Introduction to the Quality Payment Program

Health Care Compliance Association
Annual Regional Meeting
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Nancy L. Fisher, RN, MD, MPH
Chief Medical Officer, CMS, Region X

What is the Quality Payment Program?

What Does the Quality Payment Program Do?

- Creates Medicare payment methods that promote quality over volume by:
  - Repealing SGR formula
  - Creating two tracks:
    - Merit-based Incentive Payment System (MIPS)
    - Advanced Alternative Payment Models (Advanced APMs)
  - Streamlining legacy programs
  - Providing 5% incentive to Advanced APM participants
  - Establishing PTAC, the Physician-focused Payment Model Technical Advisory Committee
### Quality Payment Program Strategic Goals

<table>
<thead>
<tr>
<th>Improve beneficiary outcomes</th>
<th>Enhance clinician experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase adoption of Advanced APMs</td>
<td>Maximize participation</td>
</tr>
<tr>
<td>Improve data and information sharing</td>
<td>Ensure operational excellence in program implementation</td>
</tr>
</tbody>
</table>

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

### Ready, Set, Go!
Preparing for 2017 participation in MIPS

### 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 the function.

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Physician Assistants</th>
<th>Nurse Practitioner</th>
<th>Clinical Nurse Specialist</th>
<th>Certified Registered Nurse Anesthetists</th>
</tr>
</thead>
</table>

**These clinicians include:**

...
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
  - See 100 or fewer Medicare Part B patients a year
- Significantly participating in Advanced APMs
  - Receive 25% of your Medicare payments
  - See 100% of your Medicare patients through an Advanced APM

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

- Established low-volume threshold
  - Less than or equal to $30,000 in Medicare Part B allowed charges
  - Less than or equal to 100 Medicare patients
- Reduced requirements for improvement Activities performance category
  - One high-weighted activity
  - Two medium-weighted activities
- Increased 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 (QP).

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 < 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
**Pick Your Pace for Participation for the Transition Year**

<table>
<thead>
<tr>
<th>Participate in an Advanced Alternative Payment Model</th>
<th>MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Same practices may choose to participate in an Advanced Alternative Payment Model in 2017</td>
<td>Test Pace</td>
</tr>
<tr>
<td>• Submit some data after January 1, 2017</td>
<td>Neutral or small payment adjustment</td>
</tr>
<tr>
<td>• Fully participate starting January 1, 2017</td>
<td>Neutral or small payment adjustment</td>
</tr>
</tbody>
</table>

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

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**MIPS: Choosing to Test for 2017**

- 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 1 Advanced Care Information Measure

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**MIPS: Partial Participation for 2017**

- 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

Need to send performance data by March 31, 2018
MIPS: Full Participation for 2017

- 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.

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

**MIPS**

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What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

- PQRS
- VM
- EHR

**Legacy Program Phase Out**

- Last Performance Period: 2016
- PQRS Payment End: 2018
Quality Payment Program

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?

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Submit</th>
<th>Feedback Available</th>
<th>Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 31, 2018</td>
<td></td>
<td></td>
<td>Feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Payment Adjustment</td>
</tr>
</tbody>
</table>

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

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 payments in 2019.

How Do Clinicians Participate in MIPS?

1. **Individual** – under an NPI number and TIN where they reassigned benefits
2. **As a Group** –
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As a MIPS APM entity

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

Get your Data to CMS

<table>
<thead>
<tr>
<th>Quality</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ QCDR (Qualified Clinical Data Registry)</td>
<td>✓ QCDR (Qualified Clinical Data Registry)</td>
<td></td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
<td></td>
</tr>
<tr>
<td>✓ EHR</td>
<td>✓ EHR</td>
<td></td>
</tr>
<tr>
<td>✓ Claims</td>
<td>✓ Administrative Claims</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS Web interface</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(groups of 25 or more)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAHPS for MIPS Survey</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advancing Care Information</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Attestation</td>
<td>✓ Attestation</td>
<td></td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
<td></td>
</tr>
<tr>
<td>✓ EHR Vendor</td>
<td>✓ EHR Vendor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving Activities</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Attestation</td>
<td>✓ Attestation</td>
<td></td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
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</tr>
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<td>✓ EHR Vendor</td>
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</tr>
</tbody>
</table>

Quality Payment Program

Working with a Third Party Intermediary

<table>
<thead>
<tr>
<th>Intermediary</th>
<th>Approval Needed</th>
<th>Cost to Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Vendor</td>
<td>EHR Vendors Must be certified by ONC</td>
<td>✓</td>
</tr>
<tr>
<td>QCDR</td>
<td>QCDRs must be approved by CMS</td>
<td>✓</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>Qualified Registries must be approved by CMS</td>
<td>✓</td>
</tr>
<tr>
<td>CMS Approved CAHPS Vendor</td>
<td>CAHPS Vendors must be approved by CMS</td>
<td>✓</td>
</tr>
</tbody>
</table>

Quality Payment Program

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)**: Strategies to support more than 90,000 clinician practices over the next 4 years in focusing, 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 MIPS participation under MIPS
Understanding the MIPS Performance Categories

What are the Performance Category Weights?
Weights assigned to each category based on a 1 to 100 point scale

<table>
<thead>
<tr>
<th>Category</th>
<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

Transition Year Weights — 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

Select 6 of about 100 quality measures (minimum of 50 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

60% of final score

May also select specialty-specific set of measures

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

QPP Website Home Page

Quality Payment Program
Modifying Medicare to promote better care and reduce spending for a healthier America

Screen Shot of Quality Measures

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: 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
  - Advancing Care Information Objectives and Measures
- Option 2
  - Combination of the two measure sets

For those using 2014 Certified EHR Technology:

