July 2017

Q&A: CY 2018 Proposed Rule
Updates to the MACRA Quality Payment Program

Comments due by August 21, 2017

Background

On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) released a Proposed Rule[1] outlining changes to the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[2] CMS also has released a Fact Sheet on the Proposed Rule. As you know, eligible clinicians must participate in one of two tracks of the QPP in order to fulfill the requirements of MACRA:

1. Participate in an Advanced Alternative Payment Model (APM), which provides a 5% incentive payment on allowable Part B charges in lieu of a Merit-based Incentive Payment System (MIPS) payment adjustment; or,

2. Be subject to MIPS, which provides positive or negative payment adjustments on allowable Part B charges.

The Proposed Rule features policies for CY 2018 (the second performance year of the QPP), which impact payments for Part B services furnished in CY 2020, as well as a few that retroactively impact CY 2017 performance. Key takeaways include:

- Clarifying that to the extent the agency can associate Part B drugs and other items with an individual clinician, such charges will be subject to MIPS payment adjustments, with few exceptions, starting in 2019 (i.e., retroactive to the start of the 2017 performance period)
- Continuing to give no weight to the cost performance category in 2018, meaning that performance on cost will not impact 2020 payments
- Continuing to exclude Part D drugs from the cost measure calculation (while Part B drugs are included)
- Proposing adjustments to the MIPS scoring methodology that would gradually make it harder for clinicians to achieve the minimum score necessary to avoid a payment penalty and/or achieve positive payment adjustments
- Adding new bonus points in MIPS scoring for clinicians in small groups (15 or fewer clinicians) or who treat complex patients
- Increasing the low-volume exclusion to clinicians who bill $90,000 or less, or see 200 or fewer Medicare Part B patients annually

This document is designed to provide an overview of the QPP, including key changes in CY 2018. Included below is a table of contents with links that will take you to specific information of interest.

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1. The Merit-Based Incentive Payment System (MIPS) and Key Changes for 2018

1.1. General Overview

Q. What is MIPS?

A. Established by MACRA, MIPS is a unified, performance-based physician payment system that begins adjusting Medicare Part B reimbursement to eligible clinicians in 2019 based on prior year performance in four different categories: cost; quality; improvement activities; and advancing care information.[3]

Q. What are the minimum requirements for participating in MIPS in 2018?

A. CMS opted to make the first performance period (2017) a "transition year" by:

- Establishing a "pick your pace" approach allowing clinicians to engage in MIPS by submitting a full year of data, a partial year of data, or to "test" MIPS and submit only a minimal amount of data;
- Setting the minimum performance threshold at 3 points; and
- Allowing MIPS eligible clinicians and groups to avoid a payment reduction in 2019 if they report on at least one quality measure for at least 90 days during the performance period (thus, clinicians can wait until as late as October 2, 2017 to begin).[4]

CMS plans to continue some of the "transition" policies for 2018 by:

- Retaining the abbreviated 90-day periods for several performance categories (advancing care information and improvement activities); and
- Continuing the current data completeness standard that only requires measures under the quality category to be reported for 50% of patient encounters.[5]

However, the agency also proposes to begin gradually ramping up the performance standards by:

- Raising the minimum performance threshold score from 3 to 15 points,[6] and
- Requiring data on quality measures for all 12 months of 2018 (rather than the 90 days of data permitted in 2017).[7]

Therefore, clinicians who focused on meeting the bare minimum "testing" requirements in 2017 would need to increase their performance in one or more categories in order to continue avoiding a payment reduction.

Q. How can an eligible clinician or group score 15 points in 2018 to avoid a negative payment adjustment in 2020?

A. MIPS eligible clinicians and groups would still be able to report less than the required measures and activities and earn enough points to avoid a negative payment adjustment in 2020. Examples of ways to achieve 15 points in 2018 would include:

- Reporting all required improvement activities;
- Meeting the advancing care information base score (by reporting the 5 base measures), and submitting 1 quality measure that meets data completeness;
- Meeting the advancing care information base score and submitting 1 medium-weighted improvement activity; or
- Submitting 6 quality measures that meet data completeness criteria.[8]

This is not an exhaustive list as there are many other combinations of data reporting that would meet or exceed the performance threshold.

