Carolinas Chapter
American Association of Clinical Endocrinologists

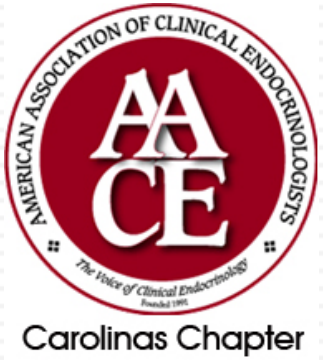
2017 ANNUAL MEETING
FRIDAY PRESENTATIONS

August 25-27, 2017

The Pinehurst Resort, Village of Pinehurst

This continuing medical education activity is jointly provided by the
Carolinas Chapter - American Association of Clinical Endocrinologists and
the Southern Regional Area Health Education Center

The Pivotal Role of MACRA in Health System Transformation



Objectives

- By the end of this session, you will be able to:
  - Explain what MACRA is and what it is intended to accomplish
  - Describe the major elements of the Quality Payment Program
  - Discuss key elements of the 2018 proposed changes
  - Identify resources to assist clinicians with the Quality Payment Program

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Outline

- Background
- Key elements of the QPP
- 2017 requirements
- Quality measures and other issues identified by AACE
- 2018 proposed rule
- Access to resources
- Q & A

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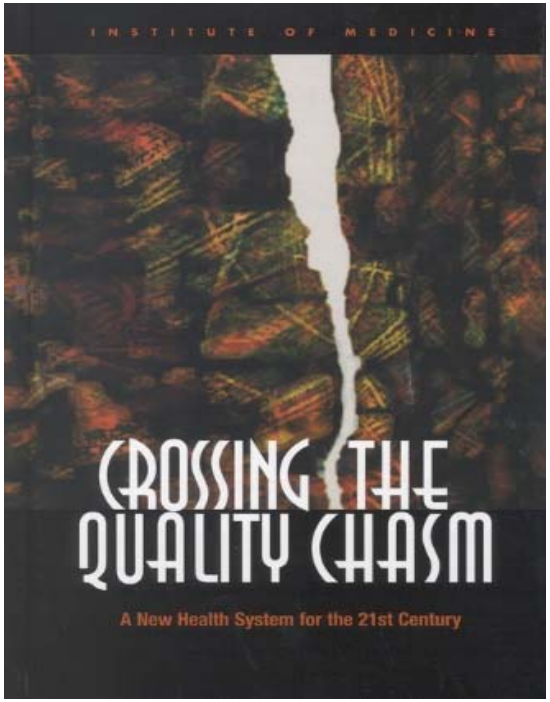
Background



1. Patient safety-reducing harm
2. Care effectiveness—avoiding over and underuse of resources
3. Patient-centeredness--relates both to customer service and to considering and accommodating individual patient needs when making care decisions
4. Timeliness—reduced wait times
5. Care efficiency, and
6. Equity—reducing disparities

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Background

- Revelations of the 21st Century
  - *1999—To Err is Human, Institute of Medicine*
  - *2000*--World Health Organization ranking of health systems
  - *2003--The Quality of Health Care Delivered to Adults in the United States,* Elizabeth McGlynn, NEJM
  - 2009--*The Cost Conundrum*, Atul Gawande, The New Yorker
  - Dartmouth Atlas
  - Numerous other studies and reports…

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Background

- …have underscored that our health care system is:
  - Too expensive
  - Too wasteful and inefficient
  - Too variable in terms of quality, cost and patient experience
  - Too siloed and fragmented
  - Too difficult for our most vulnerable and expensive populations-and even for our more educated patients-to navigate and understand

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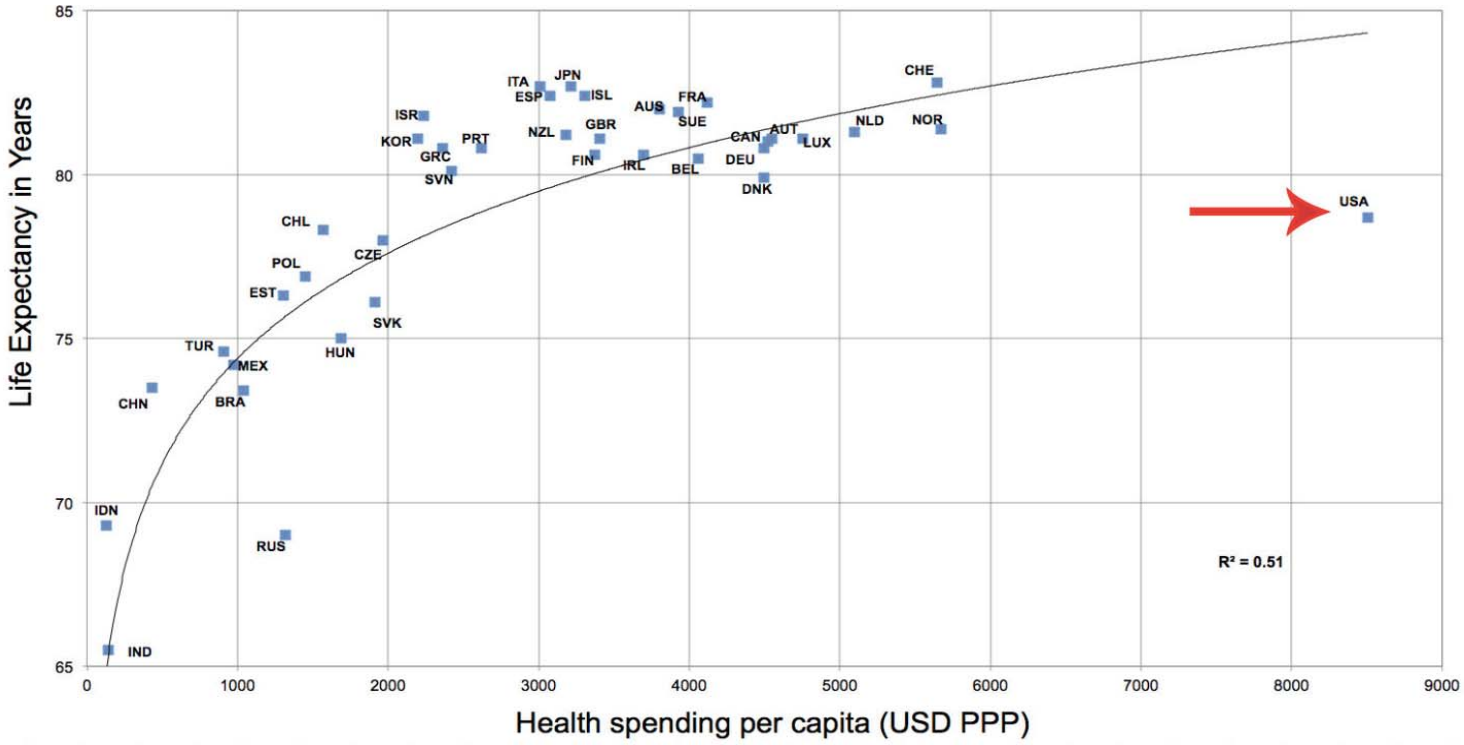
US Health System Performance



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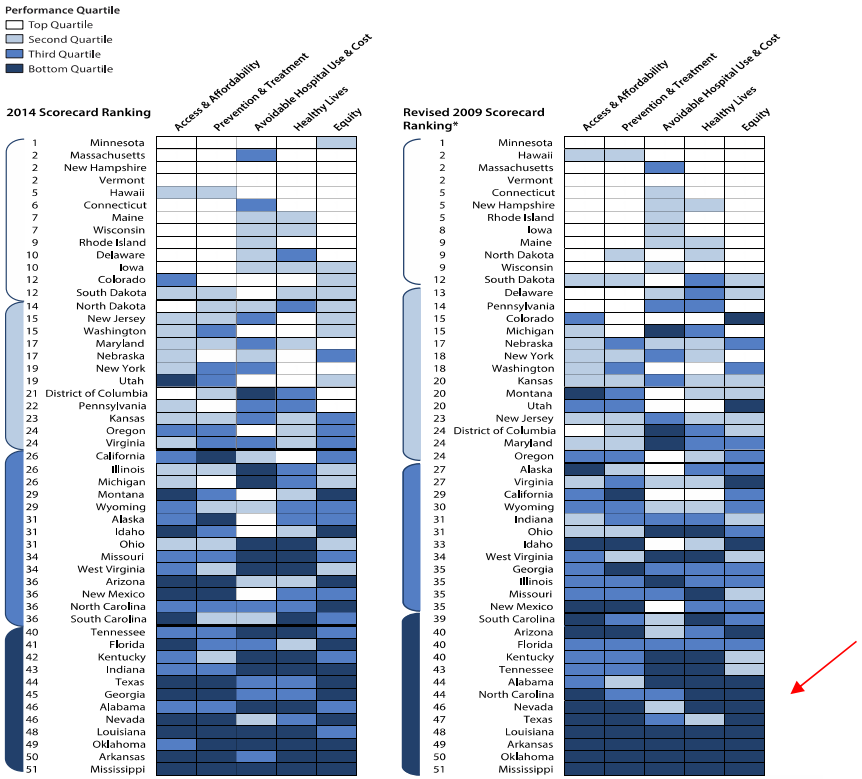
NC Health System Performance

Exhibit 3. State Scorecard Summary of Health System Performance Across Dimensions



Note: Several indicators have changed since the 2009 *State Scorecard*. Therefore, the 2009 *Scorecard* ranking has been revised to reflect the addition of several new indicators and updated definitions for others. The revised 2009 *Scorecard* ranking generally reflects the period five years prior to the time of observation for the latest year of data available, though this varies by indicator. If historical data were not available for a particular indicator, the most current year of data available were used as a substitute in the revised 2009 *Scorecard* ranking.
Source: Commonwealth Fund Scorecard on State Health System Performance, 2014.

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Background

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Background

- Move to Value is ~ 16 y.o:
  - 2000—PGP demo authorized
  - 2005—PGP demo started
  - 2007—IHI "Triple Aim" framework
  - 2010—ACA (MSSP, Bundles, CMMI)
  - 2015—Announcements by CMS and National Payers
  - 2015—MACRA
  - 2016—Medicaid Mega Reg finalized

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Background

While the main focus of the **ACA** was Health Insurance Reform, a handful of provisions promoted care delivery and payment reforms:

- MSSP (ACO)
- Bundled Payments
- CMMI

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Background

- The main focus of **MACRA**, however, is health care delivery and payment Reform
- Unlike the ACA, MACRA passed with strong bipartisan support
- Despite strong partisan rhetoric, MACRA builds on key provisions of the ACA.

