteria, the agency has identified 6 measures as topped out; the first year they could be removed would be 2021.

The agency is also seeking comment on what the best timeline for removing both outcome and non-outcome measures that cannot be reliably scored against a benchmark.

Improvement Bonus

The MACRA statute allows CMS to implement improvement scoring that rewards improvement in performance for an individual MIPS eligible clinician or group for a current performance period

compared to the prior performance period. The improvement percent score may not total more than 10 percentage points and will be calculated as follows:

> 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 plans to implement a facility-based scoring option on a limited basis in the 2018 performance year. The agency proposes to incorporate additional facility-based measures under MIPS by using inpatient hospital measures. The agency proposes 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.

Individual MIPS eligible clinicians or groups who wish to have their quality and cost performance category scores determined based on a facility's performance must elect to do so. CMS requests comments on what other programs, if any, it should consider including for facility-based measurement under MIPS in future program years.

A clinician is eligible for facility-based measurement under MIPS if they are determined to be facility-based as an individual if he furnishes 75 percent or more of his covered professional services in sites of service identified by the place of service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS code 21) or an emergency room (POS code 23) based on claims for a period prior to the performance period as specified by CMS. A facility-based group is a group in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals.

Cost Performance Criteria

CMS is proposing to change the weight of the cost performance category from 10 percent to zero percent for the 2020 MIPS payment year. The agency remains concerned about clinicians' understanding of cost measures and will use this additional year to conduct more outreach to interested providers and to develop more episode-based measures. However, CMS seeks comment on whether it would be wise to keep the 2020 weight at 10 percent since it will be increased to 30 percent in 2021.

CMS will continue to provide confidential feedback to clinicians on their performance on the Total per Capita Cost and Medicare Spending per Beneficiary measures. In December 2017, CMS will propose the operational list of care episodes and patient condition groups.

Improvement Activities Performance Criteria

CMS is not proposing any changes to the scoring of the improvement activities performance category or to the policies for incentivizing the use of health IT in this proposed rule. The agency will continue to consider including emerging certified health IT capabilities as part of activities within the Improvement

Activities Inventory in future years and requests comment on how they might provide flexibility for MIPS eligible clinicians to effectively demonstrate improvement through health IT usage while also measuring such improvement.

CMS also proposes that the term "recognized" be accepted as equivalent to the term "certified" when referring to the requirements for a patient-centered medical home to receive full credit for the improvement activities performance category for MIPS.

CMS is proposing new, high-weighted activities for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being. Some of these activities include MIPS Eligible Clinician Leadership in Clinical Trials or CBPR; Providing Education Opportunities for New Clinicians; Participation in User Testing of the Quality Payment Program Website; Participation in Population Health Research; CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain; and Cost Display for Laboratory and Radiographic Orders. A full list of the activities can be found on Table F in the proposed rule.

The agency is seeking comment on whether to establish a minimum threshold of the clinicians that must complete an improvement activity for the entire group to get credit. They are also interested in receiving comments on how performance improvement on these activities could be measured without imposing additional burdens on clinicians.

Advancing Care Information Performance Category

Base Score

For the 2018 performance period, CMS is not proposing any changes to the base score methodology in this category. MIPS eligible clinicians must report a numerator of at least one for the numerator/denominator measures, or a "yes" response for the yes/no measure in order to earn the 50 percentage points in the base score. If the base score requirements are not met, a MIPS eligible clinician would receive a score of zero for the ACI performance category.

Performance Score

CMS is proposing to modify 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, CMS is proposing that 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 for the following measures, up to a maximum of 10 percentage points. A clinician who chooses to report to more than one public health agency or clinical data registry may receive credit in the performance score for the submission to more than one agency or registry; however, the MIPS eligible clinician would not earn more than a total of 10 percentage points for such reporting.