1.2. MIPS Performance Categories

Q. What are the MIPS performance categories and how will they be weighted?

A. MIPS eligible clinicians' performance is evaluated across four performance categories: cost; quality; improvement activities; and advancing care information. In 2018, CMS proposes to continue the current relative weighting of the four performance categories:[9]

Performance Category	Payment Adjustment
Quality	60 percent—i.e., largest impact on 2018 score/2020 payments
Cost (Resource Use)	0 percent—i.e., will not impact 2018 score/2020 payments
Improvement Activities	15 percent
Advancing Care Information	25 percent

Q. What must clinicians do to satisfy the MIPS reporting requirements for each category?

A. MIPS eligible clinicians must proactively submit data to satisfy each performance category, with the exception of the cost category (which collects information based on administrative claims data). CMS proposes to allow clinicians to report using a combination of applicable data reporting mechanisms (e.g., via qualified

registry or EHR).[10] This is a change from current policy, which requires clinicians to report data using a single reporting mechanism per performance category.

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups
Quality	Claims QCDR Qualified registry EHR	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) Administrative claims (for readmission measure – no submission required)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified registry EHR	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
Advancing Care Information	Attestation QCDR Qualified registry EHR	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)

1.2.1. Quality Performance Category

Q. How will the quality performance category be weighted in 2018?

A. Quality is a performance category that evaluates eligible clinicians and groups for their performance on self-selected measures. Except in circumstances where the weight of another performance category is reassigned to quality (discussed below), CMS proposes to again weight the category 60% of the MIPS composite score.

Q. What must clinicians do to satisfy the quality category requirements?

A. CMS proposes that in 2018, eligible clinicians would continue to be required to report a minimum of 6 quality measures, including at least one outcome measure or, if none are applicable, a high-impact measure. Clinicians would also have the option of reporting a full specialty-specific or subspecialty-specific measure set, even if fewer than 6 measures.

Q. How is performance on quality measures scored?

A. For the 2017 performance period, MIPS eligible clinicians receive 3 to 10 points for each scored quality measure based on the clinicians' performance compared to measure benchmarks. For 2018, CMS proposes to decrease the measure floor to 1 point for poor performance on most measures, or for failing to satisfy the data completeness standard (which in 2017 requires clinicians to report data on at least 50% of patient encounters). CMS proposes to retain the 50% data completeness standard for 2018, and then to increase it to 60% in 2019.[11] Small practices of 15 or fewer eligible clinicians would still have a 3-point floor for failing to meet this standard.[12]

CMS also proposes to require that quality measures capture performance across the entire 12 months of 2018, rather than the 90-day period permitted in 2017.

Q. Are there any specific quality measures that clinicians are required to report?

A. In general, clinicians and groups may select and report on any applicable quality measures. CMS recommends, but does not require, that clinicians report a full specialty measure set.[13] Consistent with 2017 policy, CMS proposes to automatically calculate the All-Cause Hospital Readmission (ACR) population measure for groups of 16 or more eligible clinicians with sufficient volume of at least 200 cases.[14]

CMS does not propose to require groups (or individual clinicians) to participate in the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey, but proposes to continue a scoring incentive for those that do. Up to a 10% bonus would be available for submitting additional "high-priority" measures, as identified by CMS for each available measure.

1.2.2. Advancing Care Information Performance Category

Q. How will the advancing care information performance category be weighted in 2018?

A. For the advancing care information performance category, which replaced the EHR "Meaningful Use" Incentive Program, MIPS eligible clinicians must use Certified EHR Technology (CEHRT) and report a customizable set of measures that reflect their use of CEHRT in their day-to-day practice. Unless an exemption from the performance category applies, CMS proposes that it would again be weighted 25% of the MIPS composite score.

Q. What must clinicians do to satisfy the advancing care information category requirements?

A. After previously planning to require compliance with the 2015 Edition in 2018, CMS proposes to accept EHR certified to the 2014 Edition, and award bonus points to those using EHR certified to the 2015 Edition.[15]

CMS proposes to maintain the existing scoring methodology in 2018, in which eligible clinicians and groups must satisfy a base set of 4 to 5 objectives and measures (depending on the edition used), which is worth 50% of the category score. Clinicians then earn 10% for each additional EHR measure they successfully report, up to 90%. CMS proposes a revised bonus scoring policy for using EHR certified to the 2015 Edition (10%) and reporting to

public health registries (5%). Totaling the different components of the advancing care information scoring methodology, clinicians could earn up to 155%, but would not be able to count more than the maximum 100% of points available in the advancing care information category (representing 25% of the MIPS composite score).[16]