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MACRA

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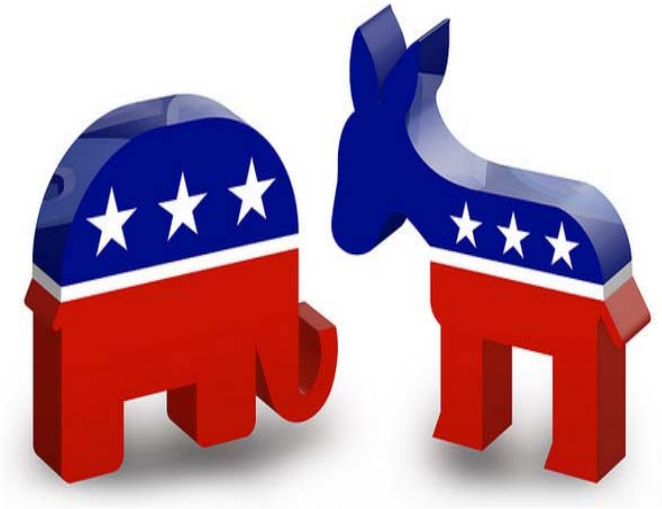
MACRA

Passed with Strong Bipartisan Support



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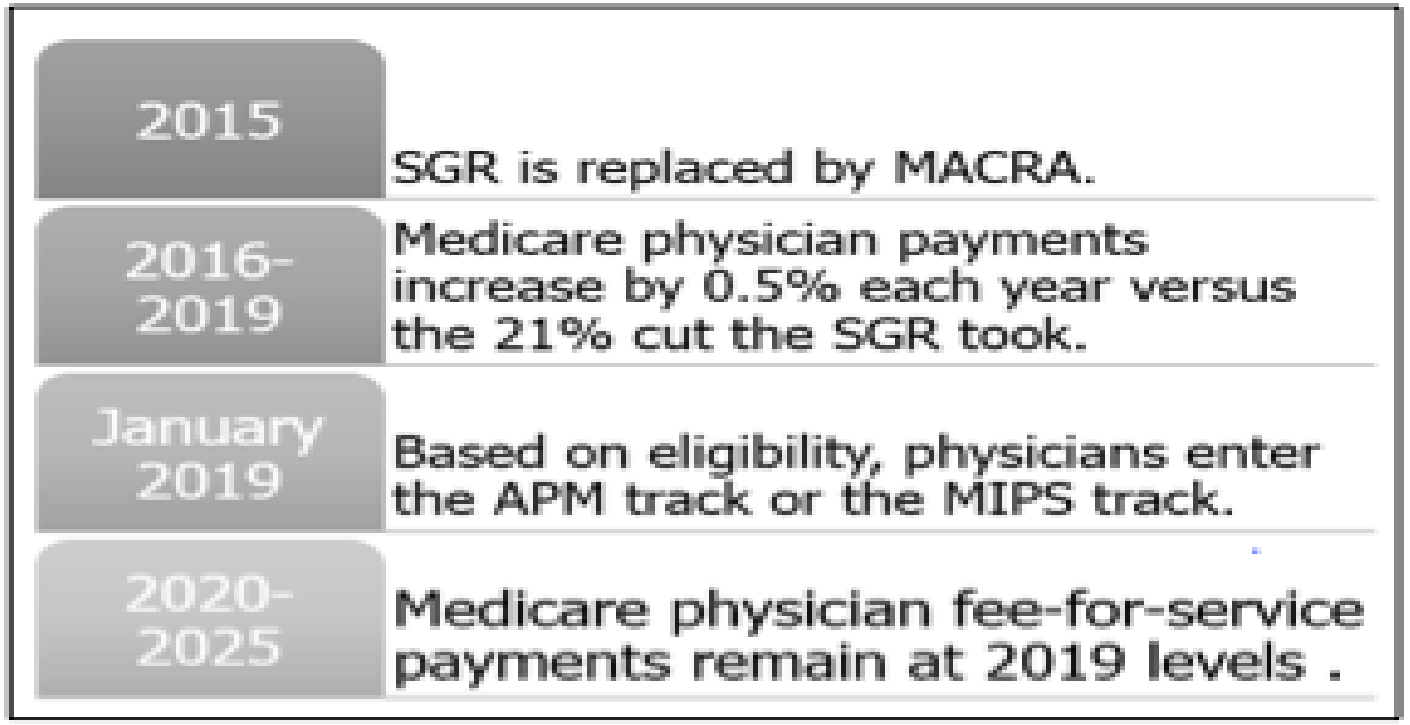
MACRA



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MACRA

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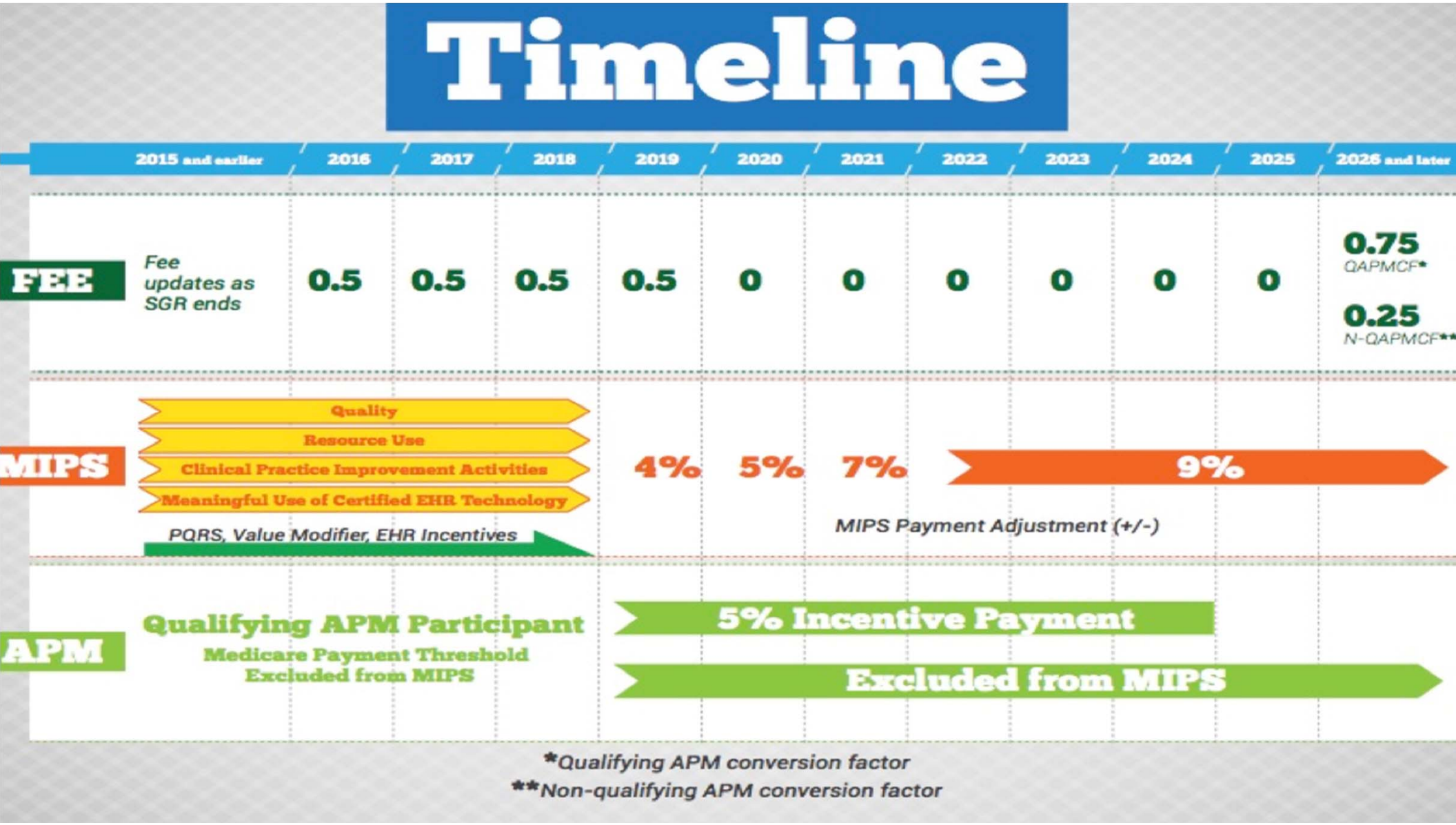
Timeline
2015 and earlier
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026 and later
FEE
Fee updates as SGR ends
0.5
0.5
0.5
0.5
0
0
0
0
0
0
0.75
QAPMCF*
0.25
N-QAPMCF**
MIPS
Quality
Resource Use
Clinical Practice Improvement Activities
Meaningful Use of Certified EHR Technology
PQRS, Value Modifier, EHR Incentives
4%
5%
7%
9%
MIPS Payment Adjustment (+/-)
APM
Qualifying APM Participant
Medicare Payment Threshold
Excluded from MIPS
5% Incentive Payment
Excluded from MIPS
*Qualifying APM conversion factor
**Non-qualifying APM conversion factor

MACRA

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MACRA

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MACRA

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Quality Payment Program (QPP)

- The QPP has 6 strategic goals:
  1. Improve beneficiary outcomes
  2. Enhance clinician experience
  3. Increase adoption of Advanced Alternate Payment Models
  4. Maximize participation
  5. Improve data and information sharing, and
  6. Ensure operation excellence in program implementation

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Quality Payment Program (QPP)