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

MIPS Performance Category: Advancing Care Information

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
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<td>Request/Accept a Summary of Care</td>
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**MIPS Performance Category: Advancing Care Information**

### Advancing Care Information Objectives and Measures

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<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access*</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient Specific Education</td>
</tr>
<tr>
<td>Patient Engagement</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Patient Engagement</td>
<td>Patient-Generated Health Data</td>
</tr>
<tr>
<td>Patient Engagement</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>Patient Engagement</td>
<td>Health Information Exchange*</td>
</tr>
<tr>
<td>Patient Engagement</td>
<td>Public Health and Clinical Data Reporting</td>
</tr>
<tr>
<td>Patient Engagement</td>
<td>Hospital Readmission Reporting</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange*</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Public Health Reporting</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Immunization Registry Reporting</td>
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### 2017 Advancing Care Information Transition Objectives and Measures

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**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 the difference in the MIPS final score.**

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**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

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

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

Bonus points are available

MIPS Scoring for Quality (60% of Final Score)

Year 1 participants automatically receive 3 points for completing and submitting a measure

If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points
- Reliable score means the following:
  - Benchmarks exists (see next slide for rules)
  - Sufficient case volume (>=20 cases for most measures; >=200 cases for readmissions)
  - Data completeness met (at least 50 percent of possible data is submitted)

If a measure cannot be reliably scored against a benchmark, then clinician receives 3 points
- Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

More About Benchmarks

Why this matters? Not all measures will have a benchmark. If there is no benchmark, then a clinician only receives 3 points.
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 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% Required Base score (50%)
- 90% Performance score (up to 90%)
- 15% 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): Base Score

Base score (worth 50%)

Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

2017 Advancing Care Information Transition Measures
- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.
MIPS Scoring for Advancing Care Information (25% of Final Score)

Each measure is worth 10 percentage points. Clinicians are given a "performance rate" for each measure, and rates correspond to category percentages as follows:

1-10 = 1%
11-20 = 2%
21-30 = 3%
31-40 = 4%
41-50 = 5%
51-60 = 6%
61-70 = 7%
71-80 = 8%
81-90 = 9%
90-100 = 10%

Performance Score
6 optional measures:
1. Patient Specific Education
2. View, Download or Transmit
3. Secure Messaging
4. Patient Generated Health Data
5. Clinical Information Reconciliation
6. Public Health and Clinical Data Registry Reporting (5 options)

MIPS Scoring for Advancing Care Information (25% of Final Score): Bonus Score

Bonus Score
- 5% for reporting on any of these Public Health and Clinical Data Registry Reporting measures:
  - Syndromic Surveillance Reporting
  - Electronic Case Reporting
  - Public Health Registry Reporting
  - Clinical Data Registry Reporting
- 10% for using CEHRT to report certain Improvement Activities

Calculating the Final Score Under MIPS

Final Score =

Clinician Quality performance category score * actual Quality performance category weight
Clinician Cost performance category score * actual Cost performance category weight
Clinician Improvement Activities performance category score * actual Improvement Activities performance category weight
Clinician Advancing Care Information performance category score * actual Advancing Care Information performance category weight

* 100
Transition Year 2017

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| >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 |

Getting Started...

- Determine you eligibility status
- Gauge your readiness and choose “how” you want to start
- Choose if you will be reporting as an individual or group
- Decide if you will work with a third party intermediary
- Review the program timeline for dates
- Choose a data submission option
- Reach agreement with Bonus Payments and Reporting Periods
- Assess your Feedback
- Ready, set, go!

Introduction to Advanced Alternative Payment Models (APMs)
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

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

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 Arrangement)
- Comprehensive Primary Care Plus (PCP)
- 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.
Quality Payment Program

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.

Quality Payment Program

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 (CC) 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.

Quality Payment Program

What is the APM Scoring Standard?
### Shared Savings Program (All Tracks) under the APM Scoring Standard

<table>
<thead>
<tr>
<th>Reporting Requirement</th>
<th>Performance Score</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advancing Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above outlines the requirements and their associated weights for the Shared Savings Program (All Tracks) under the APM Scoring Standard.

### Next Generation ACO Model under the APM Scoring Standard

<table>
<thead>
<tr>
<th>Reporting Requirement</th>
<th>Performance Score</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
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</tr>
<tr>
<td>Cost</td>
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<td>Improvement Activities</td>
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<td></td>
</tr>
<tr>
<td>Advancing Care</td>
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<td></td>
</tr>
</tbody>
</table>

This table details the reporting requirements and their respective weights for the Next Generation ACO Model under the APM Scoring Standard.

### All Other APMs under the APM Scoring Standard

<table>
<thead>
<tr>
<th>Reporting Requirement</th>
<th>Performance Score</th>
<th>Weight</th>
</tr>
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<tbody>
<tr>
<td>Quality</td>
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<tr>
<td>Cost</td>
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<tr>
<td>Improvement Activities</td>
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<td>Advancing Care</td>
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</table>

The table above summarizes the reporting requirements and their weights for all other APMs under the APM Scoring Standard.
Quality Payment Program

Where can I go to learn more?

Independent PFPM Technical Advisory Committee

Health Care Payment Learning and Action Network

- Medicare alone cannot drive sustained progress towards alternative payment models (APMs)
- Success depends upon a critical mass of partners adopting new models
- The network purpose:
  - Convene payers, purchasers, consumers, states and federal partners to develop a common pathway for success
  - Identify areas of alignment, avoid movement by aligning to activities
  - Collaborate to generate evidence, share approaches, and remove barriers
  - Develop common approaches to core issues such as beneficiary attribution
  - Offer implementation guidance for payers and purchasers

For more information on the PFPM go to: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee
Thank You

nancy.fisher@cms.hhs.gov