Q. Who is exempt from the advancing care information performance category?

A. The following categories of clinicians are already automatically exempt from the advancing care information category, unless they report as part of a group or virtual group (in which case they will be scored under the performance category):

- **Facility-based clinicians.** Hospital-based clinicians are exempt from the performance category on the presumption that they have limited control over their facility's CEHRT policies. CMS currently defines hospital-based clinicians as those who deliver 75% or more of their covered professional services in the inpatient or emergency room setting.[17] The agency proposes to expand this definition to include those who deliver 75% or more of their covered professional services in other on-campus outpatient hospital settings.[18] As required by the 21st Century Cures Act,[19] CMS will extend the hospital-based exemption from the advancing care information category to eligible professionals who furnish at least 75% of their covered professional services in an ambulatory surgery center (ASC) during the applicable annual period ending August 31st prior to the performance year (e.g., September 1, 2016 through August 31, 2017 for the 2018 performance period). This change is retroactive to the 2017 performance period.[20]

- **Non-patient facing clinicians and groups.** Non-patient facing clinicians and groups are automatically exempt from the performance category. A non-patient-facing clinician is one who bills 100 or fewer patient-facing encounters (including telehealth services) during the same applicable annual period.[21]

- **Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists (CRNAs)**. Although CMS encourages these clinician types to participate, if they opt not to submit any ACI measures, the 25% weight normally assigned to the category reassigned to the quality performance category, for a total weight of 85% in 2018. Exempt clinicians who opt to submit their advancing care information performance essentially waive their exemption and will be scored for the category, which will then account 25% of their MIPS composite score.

In addition to those listed above, CMS also proposes several new exemptions from the performance category in 2018, including exemptions for:

- **Clinicians whose EHR was decertified by the Office of the National Coordinator for Health IT (ONC).** For clinicians and groups whose EHR is issued a "termination of certification," they would need to submit a hardship exemption with documentation by December 31st of the performance period. This exemption will be available for 2017 (to clinicians who submit by December 31, 2017), and they would then be exempted from the performance category for 2 consecutive years.[22]

- **Solo practitioners, groups, and virtual groups of 15 or fewer eligible clinicians.** Clinicians in small groups of 15 or fewer would also need to submit a hardship exemption by the end of the performance period and would need to demonstrate "overwhelming barriers" to the adoption of CEHRT, such as lack of internet connectivity. As proposed, this exemption would begin with the 2018 performance period, and thus applications would need to be submitted by December 31, 2018. It would not be time-limited like the statutory exemptions, and thus could be claimed by small practices indefinitely.[23]

- **Others with qualifying hardships**.[24] Other clinicians seeking an exemption for other reasons (e.g., lack of sufficient internet connectivity) would need to submit a hardship application prior to the start of the performance period and would only be eligible for the exemption for up to 5 years. However, CMS solicits comments on whether others, such as those in rural areas, should be entitled to the same hardship exemption policy proposed for small groups.

In each instance where a clinician or group is exempt from advancing care information, the 25% weight would be reassigned to the quality performance category (making the quality performance category therefore worth a total of 85% of the MIPS composite score in 2018).[25]

1.2.3. Improvement Activity Performance Category

Q. How will the improvement activity performance category be weighted in 2018?

A. Improvement activities is a performance category that rewards clinicians and groups for undertaking practice-related changes to improve patient safety, health outcomes, and experience of care. Examples include activities that promote care coordination, enhance patient access, share public health data, and promote patient engagement. Each year, the improvement activities category is assigned a weight of 15% of the MIPS composite score.[26]

Q. What must clinicians do to satisfy the improvement activity category requirements?

A. CMS proposes no changes to the scoring methodology for 2018, so clinicians would still be required to attest to completing four "medium-weighted" activities (worth 10 points each) or two "high-weighted" activities (worth 20 points each), or another combination totaling 40 points. Small practices, rural practices, or practices located in health professional shortage areas (HPSAs), as well as non-patient-facing clinicians (defined as those with 100 or fewer patient-facing encounters), would only need to report one high-weighted or two medium-weighted activities (i.e., 20 points) to satisfy this category.[27]

Q. How do clinicians report performance under the improvement activities category?

A. MIPS eligible clinicians and groups may report data on improvement activities via qualified registry, QCDR, EHR submission mechanisms, CMS Web Interface, or attestation. Reporting is binary in that clinicians need only attest "yes" or "no" to satisfying the activity for the requisite performance period. Consistent with the transition year, CMS proposes that clinicians need only perform these activities for a continuous period of 90 days during 2018, but will consider extending the required performance period in future years.[28]