- Resources:
  - Quality Payment Program Fact Sheet
  - "MACRONYM" Glossary

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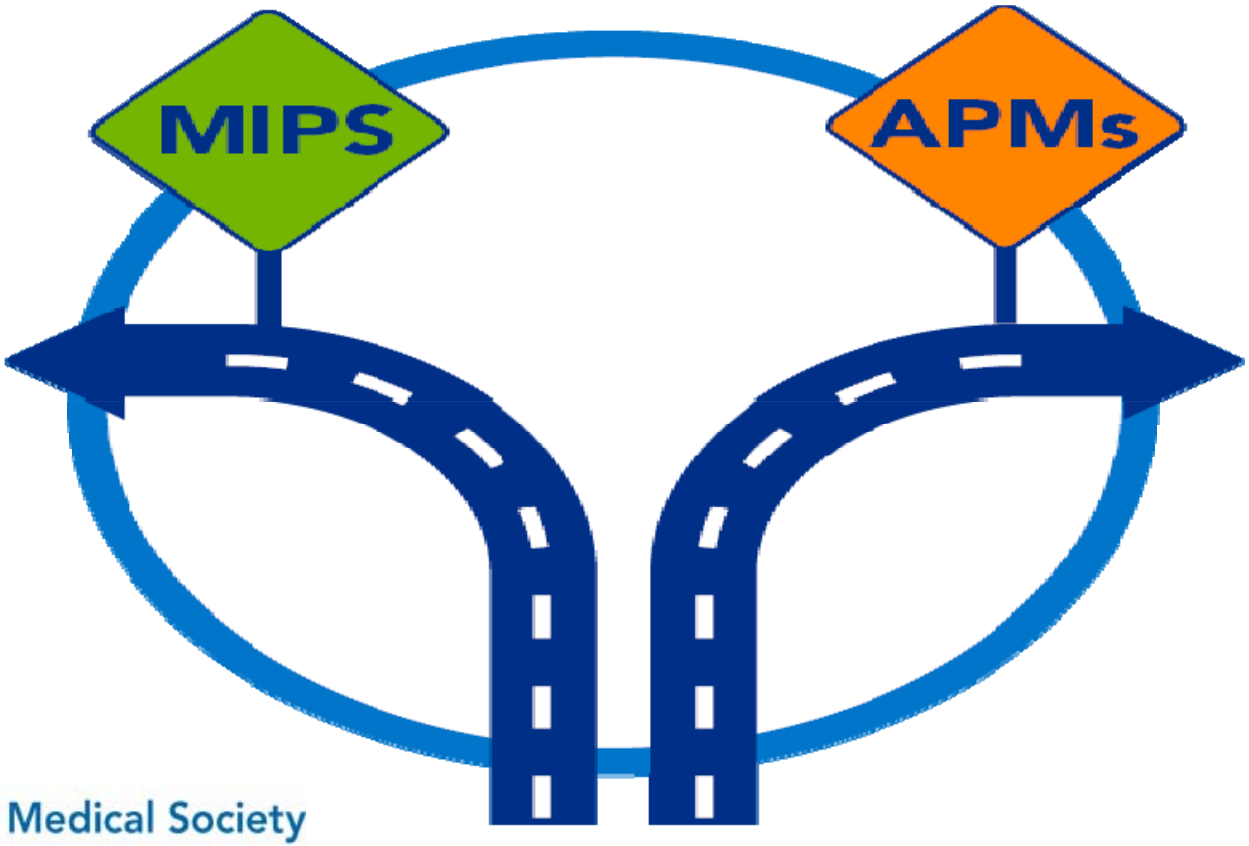
Quality Payment Program (QPP)



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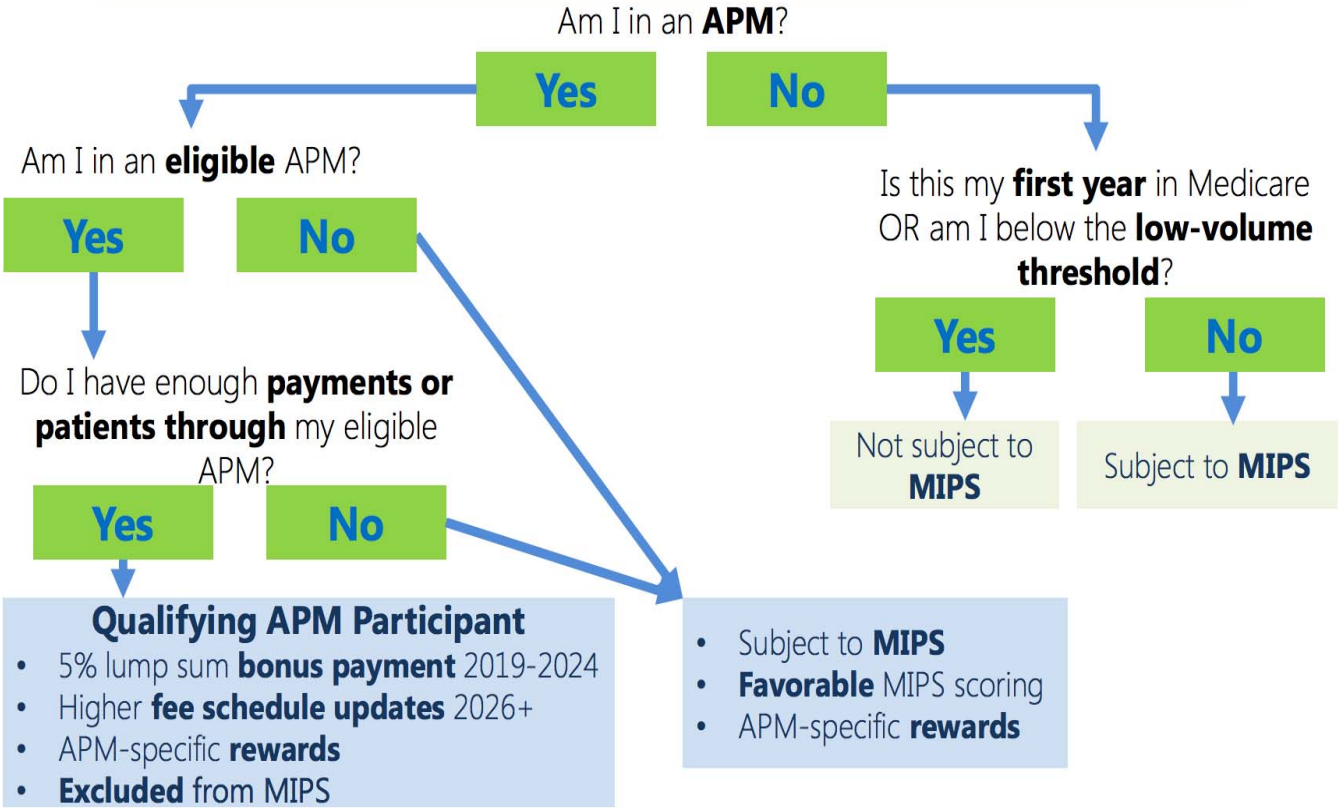
How will MACRA affect me?



Quality Payment Program (QPP)

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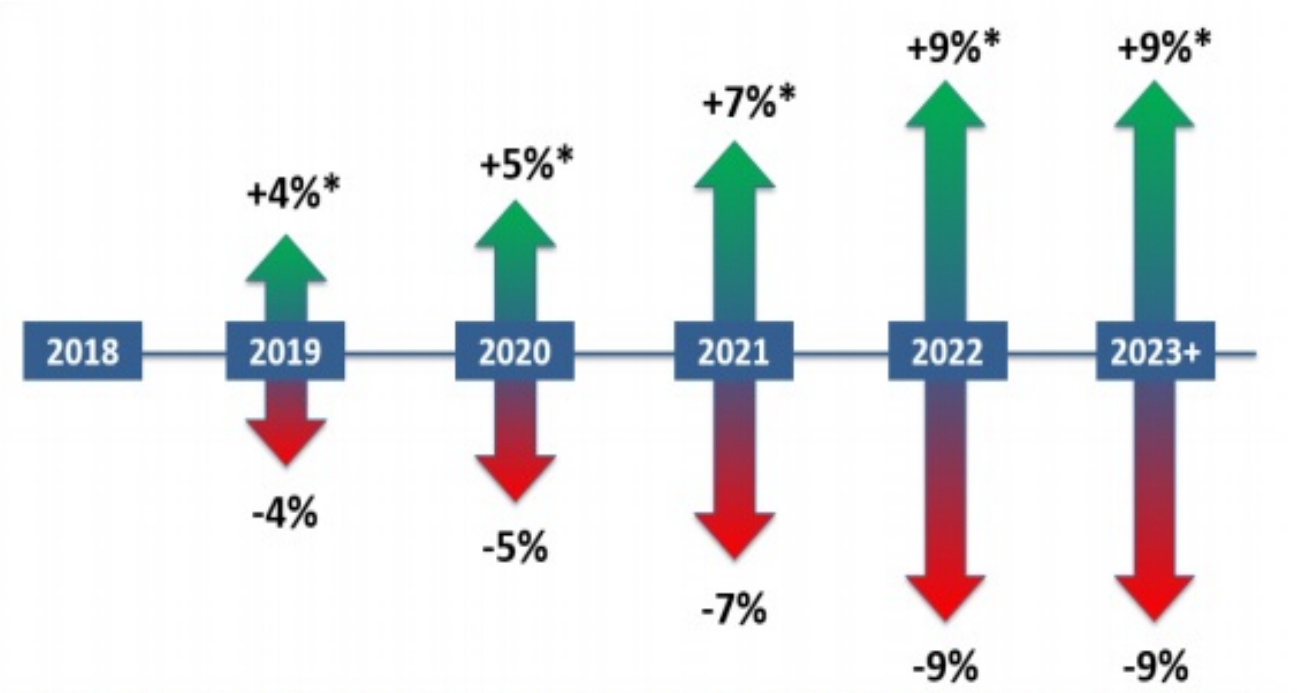
Quality Payment Program (QPP)

Figure 1. Potential "Payment Adjustments" Under MIPS by Year



**Maximum amount of incentive payments under MIPS could increase further for "exceptional performers."*

Quality Payment Program (QPP)

- Who is subject to MIPS beginning 1/1/17?
  - "Eligible Clinicians"
    - Physicians (MDs, DOs, Optometrists, Podiatrists, Dentists and Chiropractors)
    - Physician Assistants
    - Nurse Practitioners
    - Certified Registered Nurse Anesthetists
    - Clinical Nurse Specialists

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Quality Payment Program (QPP)

- Who is exempt from MIPS for 2017 Performance Year?
  - Eligible clinicians newly enrolled in Medicare
  - Low-volume thresholds apply to clinicians who:
    - Medicare Part B allowed charges of $30,000 or less; OR
    - 100 or fewer Part B-enrolled Medicare beneficiaries
  - Certain participants in Advanced Alternative Payment Models

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Quality Payment Program (QPP)