CMS proposes 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 fulfill the Immunization Registry Reporting

Measure, 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 proposing that a clinician may only earn the bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry that is different from the agency/agencies or registry/or registries to which he reports to satisfy the performance score requirements. A clinician would not receive credit under both the performance score and bonus score for reporting to the same agency or registry. For the Advancing Care Information Objectives and Measures, a bonus of 5 percentage points would be awarded if the clinician reports "yes" for any one of the following measures associated with the Public Health and Clinical Data Registry Reporting objective:

- Syndromic Surveillance Reporting;
- Electronic Case Reporting;
- Public Health Registry Reporting; or
- Clinical Data Registry Reporting.

For the 2018 Advancing Care Information Transition Objectives and Measures, a bonus of 5 percent would be awarded if the clinician reports "yes" for either of the following measures associated with the Public Health Reporting objective: Syndromic Surveillance Reporting or Specialized Registry Reporting. To earn the bonus score, the clinician must be in active engagement with one or more additional public health agencies or clinical data registries that is/are different from the agency or registry that they identified to earn a performance score.

To encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products, CMS is proposing to offer a bonus of 10 percentage points for MIPS eligible clinicians who report the Advancing Care Information Objectives and Measures for the performance period in CY2018 using only 2015 Edition CEHRT.

Performance Periods for the Advancing Care Information Performance Category

CMS is maintaining this policy as finalized for the CY2018 performance period, and will accept a minimum of 90 consecutive days of data. CMS is proposing the same policy for the advancing care information performance category for the CY2019 performance period, QPP Year 3, and would accept a minimum of 90 consecutive days of data.

Hospital-based MIPS Eligible Clinicians

As discussed in last year's final rule, CMS will assign a weight of zero percent to the advancing care information performance category in the final score for clinicians who meet specific criteria: hospital-based clinicians, clinicians who are facing a significant hardship, and certain types of non-physician

practitioners (NPs, PAs, CRNAs, CNSs) who are MIPS eligible clinicians. CMS has added a new category of hardship exceptions for small practices with 15 or fewer clinicians.

A hospital-based clinician would have the option to report the advancing care information measures for the performance period for the MIPS payment year for which they are determined hospital-based. However, if a MIPS eligible clinician who is determined to be hospital-based chooses to report on the advancing care information measures, they would be scored on the advancing care information performance category like all other clinicians, and the category would be weighted at 25 percent, regardless of their score.

Complex Patient Bonus

CMS is proposing to add a complex patient bonus (not exceeding three points) to the final score for the 2020 MIPS payment year for clinicians that submit data for at least one performance category. CMS will calculate an average HCC risk score, using the model for Medicare Advantage risk adjustment, for each MIPS eligible clinician or group, and use that average HCC risk score as the complex patient bonus. This would be done by averaging HCC risk scores for beneficiaries cared for by the clinician or clinicians in the group during the second 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.

HCC risk scores for beneficiaries would be calculated based on the calendar year immediately prior to the performance period. For the 2018 MIPS performance period, the HCC risk scores would be calculated based on beneficiary services from the 2017 calendar year.

For MIPS APMs and virtual groups, CMS would use the beneficiary weighted average HCC risk score for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM Entity or virtual group as the complex patient bonus. The agency would calculate the weighted average by taking the sum of the individual clinician's (or TIN's as appropriate) average HCC risk score, multiplied by the number of unique beneficiaries cared for by the clinician and then divide by the sum of the beneficiaries cared for by each individual clinician (or TIN as appropriate) in the APM Entity or virtual group.

The agency is requesting comments on the option of including dual eligibility as a method of adjusting scores as an alternative to the HCC risk score or in addition to the HCC risk score.

MIPS APMs

For the 2018 performance period, CMS is proposing modifications to the quality performance category reporting requirements and scoring for clinicians in most MIPS APMs.

APM Scoring Standard for Clinicians in MIPS APMs

CMS proposes to do 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; define Other MIPS APMs; and add scoring for quality improvement to the

MIPS APM quality performance category for MIPS APMs beginning in 2018. The agency also proposes 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 proposes 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.