Q. What "improvement activities" can clinicians report in 2018?

A. Currently, there are 14 high-weighted activities and 78 medium-weighted activities in the Improvement Activities Inventory. CMS will continue to solicit nominations for additional activities outside of the rulemaking process, similar to the annual Call for Measures, and will finalize the Inventory by November 1st of each year. For 2018, the agency proposes to:

- Add 20 new activities to the Inventory;
- Modify 27 existing activities in the Inventory; and
- Broaden the definition of a patient-centered medical home (PCMH) to accommodate more participants of the Comprehensive Primary Care Plus (CPC+) model.[29]

1.2.4. Cost Performance Category

Q. How will the cost performance category be weighted in 2018?

A. For the 2018 performance year, CMS will continue to collect data on the cost performance category, but such data would not impact a clinician's composite score or corresponding payment adjustment. *The agency solicits comments on whether it should assign at least a 10% weight to the category in 2018, instead of the proposed 0%.*[30] The weight assigned to the cost performance category is statutorily mandated to increase to 30% in 2019,[31] therefore, CMS is unlikely to further delay the implementation of this measure.

Q. What must clinicians do to satisfy the cost category requirements?

A. CMS intends to evaluate performance in 2018 based on two measures—(1) total per capita cost and (2) the Medicare Spending per Beneficiary (MSPB)—and to provide feedback to clinicians.[32] CMS calculates these measures by reviewing administrative claims data. Therefore, clinicians are not required to submit any data to satisfy this measure.

Q. Are Medicare Part D drug costs included in the cost measures?

A. No, Medicare Part D prescription drug costs are not included in the cost measures. While CMS has indicated that the agency will explore ways to account for Part D drugs in the future,[33] the agency makes no mention of this issue in the Proposed Rule. Including Part B and Part D drug costs would reduce any potential incentive to prescribe Part D drugs over Part B drugs out of a concern for performing worse on cost measures.

Q. Will a clinician's score on the cost category include episode-based cost measures?

A. In 2017, the cost category also features 10 episode-based measures for specific procedures ranging from colonoscopy and biopsy to knee replacement. However, CMS proposes to eliminate all of these measures for 2018 and to continue working with relevant experts to develop alternative episode-based cost measures.

1.3. MIPS Scoring and Payment

Q. What is the potential 2020 payment impact based on 2018 performance?

A. In 2020, the MIPS payment adjustment will range from -5% to +5% based on 2018 performance, and high-performing clinicians will be eligible to receive bonus payments in excess of the 5% positive adjustment. The maximum MIPS payment adjustment gradually increases each year until reaching plus or minus 9% in 2022 and beyond.

Q. Are there any bonus points that apply to the MIPS composite score?

A. Although clinicians cannot carry over bonus points from an individual performance category, CMS proposes to establish two overarching bonus scoring opportunities:

- **Clinicians in small practices of 15 or fewer clinicians** will have the opportunity to earn 5 points automatically by attesting to practicing in a group of this size. The agency is soliciting comments on whether it should extend the small practice bonus to clinicians in larger practices who practice in rural areas.[34]

- **Clinicians and groups caring for complex patients** will have the opportunity to earn up to 3 points.[35] CMS would determine patient complexity by calculating the average Hierarchical Conditions Category (HCC) risk score of a clinician's patients, but is also considering other factors, such as dual eligibility status.[36]

Q. Does MIPS recognize improvement in performance in addition to achievement?

A. The MIPS scoring methodology does not currently recognize improvement, but the Proposed Rule outlines a new approach for measuring and rewarding improvement within the quality and cost performance categories. Beginning with the 2018 performance period, CMS proposes to reward improvement in the quality performance category, at the category level, with up to 10% added to the achievement score.[37]

Q. How will the 2018 composite score translate into the clinician's Part B payment adjustment in 2020?

A. By law, the MIPS composite score is compared to a "performance threshold," which is set at either the mean or median composite score for all participating clinicians in a given performance year. If a clinician's score falls above the average, they should receive a positive payment adjustment. If the clinician's score falls below the average, they would receive a negative adjustment. However, CMS continues to propose transition year policies that would set the performance threshold at a fixed level (not linked to average performance) that would result in averting penalties for most clinicians.

For 2017, CMS finalized a 3-point performance threshold to essentially ensure that clinicians who report *any* measures avoid a payment reduction in 2019.