- Special Considerations
  - Rural practices (practices in rural and geographic HPSAs)
  - Small practices (15 or fewer clinicians and solo practitioners)
  - Non-patient facing clinicians—bill 100 or fewer patient facing encounters (including Medicare telehealth services); if a group, then more than 75% of the NPIs billing under the group's TIN must meet the definition of a non-patient facing clinician
  - Exceptions:
    - ½ the Improvement Activities–one high priority or 2 medium priority activities (compared to 2 high or 4 medium)

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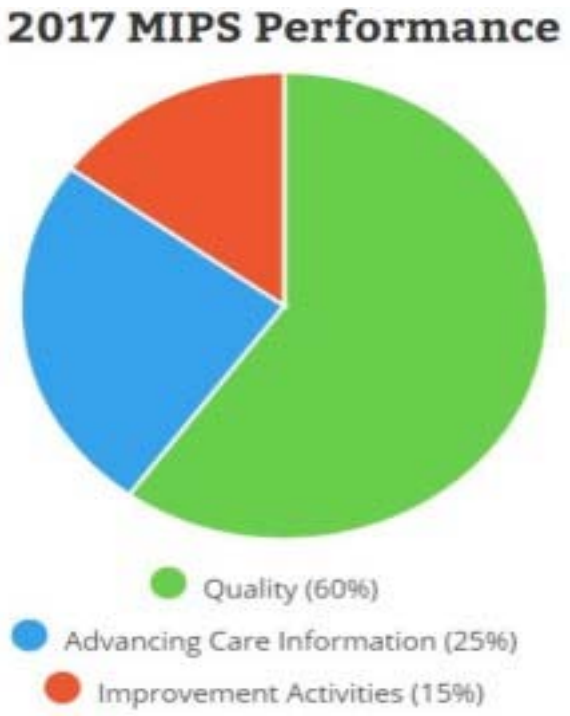
What is the Merit-based Incentive Payment System?

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

Quality Payment Program (QPP)



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Quality Payment Program (QPP)

2018/20

Quality	50%
Cost/Resource Use	10%
Improvement Activities	15%
Advancing Care Information	25%

2019/21 and beyond

Quality	30%
Cost/Resource Use	30%
Improvement Activities	15%
Advancing Care Information	25%

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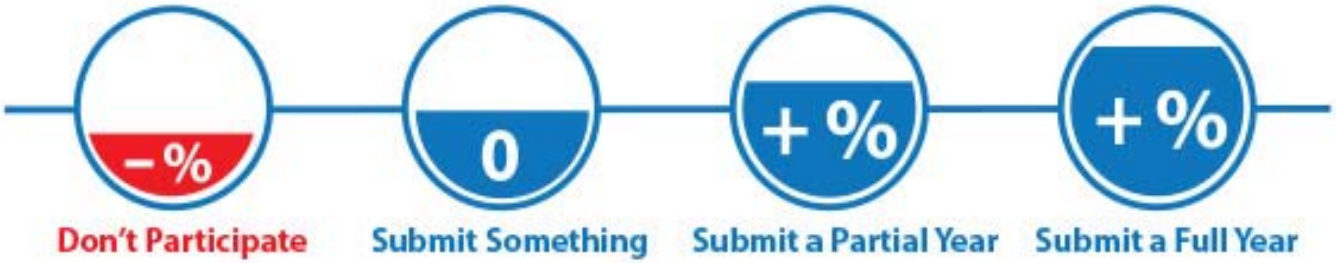
Quality Payment Program (QPP)



Don't Participate

Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Submit Something

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

Submit a Partial Year

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Submit a Full Year

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

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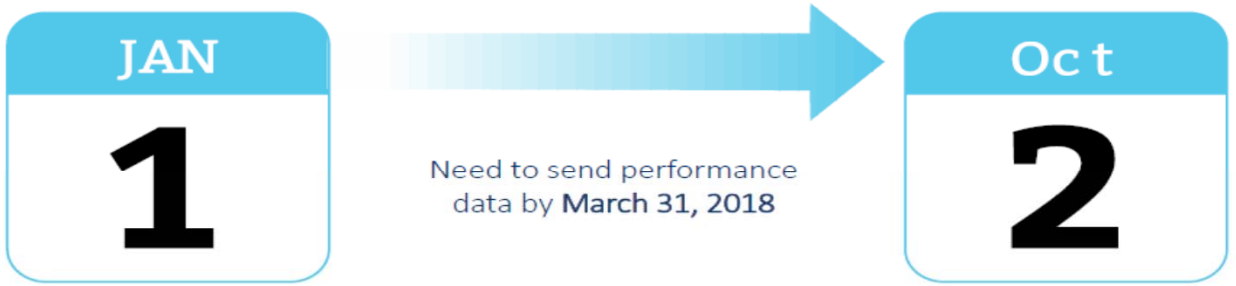
MIPS: Partial Participation for 2017

Submit a Partial Year

- 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



MIPS: Full Participation for 2017

Submit a Full Year

- 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.**

Quality Payment Program (QPP)

- Reporting
  - An individual (NPI and assigned TIN)
  - As a group (2 or more individuals who are assigned their billing rights to a TIN)
  - If in an APM, then would report as APM entity
  - * If clinicians participate as a group, then they are assessed as a group across all 4 MIPS performance categories.

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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

60%

60% of final score

Select 6 of about 300 quality measures (minimum of 90 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

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

May also select specialty-specific set of measures

MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- *Keep in mind:*

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)

Only the scoring is different

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

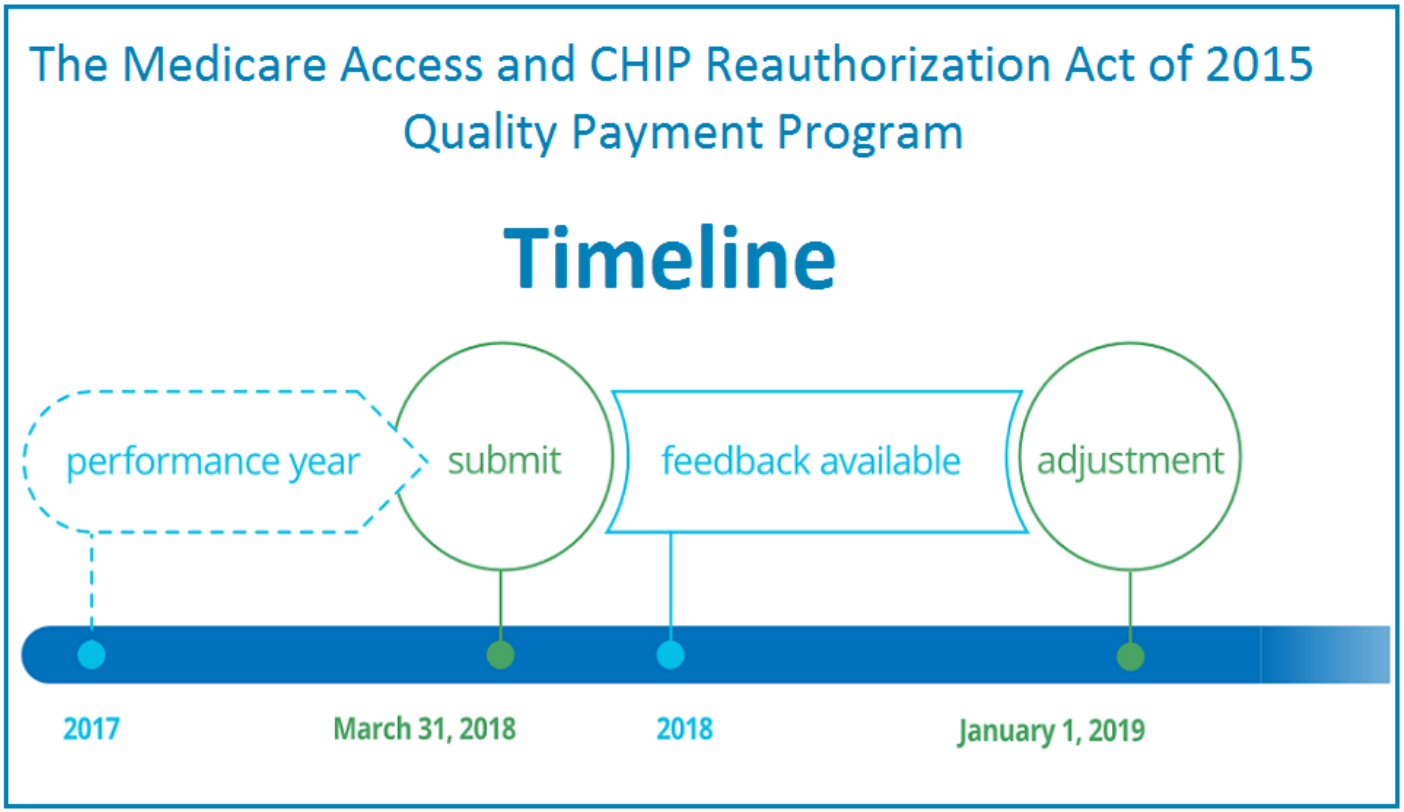
For those using EHR Certified to the 2015 Edition:

Option 1	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets

For those using 2014 Certified EHR Technology:

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

Quality Payment Program (QPP)



Calculating the Final Score Under MIPS

Final Score =

[Clinician Quality performance category score x actual Quality performance category weight] + [Clinician Cost performance category score x actual Cost performance category weight] + [Clinician Improvement Activities performance category score x actual Improvement Activities performance category weight] + [Clinician Advancing Care Information performance category score x actual Advancing Care Information performance category weight] × 100

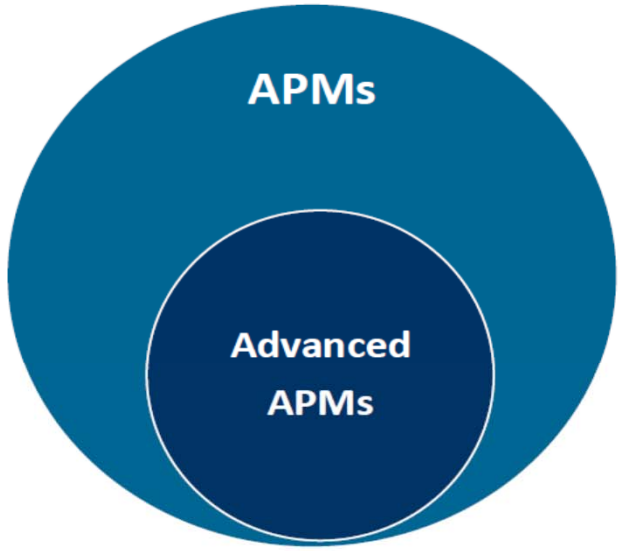
Transition Year 2017

Final Score	Payment Adjustment
≥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

Alternative Payment Models (APMs)

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- Can apply to a specific condition, care episode or population.
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of 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

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 Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- 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.