CMS seeks comment on whether there may be potential conflicts or inconsistencies between the generally applicable MIPS policies and those under the APM scoring standard, particularly where these could impact CMS' goals to reduce duplicative and potentially incongruous reporting requirements and performance evaluations that could undermine CMS' ability to test or evaluate MIPS APMs, or whether certain generally applicable MIPS policies should be made explicitly applicable to the APM scoring standard.

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 proposes to add 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 is not proposing changes to these policies and welcomes comment on the proposal to continue to waive the weighting of the cost performance category for the 2020 payment year forward.

MIPS APM Quality Performance Category

For Web Interface reporting MIPS APMs (MSSPs and Next Generation ACOs), CMS established that quality performance data that are not submitted to the CMS Web Interface (i.e. the CAHPS for ACOs survey and claims-based measures) will not be included in the MIPS APM quality performance category score for 2017. CMS proposes 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. The agency would 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 proposes to weight 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. CMS proposes these weights to align the Other MIPS APM performance category weights with those assigned to the Web Interface reporters.

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. In such instances, under the APM scoring standard, CMS proposes to reweight the affected performance category to zero.

Advanced Alternative Payment Models

CMS proposed some modifications to the Advanced Alternative Payment Model (APM) track. The proposals include:

- Modifying the nominal risk standard through performance year 2020 to 8 percent of the estimated total Medicare Parts A and B revenue for the entity;
- Redefined the nominal risk standard of Advanced APM Medical Home Model Standard;
- Full capitation models count as Advanced APMs, but Medicare Advantage models still do not qualify automatically as Advanced APMs; and
- Outlining more detailed requirements for the All Payer Advanced APM option.

Nominal Risk

CMS proposes to no change to the threshold for nominal risk for the next two years, keeping it 8 percent. CMS is also proposing to create an additional methodology for defining nominal risk based on practice revenue and welcomes comments on this topic.

Medical Home Model Financial Risk Standard

CMS proposes to exempt Round 1 participants in the Comprehensive Primary Care Plus Model (CPC+) from the requirement that the medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization.

Medical Home Model Nominal Amount Standard

For performance year 2018, CMS proposes to adjust 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 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.

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

CMS proposes changing the name of the QP performance period to the Medicare QP performance period. The agency also proposes to modify the period that payment/patient threshold calculations are based on for certain Advanced APMs. For Advanced APMs that start or end during the Medicare QP performance period, QP Threshold Scores would be 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 Medicare QP performance period.

All-Payer Combination Option QP Performance Period

CMS proposes creating a separate All-Payer QP Determination Period that and 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.

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 the existing Total Risk standard, CMS proposes an additional revenue-based nominal amount standard of 8 percent. 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.

Payer-Initiated Determination of Other Payer Advanced APMs

In performance year 2019, CMS proposes allowing payers to submit payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models before the relevant All-Payer QP performance period.

This option would be offered to other payer types in future years.

All-Payer Combination Option QP Determinations

QP determinations under the All-Payer Combination Option would be calculated at the individual eligible clinician level only. 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 proposes making the QP determination under the All-Payer Combination Option using a weighted Medicare Threshold Score that will be factored into an All-Payer Combination Option Threshold Score calculated at the individual eligible clinician level.

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

CMS is proposing that APM Entities or eligible clinicians may submit information regarding their payment arrangement to CMS and request that CMS make Other Payer Advanced APM determinations, when the determination had not already been made through the Payer-Initiated process. CMS also proposes eliminating the requirement for attestation from the payer; APM Entities or eligible clinicians would need to certify information they submit.

Physician-Focused Payment Model Technical Advisory Committee

MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which is currently evaluating potential payment models submitted by stakeholders. CMS is seeking comments on potentially expanding PTAC's review process to also include Medicaid models.