For 2018, CMS proposes to continue to use administrative discretion to establish a performance threshold that is less than average performance, but to increase the threshold from 3 to 15 points, to avoid a negative payment adjustment.[38] The agency would, however, maintain the exceptional performance threshold at 70 points, above which clinicians are entitled to additional bonus payments beyond the maximum 5% positive adjustment.[39]

CMS estimates that only 3.9% of MIPS eligible clinicians will have a negative payment adjustment in 2020, whereas 96.1% of clinicians will end up with either a neutral or positive payment adjustment, and 76.8% would receive an additional bonus for exceeding the 70-point exceptional performance threshold.[40]

Q. Will the MIPS payment adjustment apply to Medicare payments for Part B drugs?

A. Yes. The 2017 QPP Final Rule stated only that "the MIPS payment adjustment applies only to the amount otherwise paid under Part B with respect to items and services furnished by a MIPS eligible clinician during a year," and did not clarify whether the payment adjustment applies to payments for Part B drugs and other separately billed items (e.g., durable medical equipment) themselves.[41] The Proposed Rule clarifies that to the extent the agency can associate Part B drugs and other items with an individual clinician (regardless of what entity purchases the item), such charges will be subject to MIPS payment adjustments in addition to payments for charges for professional services.[42] The agency will make an exception for Part B drugs that accompany durable medical equipment (DME) and are supplied by a MIPS eligible clinician, and thus such drugs would not be subject to a MIPS payment adjustment.

Notably, because CMS frames this as a clarification rather than a new proposal, it will be applicable to the first year that MIPS payment adjustments take effect, 2019.

Q. Will CMS make information about MIPS performance available to the public?

A. Yes, MACRA requires CMS to publish MIPS performance information to the Physician Compare Website.[43] Clinicians are given a 30-day preview period to review and correct any MIPS performance information before it is made public.[44]

1.4. MIPS Participation Reporting Options

Q. Will MIPS eligible clinicians be evaluated individually or as part of their group practice?

A. Currently, MIPS eligible clinicians have the option to have their performance evaluated either individually or collectively as part of their group practice.[45]

- **Individual Reporting.** MIPS eligible clinicians may choose to report their performance under the program as an individual clinician, even if they are part of a group for purposes of billing Medicare. If a group practice elects to have their clinicians evaluated at the individual level, the MIPS scoring and payment adjustments applies based on the Tax Identification Number (TIN) and National Provider Identifier combination (TIN/NPI) for each eligible clinician in the group.[46]

- **Group Reporting.** If clinicians in a group practice choose to have their performance evaluated as a group, CMS identifies the group using the TIN to which the clinicians in the group have reassigned their Medicare billing rights.[47] If a group elects this reporting option, the same MIPS payment adjustment applies to all members of the group based on the group's aggregated reporting on across the MIPS performance categories. In addition, MIPS eligible clinicians who participate in certain APMs (but do not qualify for the Advanced APM payment track) will have their performance evaluated at the "APM Entity" level.[48] CMS is not proposing any changes to the group reporting option for 2018 other than a claims review process to determine group size, which would replace the current attestation.

In addition to the individual and group reporting options, CMS proposes to implement a "virtual group" option for eligible clinicians to participate in MIPS beginning in 2018:

- **Virtual Groups**. As proposed, CMS would allow solo practitioners and small groups of 10 or fewer clinicians to virtually link up with other solo practitioners and/or small groups for purposes of combining performance. Virtual groups have no maximum number of clinicians and may span any location or specialty so long as each clinician is independently eligible for MIPS.[49] This arrangement would allow members of the group to satisfy different reporting criteria across the quality and cost performance categories on behalf of the group. Virtual groups would need to form and register by December 1 preceding the performance period (i.e., December 1, 2017 for the 2018 performance period), and CMS intends to allow virtual groups to begin registering sometime in mid-September, prior to the publication of the final rule.[50] In future years, CMS intends to have an electronic election process.

Q. Are facility-based clinicians able to use facility performance in lieu of MIPS reporting?

A. CMS proposes to establish a facility-based reporting option beginning in 2018. As proposed, clinicians who perform 75% or more of their allowable charges in the inpatient or emergency room (but not other outpatient) hospital settings would be allowed to substitute their facility's performance in the Hospital Value Based Purchasing (VBP) program for individual performance in the quality and cost performance categories.[51]

1.5. Exclusions from MIPS

Q. In general, what types of practitioners are subject to MIPS?

A. "MIPS eligible clinicians," a group that includes both physicians and the following types of non-physician practitioners eligible to bill under Medicare Part B, are required to participate in the program:

- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists; and
- Certified registered nurse anesthetists.[52]

CMS is not proposing to expand the types of clinicians eligible to participate in MIPS in 2018, such as physical and occupational therapists, speech language pathologists, clinical social workers, and others, but will consider their participation in future years, even as soon as 2019.