Future Advanced APM Opportunities

In future performance years, we anticipate that the following models will be Advanced APMs:

- Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
- New Voluntary Bundled Payment Model
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- ACO Track 1+

Keep in mind: The Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review and assess proposals for Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

Qualifying APM Participant (QP)

Qualifying APM Participants (QPs) are clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.

Beginning in 2021, this threshold % may be reached through a combination of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

Advanced Alternative Payment Models

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

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

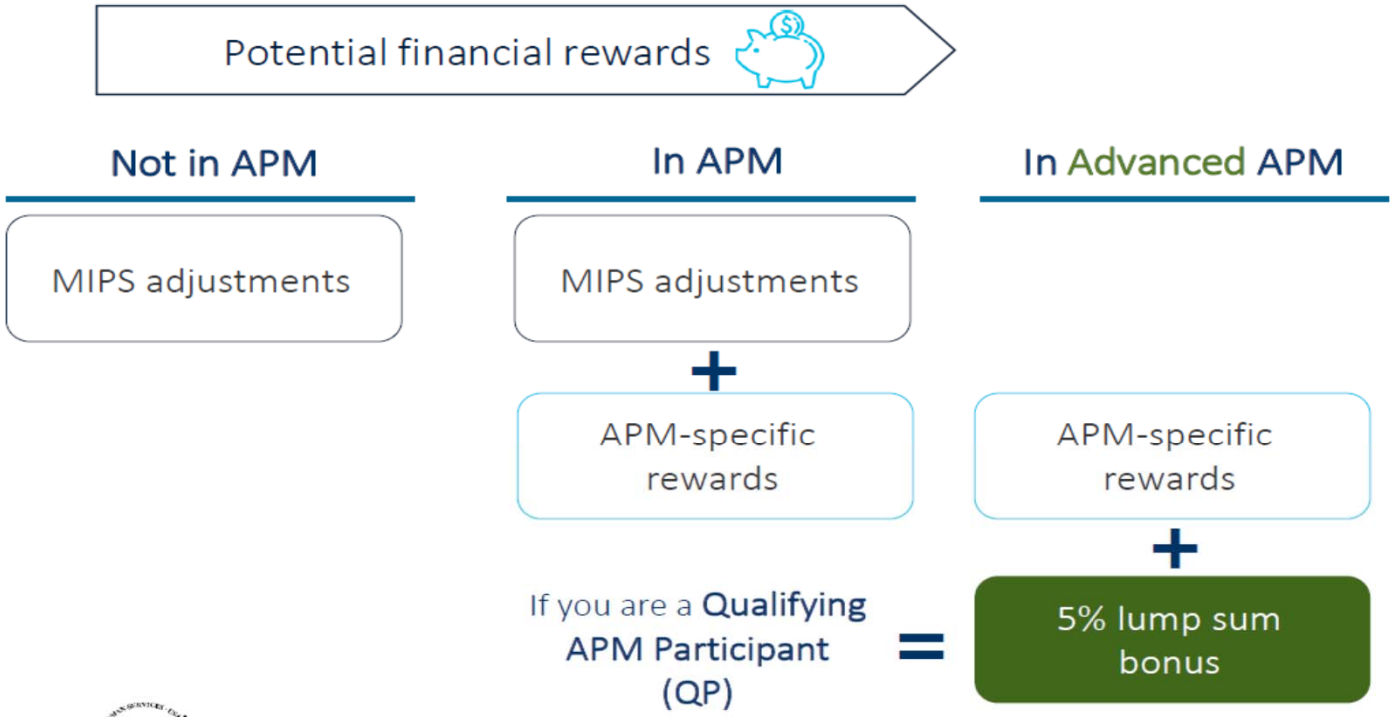
How do Eligible Clinicians become Qualifying APM Participants?—Step 3

3

✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

The Quality Payment Program provides **additional** rewards for participating in APMs.



Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;
2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

What if Clinicians do not meet the QP Payment or Patient Thresholds?

- Clinicians who participate in Advanced APMs, but do not meet the QP threshold, may become "Partial" Qualifying APM Participants (Partial QPs).
- Partial QPs choose whether to participate in MIPS.

Medicare-Only Partial QP Thresholds in Advanced APMs						
Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments	20%	20%	40%	40%	50%	50%
Percentage of Patients	10%	10%	25%	25%	35%	35%

RESOURCES

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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):

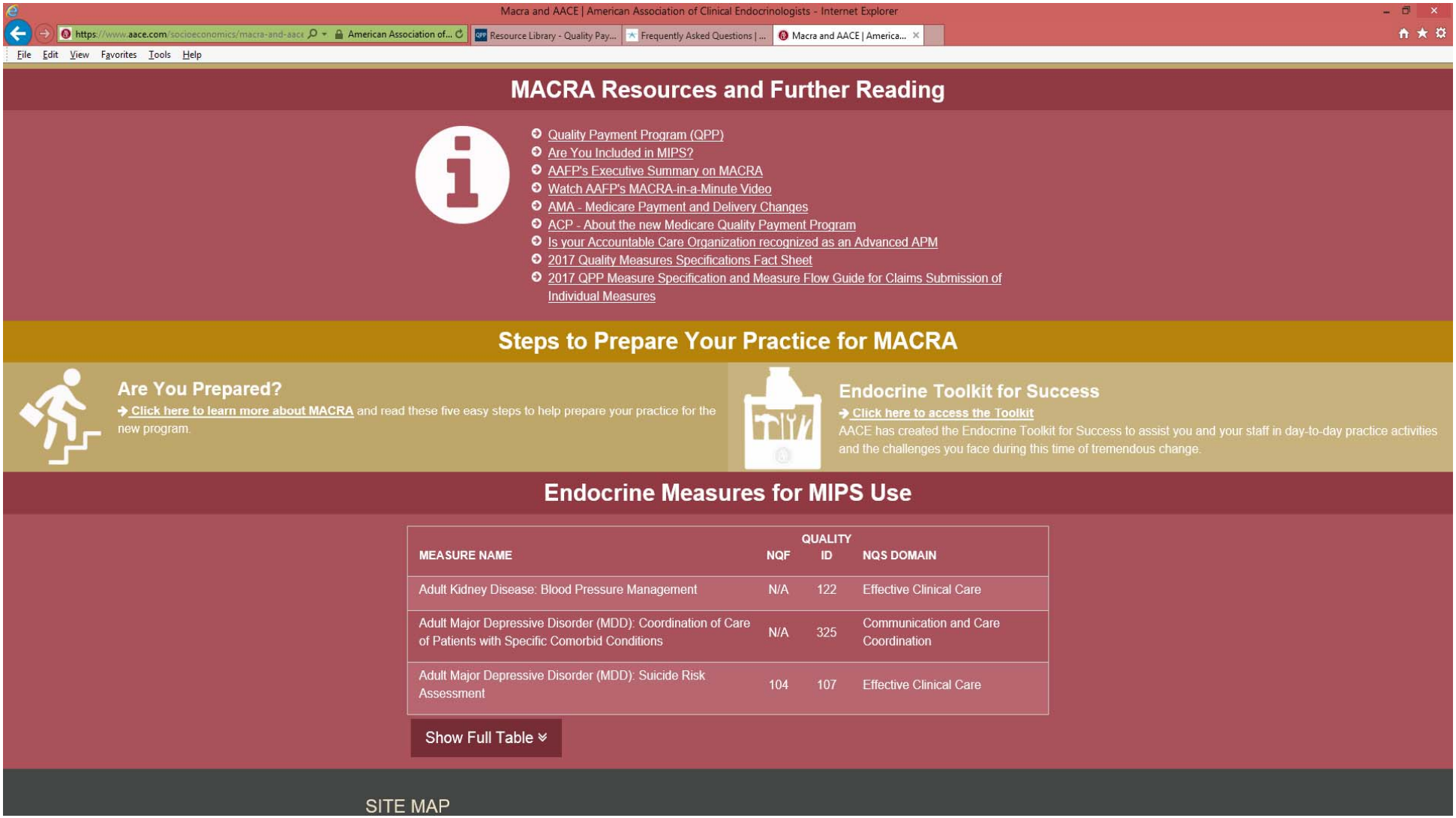
- Designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