Q. Who is excluded from MIPS?

A. MACRA excludes the following categories of clinicians from MIPS:

- New Medicare-enrolled eligible clinicians;
- Qualifying APM participants (QPs) and partial qualifying APM participants (Partial QPs) (these categories are discussed in more detail in the APM section below); and
- Otherwise eligible clinicians who treat a low-volume of Medicare beneficiaries.[53]

Q. Who is excluded from MIPS under the "low-volume" exclusion?

A. Currently, eligible clinicians and groups are excluded from MIPS if, during a defined annual period, they have less than or equal to either:

- $30,000 in Medicare Part B allowed charges; or
- 100 Medicare patients treated.[54]

For 2018, CMS proposes to increase the low-volume exclusion dollar threshold from $30,000 to $90,000, and the low-volume visit threshold from 100 to 200 patients. If finalized, this change would reduce the total number of otherwise eligible clinicians participating in MIPS by 134,000, resulting in more than half a million clinicians excluded on the basis of low-volume.[55]

Clinicians that fall below either of these thresholds are currently ineligible to participate in MIPS. However, CMS is considering allowing clinicians that are only able to exceed one threshold to opt into participation in MIPS beginning in 2019.[56]

Q. How does the low-volume exclusion apply to groups?

A. Clinicians may report as a group as long as at least one clinician in the group exceeds both low-volume thresholds, regardless of whether other individual clinicians in the group exceed these thresholds or not. However, groups that participate at the group level must report data for all clinicians and may not exclude performance data associated with individual clinicians that fall below the thresholds. Groups may also opt to participate in MIPS at the individual level, and thus only those individual clinicians who exceed both thresholds would be eligible to participate in MIPS if reporting individually.

Q. Will charges for Part B drugs count towards the low-volume MIPS exclusion?

A. Yes, the Proposed Rule states that the amounts for Part B drugs and other separately billed items that the agency can associate with individual clinicians *will* count toward the low-volume dollar threshold.[57] The agency will make an exception for Part B drugs that accompany DME and are supplied by a MIPS eligible clinician. CMS frames this policy as a clarification rather than a new proposal, and thus Part B drug charges will count toward the calculation of the low-volume exclusion for 2017.

2. Incentives and Criteria for Participation in Alternative Payment Models (APMs)

2.1. Advanced APM Incentive Payments

Q. What are the main incentives under the QPP to participate in an APM?

A. MACRA establishes new payment incentives under Medicare Part B designed to encourage physicians to participate in APMs. Primary among these is the APM Incentive Payment that is available to certain qualifying participants in Advanced APMs during the years 2019 through 2024. The APM Incentive Payment is a lump sum payment that is equal to 5% of each qualifying participant's estimated aggregated payments for Medicare Part B covered professional services (services paid under or based on the Medicare Physician Fee Schedule). Advanced APM participants that qualify for this incentive are also excluded from MIPS, and beginning in 2026, will receive a higher payment update to Physician Fee Schedule rates than non-qualifying participants.[58]

Q. Do APM incentive payments apply to drugs?

A. Unlike for MIPS payment adjustments, CMS did not provide any clarifying language in the Proposed Rule as to whether APM incentive payments will also apply to drugs. However, there is no indication that the APM incentive payment would apply differently than the MIPS payment adjustment to separately billed drugs and other items. Stakeholders are seeking clarity on whether this is the case.

2.2. Advanced APM Criteria

Q. How do participants of APMs qualify for the exclusion from MIPS?

A. APM participants will qualify for the APM incentive payment and MIPS exclusion if they:

- Participate in an APM that is considered an Advanced APM; and
- Meet minimum participation thresholds.

Q. What APMs currently qualify as "Advanced APMs"?

A. Not all APMs are considered Advanced APMs. MACRA sets certain guidelines on which payment models qualify.[59] CMS released an initial set of Advanced APM determinations prior to the start of the 2017 performance period, in which the agency identified the following models that would be considered Advanced APMs under proposed criteria, including:

- Oncology Care Model (two-sided risk arrangements only, available in 2017);
- Medicare Shared Savings Program ACOs (two-sided risk arrangements only);
- Next Generation ACO Model;
- Comprehensive Primary Care Plus (CPC+) Model;
- Comprehensive ESRD Care (two-sided risk arrangements only);
- Acute Myocardial Infarction (AMI) Model and Coronary Artery Bypass Graft (CABG) Model (Track 1 – CEHRT); and
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT).[60]

In addition to the current Advanced APMs, CMS proposes to consider the following models Advanced APMs in 2018:

- Medicare ACO Track 1+ Model; and
- MSSP ACO Tracks 2 and 3.

Q. What are features of Advanced APMs?

A. In order to be an Advanced APM, the model must meet three statutory criteria:

1. Require participants to use certified electronic health record technology (CEHRT);
2. Provide for payment for covered services based on quality measures comparable to measures under the MIPS quality performance category;
3. Require that participating entities bear financial risk of more than a "nominal amount" under the APM by either:

a. **Financial Risk**: CMS requires an APM to involve two-sided "financial risk." This means that if actual expenditures for which an APM Entity is responsible under the model exceed expected expenditures during a specified performance period, CMS can (a) withhold payment for services; (b) reduce payment rates; or (3) require repayment to CMS.[61]

b. **More than a "nominal amount" of financial risk**: This concept was defined in the 2017 QPP Final Rule and means if, under the terms of the APM, the total annual amount that an APM Entity potentially owes CMS or forgoes is equal to at least:

- 8% of its average total Part A and Part B revenues (revenue-based standard); or
- 3% of the expected expenditures for which an APM Entity is responsible under the APM (benchmark-based standard).[62]

In the Proposed Rule, CMS continues the current 8% standard in 2018 and proposes to extend it through the 2020 performance year, which is a deviation from the previously planned increase up to 15%.[63]

2.3. Qualifying Advanced APM Participants

Q. What are the minimum participation thresholds to qualify for the 5% incentive payment when participating in an Advanced APM?

A. Advanced APM participants will qualify for the 5% APM incentive payment if they meet the standard for a Qualifying Advanced APM Participant (QP). For 2018, a QP would need to receive at least 25% of its payments for Part B services and/or see 20% of its patients through the APM.[64] These thresholds will rise in future performance years.

The thresholds can be met by considering only Medicare Part B payments and patients (Medicare Option), or, beginning in 2021, by considering payments and patients from additional payers (All-Payer Combination Option), with slightly modified thresholds.[65]

Q. What is the All-Payer Combination Option?

A. Beginning in 2019, eligible clinicians and APM Entities could submit aggregate payment and patient data across multiple payers to qualify for the APM Incentive Payment, even if their participation in Medicare APMs alone would not satisfy the existing standards. Other Payer Advanced APMs that would qualify to satisfy the applicable thresholds include Medicare Advantage, Medicaid, and CMS Multi-Payer Models.[66] For 2020 and later, commercial payers could apply for consideration as an Other Payer Advanced APM on an annual basis.[67]

Q. How many clinicians are expected to earn the 5% APM incentive payment in 2019?

A. For 2017, CMS estimated the number of QPs to be between 70,000 and 120,000 for payment year 2019.[68] With the qualification of new Advanced APMs combined with the re-opening to new participants of existing Advanced APMs for 2018, CMS anticipates higher numbers of QPs in subsequent years of the program. If the proposed policies are finalized, the agency estimates that between 180,000 to 245,000 eligible clinicians would become QPs for payment year 2020 based on Advanced APM participation in 2018.

Q. What are the opportunities to develop Physician-Focused Payment Alternative Payment Models?

A. MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) as an independent committee comprised of 11 members to review proposals from stakeholders on new Physician-Focused Payment Models (PFPMs) and make recommendations to CMS. The agency will utilize the PTAC as a resource for developing new APMs, but is not bound to test models recommended by the PTAC.[69]

In the CY 2017 QPP Final Rule, CMS defined a PFPM to include any APM: (1) in which Medicare is a payer; (2) in which eligible clinicians (including physicians *and* other types eligible professionals) are participants and play a core role in implementing the APM's payment methodology; and (3) which targets the quality and costs of services that eligible clinicians participating in the APM provide, order, or can significantly influence.[70] In the Proposed Rule, CMS proposes to broaden this definition to include other payers like Medicaid or the Children's Health Insurance Program (CHIP).[71]

3. More Information and Submitting Comments on the Proposed Rule

Q. Where can I find more information about the Quality Payment Program?

A. CMS maintains a website (http://qpp.cms.gov) with information and tools related to the QPP.

Q. How can an interested individual or organization submit comments on the Proposed Rule?

A. Interested stakeholders should submit comments electronically by visiting https://www.regulations.gov/docket?D=CMS-2017-0082. Alternatively, comments can be submitted by mail at the following addresses:

Regular Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

Express or Overnight Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore MD 21244-1850

The deadline for submitting comments is 5:00 p.m. EDT on **August 21, 2017**.