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 APM participation under MIPS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https://www.aace.com/socioeconomics/macra-and-aace
American Association of...
Resource Library - Quality Pay...
Frequently Asked Questions | ...
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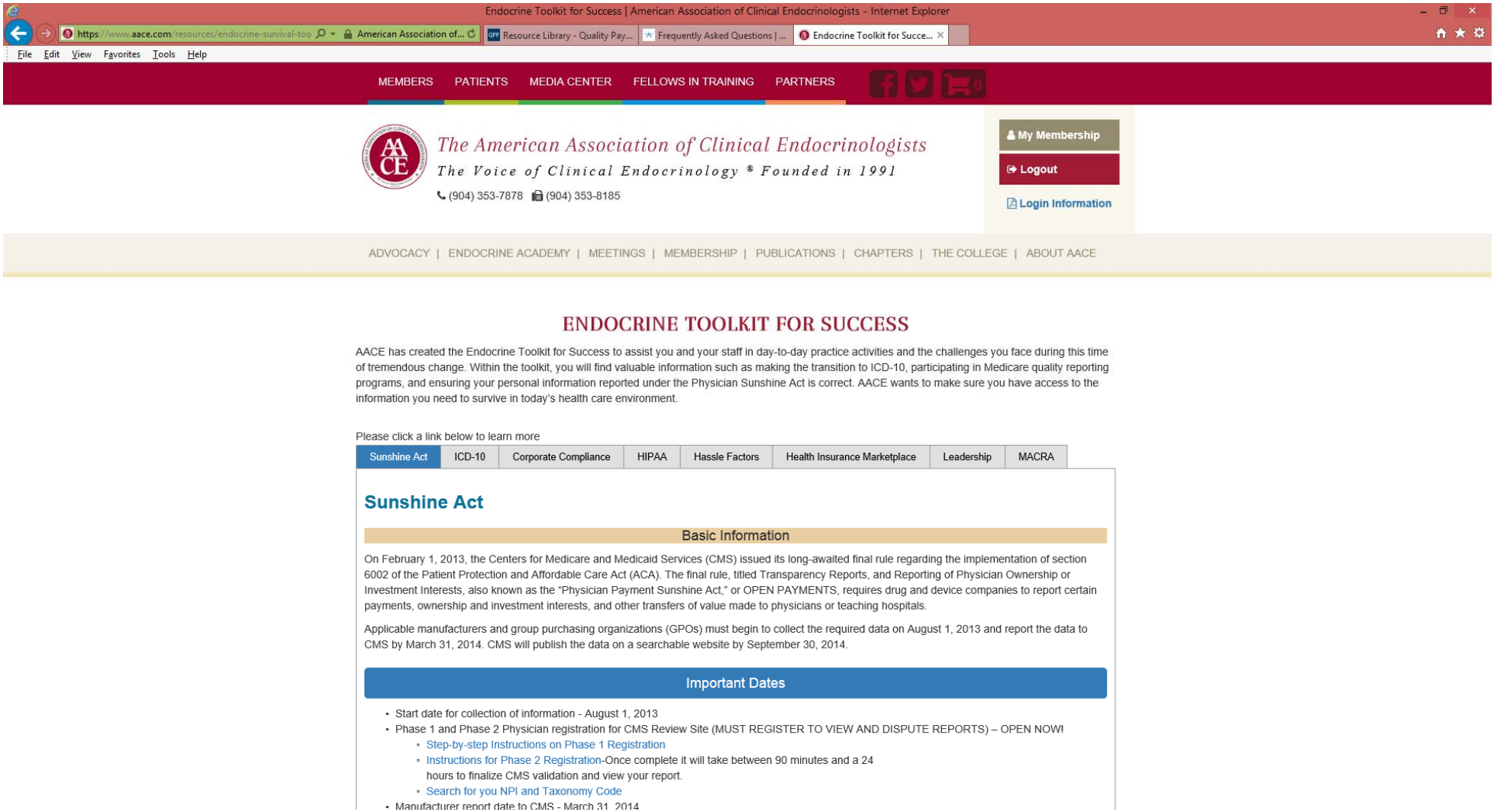
File Edit View Favorites Tools Help
MACRA Resources and Further Reading
Quality Payment Program (QPP)
Are You Included in MIPS?
AAFP's Executive Summary on MACRA
Watch AAFP's MACRA-in-a-Minute Video
AMA - Medicare Payment and Delivery Changes
ACP - About the new Medicare Quality Payment Program
Is your Accountable Care Organization recognized as an Advanced APM
2017 Quality Measures Specifications Fact Sheet
2017 QPP Measure Specification and Measure Flow Guide for Claims Submission of Individual Measures
Steps to Prepare Your Practice for MACRA
Are You Prepared?
Click here to learn more about MACRA and read these five easy steps to help prepare your practice for the new program.
Endocrine Toolkit for Success
Click here to access the Toolkit
AACE has created the Endocrine Toolkit for Success to assist you and your staff in day-to-day practice activities and the challenges you face during this time of tremendous change.
Endocrine Measures for MIPS Use
MEASURE NAME | NQF | QUALITY ID | NQS DOMAIN
Adult Kidney Disease: Blood Pressure Management | N/A | 122 | Effective Clinical Care
Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions | N/A | 325 | Communication and Care Coordination
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment | 104 | 107 | Effective Clinical Care
Show Full Table
SITE MAP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https://www.aace.com/resources/endocrine-survival-too
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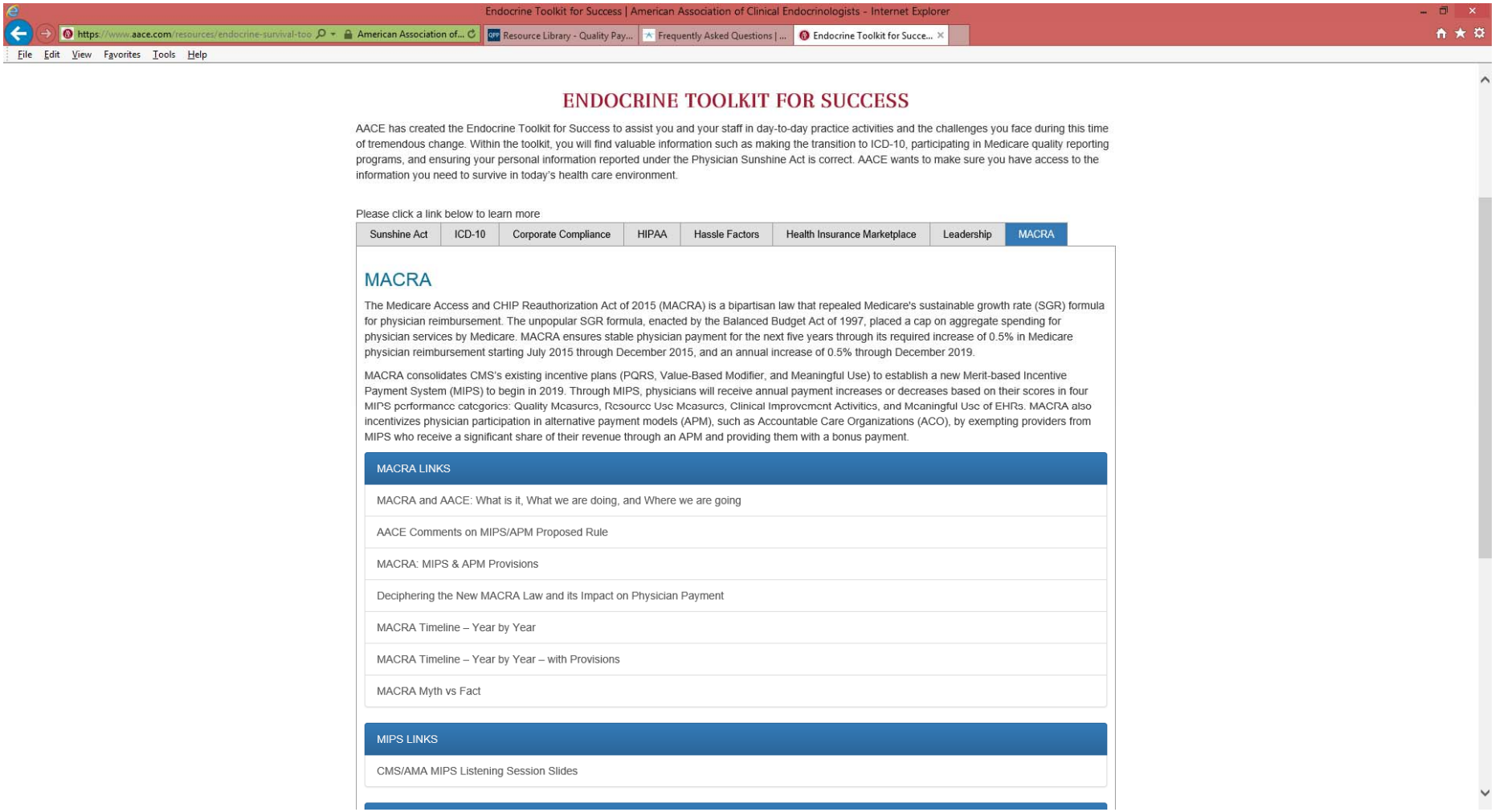
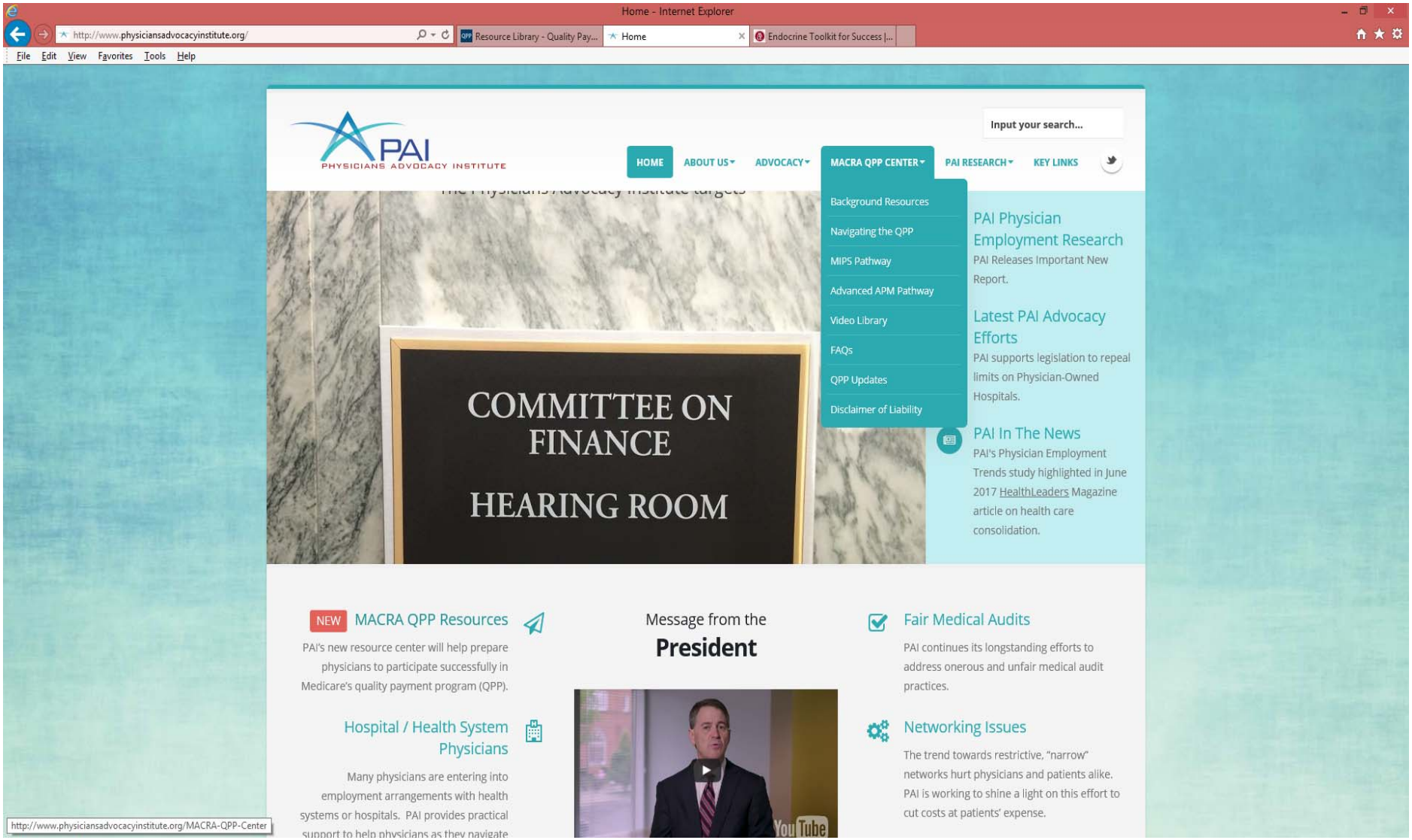
ENDOCRINE TOOLKIT FOR SUCCESS
AACE has created the Endocrine Toolkit for Success to assist you and your staff in day-to-day practice activities and the challenges you face during this time of tremendous change. Within the toolkit, you will find valuable information such as making the transition to ICD-10, participating in Medicare quality reporting programs, and ensuring your personal information reported under the Physician Sunshine Act is correct. AACE wants to make sure you have access to the information you need to survive in today's health care environment.
Please click a link below to learn more
Sunshine Act
ICD-10
Corporate Compliance
HIPAA
Hassle Factors
Health Insurance Marketplace
Leadership
MACRA
Sunshine Act
Basic Information
On February 1, 2013, the Centers for Medicare and Medicaid Services (CMS) issued its long-awaited final rule regarding the implementation of section 6002 of the Patient Protection and Affordable Care Act (ACA). The final rule, titled Transparency Reports, and Reporting of Physician Ownership or Investment Interests, also known as the "Physician Payment Sunshine Act," or OPEN PAYMENTS, requires drug and device companies to report certain payments, ownership and investment interests, and other transfers of value made to physicians or teaching hospitals.
Applicable manufacturers and group purchasing organizations (GPOs) must begin to collect the required data on August 1, 2013 and report the data to CMS by March 31, 2014. CMS will publish the data on a searchable website by September 30, 2014.
Important Dates
• Start date for collection of information - August 1, 2013
• Phase 1 and Phase 2 Physician registration for CMS Review Site (MUST REGISTER TO VIEW AND DISPUTE REPORTS) – OPEN NOW!
◦ Step-by-step Instructions on Phase 1 Registration
◦ Instructions for Phase 2 Registration-Once complete it will take between 90 minutes and a 24 hours to finalize CMS validation and view your report.
◦ Search for you NPI and Taxonomy Code
• Manufacturer report date to CMS - March 31, 2014