[1] Medicare Program; CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS-5522-P), 82 Fed. Reg. 30,010 (June 30, 2017), available at https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf [hereinafter "Proposed Rule"].
[2] The Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (2015) [hereinafter "MACRA"].
[3] MACRA § 101(b)(1)-(3).
[4] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77,008, 77,011 (Nov. 4, 2016), available at https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf [hereinafter "Final Rule"].
[5] Proposed Rule at 30,034.
[6] Proposed Rule at 30,148.
[7] Proposed Rule at 30,034.
[8] CMS PowerPoint, Proposed Rule for Quality Payment Program Year 2, slide 19 (July 2017).
[9] Proposed Rule at 30,014-16.
[10] Proposed Rule at 30,043, Table 5.
[11] Proposed Rule at 30,041-42.
[12] Proposed Rule at 30,042.
[13] Proposed Rule at 30,045.
[14] Proposed Rule at 30,043.
[15] Proposed Rule at 30,065.
[16] Proposed Rule at 30,058-59.
[17] Proposed Rule at 30,076-77.
[18] Proposed Rule at 30,078-79.
[19] 21st Century Cures Act, Pub. L. No. 114-255, § 16003, 133 Stat. 1033 (2016).
[20] Proposed Rule at 30,077.
[21] Proposed Rule at 30,021.
[22] Proposed Rule at 30,078.
[23] Proposed Rule at 30,076.
[24] Proposed Rule at 30,076-78.
[25] Proposed Rule at 30,080.
[26] MACRA § 101(c)(5)(E)(i)(III).
[27] Proposed Rule at 30,053-54.
[28] Proposed Rule at 30,055.
[29] Proposed Rule at 30,479-84, Table F & 30,486-99, Table G.
[30] Proposed Rule at 30,047-48.
[31] MACRA § 101(c)(5)(E)(i)(IV).
[32] Proposed Rule at 30,014, 30,047.
[33] Final Rule at 77,177.
[34] Proposed Rule at 30,140.
[35] Proposed Rule at 30,140.
[36] Proposed Rule at 30,138.
[37] Proposed Rule at 30,115-17.
[38] Proposed Rule at 30,148.
[39] Proposed Rule at 30,149.
[40] Proposed Rule at 30,237-38 & 30,240, Table 88.

[41] Final Rule at 77,038.
[42] Proposed Rule at 30,019.
[43] MACRA § 104(e) (codified at 42 U.S.C. § 1395w-4(q)(9)).
[44] Proposed Rule at 30,164-65.
[45] Final Rule at 77,078-79.
[46] Final Rule at 77,070-72.
[47] Final Rule at 77,078-79.
[48] Final Rule at 77,251.
[49] Proposed Rule at 30,030.
[50] Proposed Rule at 30,031-32.
[51] Proposed Rule at 30,125-26.
[52] Proposed Rule at 30,019.
[53] MACRA § 101(c) (codified at 42 U.S.C. § 1395w-4(q)(1)(C)).
[54] Final Rule at 77,539.
[55] Proposed Rule at 30,024-25.
[56] Proposed Rule at 30,026.
[57] Proposed Rule at 30,019.
[58] MACRA § 101(a)(2).
[59] MACRA § 101(e)(3)(C).
[60] See Alternative Payment Models in the Quality Payment Program (Oct. 14, 2016), available at https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.
[61] Final Rule at 77,466.
[62] Final Rule at 77,471-72.
[63] Proposed Rule at 30,173 & 30,180-81.
[64] MACRA § 101(e) (codified at 42 U.S.C. § 1395l(z)(2)).
[65] Proposed Rule at 30,178.
[66] Proposed Rule at 30,177-78.
[67] Proposed Rule at 30,183.
[68] Final Rule at 77,013.
[69] Final Rule at 77,548.
[70] Final Rule at 77,551-52.
[71] Proposed Rule at 30,209.