Endocrine Toolkit for Success | American Association of Clinical Endocrinologists - Internet Explorer
https://www.aace.com/resources/endocrine-survival-too
American Association of...
Resource Library - Quality Pay...
Frequently Asked Questions | ...
Endocrine Toolkit for Succe...
File Edit View Favorites Tools Help
ENDOCRINE TOOLKIT FOR SUCCESS
AACE has created the Endocrine Toolkit for Success to assist you and your staff in day-to-day practice activities and the challenges you face during this time of tremendous change. Within the toolkit, you will find valuable information such as making the transition to ICD-10, participating in Medicare quality reporting programs, and ensuring your personal information reported under the Physician Sunshine Act is correct. AACE wants to make sure you have access to the information you need to survive in today's health care environment.
Please click a link below to learn more
Sunshine Act
ICD-10
Corporate Compliance
HIPAA
Hassle Factors
Health Insurance Marketplace
Leadership
MACRA
MACRA
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan law that repealed Medicare's sustainable growth rate (SGR) formula for physician reimbursement. The unpopular SGR formula, enacted by the Balanced Budget Act of 1997, placed a cap on aggregate spending for physician services by Medicare. MACRA ensures stable physician payment for the next five years through its required increase of 0.5% in Medicare physician reimbursement starting July 2015 through December 2015, and an annual increase of 0.5% through December 2019.
MACRA consolidates CMS's existing incentive plans (PQRS, Value-Based Modifier, and Meaningful Use) to establish a new Merit-based Incentive Payment System (MIPS) to begin in 2019. Through MIPS, physicians will receive annual payment increases or decreases based on their scores in four MIPS performance categories: Quality Measures, Resource Use Measures, Clinical Improvement Activities, and Meaningful Use of EHRs. MACRA also incentivizes physician participation in alternative payment models (APM), such as Accountable Care Organizations (ACO), by exempting providers from MIPS who receive a significant share of their revenue through an APM and providing them with a bonus payment.
MACRA LINKS
MACRA and AACE: What is it, What we are doing, and Where we are going
AACE Comments on MIPS/APM Proposed Rule
MACRA: MIPS & APM Provisions
Deciphering the New MACRA Law and its Impact on Physician Payment
MACRA Timeline – Year by Year
MACRA Timeline – Year by Year – with Provisions
MACRA Myth vs Fact
MIPS LINKS
CMS/AMA MIPS Listening Session Slides


Home - Internet Explorer
http://www.physiciansadvocacyinstitute.org/
Resource Library - Quality Pay...
Home
Endocrine Toolkit for Success |...
File Edit View Favorites Tools Help
PAI
PHYSICIANS ADVOCACY INSTITUTE
Input your search...
HOME
ABOUT US
ADVOCACY
MACRA QPP CENTER
PAI RESEARCH
KEY LINKS
Background Resources
Navigating the QPP
MIPS Pathway
Advanced APM Pathway
Video Library
FAQs
QPP Updates
Disclaimer of Liability
COMMITTEE ON FINANCE
HEARING ROOM
PAI Physician Employment Research
PAI Releases Important New Report.
Latest PAI Advocacy Efforts
PAI supports legislation to repeal limits on Physician-Owned Hospitals.
PAI In The News
PAI's Physician Employment Trends study highlighted in June 2017 HealthLeaders Magazine article on health care consolidation.
NEW MACRA QPP Resources
PAI's new resource center will help prepare physicians to participate successfully in Medicare's quality payment program (QPP).
Hospital / Health System Physicians
Many physicians are entering into employment arrangements with health systems or hospitals. PAI provides practical
Message from the
President
YouTube
Fair Medical Audits
PAI continues its longstanding efforts to address onerous and unfair medical audit practices.
Networking Issues
The trend towards restrictive, "narrow" networks hurt physicians and patients alike. PAI is working to shine a light on this effort to cut costs at patients' expense.
http://www.physiciansadvocacyinstitute.org/MACRA-QPP-Center

2018 Proposed Rule for QPP Year 2

- Quality Payment Program Year 2
  - Offering Virtual Group participation
  - Increasing the low-volume threshold
  - Continue to allow use of 2014 CEHRT while enouaging use of 2015 edition CEHRT
  - Adding bonus points in scoring methodology for
    - Caring for complex patients
    - Using 2015 CEHRT exclusively
  - Incorporating MIPs performance improvement in scoring quality performance
  - Incorporating the option to use facility-based scoring for facility-based clinicians

North Carolina Medical Society

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2018 Proposed Rule for QPP Year 2

- CMS is also proposing more flexibilities for clinicians in small practices that would:
  - Add a new hardship exemption for clinicians in small practices under the Advancing Care Information performance category
  - Add bonus points to the final score of clinicians in small practices
  - Continue to award small practices 3 points for measures in the Quality performance category that don't meet data completeness requirements

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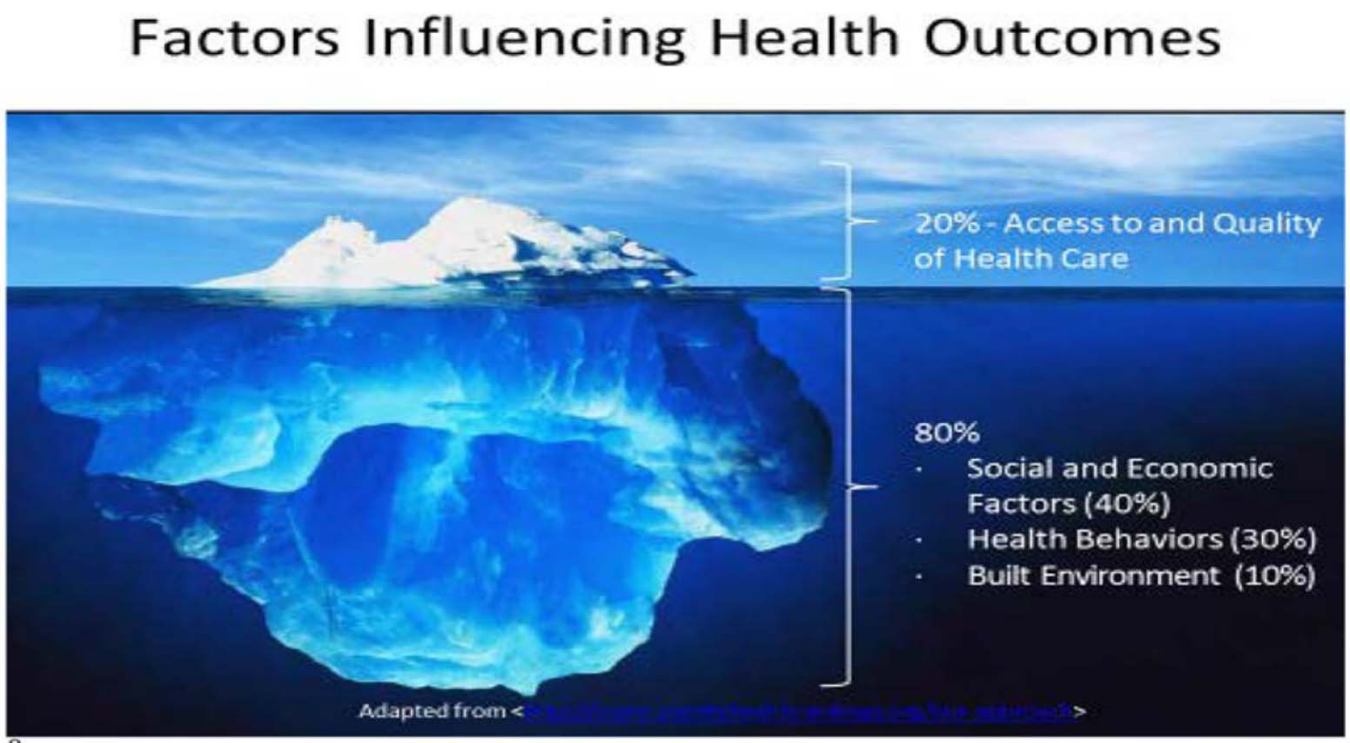
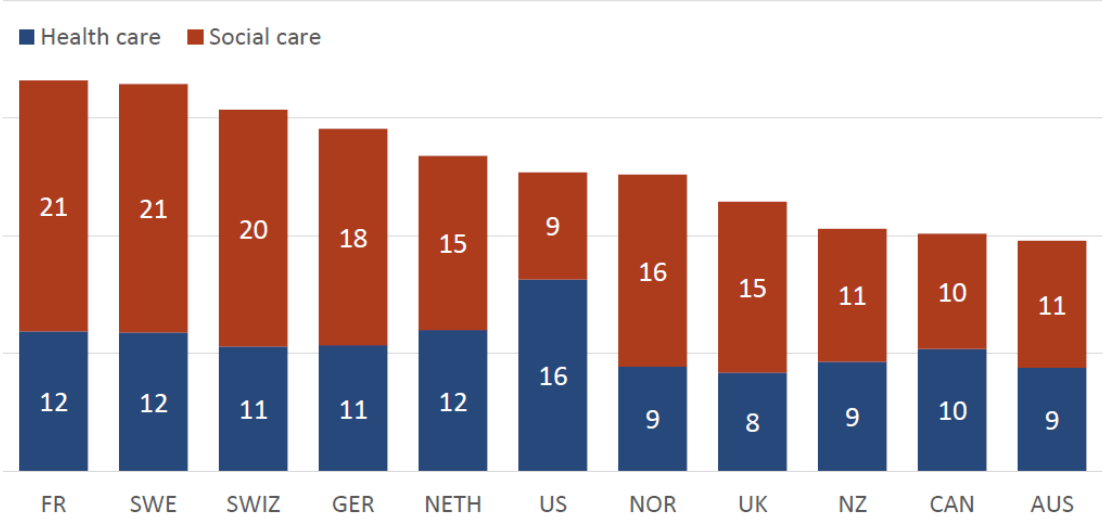
Population Health Extends Beyond the Medical Community



Need for Social Investment and Supportive Policies

Percent of GDP spent on:



Source: E. H. Bradley, L. A. Taylor, and H. V. Fineberg, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.

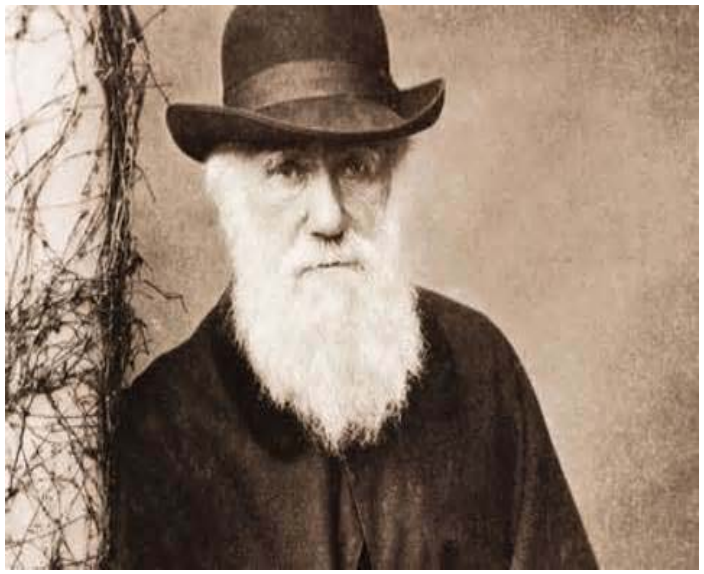
The COMMONWEALTH FUND

Mount Sinai's Population Health Vision

Thought for the Day

"It is not the strongest or the most intelligent who will survive, but those who can best manage change."

~ Charles Darwin



Questions?

Melanie Phelps, JD
SVP Health System Innovation
Deputy General Counsel
North Carolina Medical Society

mphelps@ncmedsoc.org
Cell: 919-306-5123

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The Quality Payment Program Overview Fact Sheet

Background

On October 14, 2016, the Department of Health and Human Services (HHS) issued its final rule with comment period implementing the Quality Payment Program that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program improves Medicare by helping you focus on care quality and the one thing that matters most — making patients healthier. MACRA ended the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cliffs for 13 years. If you participate in Medicare, you are part of the dedicated team of clinicians who serve more than 55 million of the country's most vulnerable Americans. The Quality Payment Program's purpose is to provide new tools and resources to help you give your patients the best possible, highest-value care.

The Quality Payment Program policy will reform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system. You can choose how you want to participate in the Quality Payment Program based on your practice size, specialty, location, or patient population.

The Quality Payment Program has two tracks you can choose from:

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

The Quality Payment Program is focused on moving the payment system to reward high-value, patient-centered care. To be successful in the long run, the Quality Payment Program must account for diversity in care delivery, giving clinicians options that work for them and their patients. CMS expects the Quality Payment Program to evolve over multiple years and therefore, finalizes the rule with an additional 60-day comment period to continue to solicit input from clinicians, patients, and others.

There is a new Quality Payment Program website, which explains the new program and help clinicians easily identify the measures and activities most meaningful to their practice or specialty. This tool allows interested clinicians and practice managers to browse and explore the program options that best fit their practice.

Who is in the Quality Payment Program?

You're a part of the Quality Payment Program and in MIPS if you bill Medicare more than $30,000 a year or provide care for more than 100 Medicare patients a year, and are a:

Physician	Physician Assistant	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetist

If 2017 is your first year participating in Medicare, then you are not required to participate in the Quality Payment Program in 2017.

When does the Quality Payment Program start?

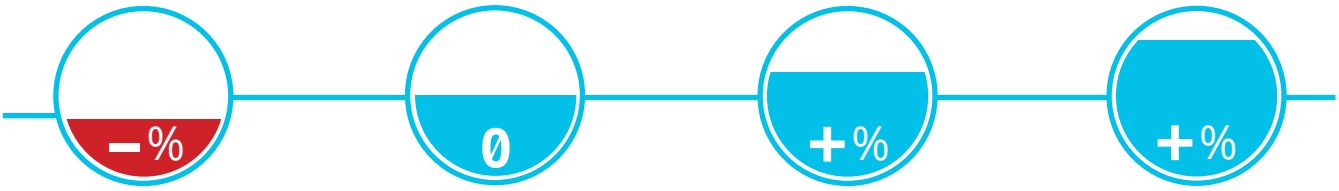
If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

How will the Quality Payment Program change my Medicare payments?

Depending on the track of the Quality Payment Program you choose and the data you submit by March 31, 2018, your 2019 Medicare payments will be adjusted up, down, or not at all. The information provided below is only relevant for the 2019 payment year. CMS will provide additional information on payment adjustments for 2020 and beyond beginning next year.

Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.



Don't Participate

Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Submit Something

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

Submit a Partial Year

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

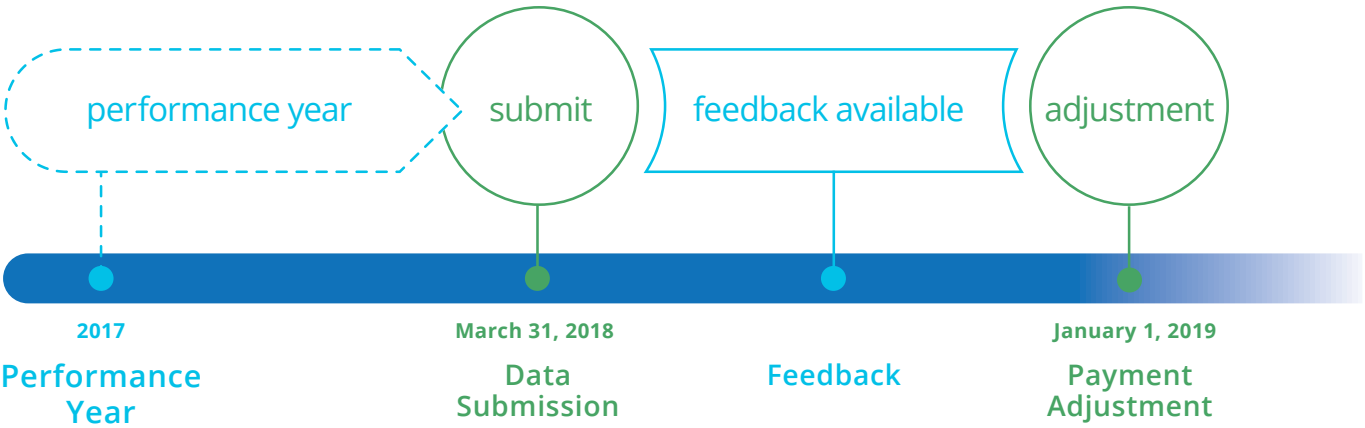
Submit a Full Year

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

The size of your payment adjustment will depend both on how much data you submit and your quality results.

Participate in the Advanced APM track: If you receive 25% of Medicare covered professional services or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% Medicare incentive payment in 2019.

For providers participating in either MIPS or an Advanced APM, the cycle of the program works like this for the 2019 payment year:



Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

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 payment in 2019.

What are Advanced Alternative Payment Models (APMs)?

An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Advanced APMs are a subset of APMs and let practices earn more for taking on some risk related to patients' outcomes. You may earn a 5% Medicare incentive payment during 2019 through 2024 and be exempt from MIPS reporting requirements and payment adjustments if you have sufficient participation in an Advanced APM. Earning an incentive payment in one year does not guarantee receiving the incentive payment in future years.

Advanced APMs must meet the following requirements:

- ✓ Be CMS Innovation Center models, Shared Savings Program tracks, or certain federal demonstration programs
- ✓ Require participants to use certified EHR technology
- ✓ Base payments for services on quality measures comparable to those in MIPS
- ✓ Be a Medical Home Model expanded under Innovation Center authority **or** require participants to bear more than nominal financial risk for losses. The final rule with comment period defined the risk requirement for an Advanced APM to be in terms of either total Medicare expenditures or participating organizations' Medicare revenue (which may vary significantly). This enhanced flexibility allows for the creation of more Advanced APMs tailored to physicians and other clinicians, such as advanced practice nurses, generally, and small practice participation in particular.

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, you must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.

Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Approximately 70,000-120,000 clinicians will qualify for the 5% bonus.

For performance years 2017 and 2018, the participation requirements only apply to Medicare payments and patients. Starting in performance year 2019, clinicians may also meet an alternative standard for Advanced APMs that will include non-Medicare payments and patients.

Increasing Advanced APM Opportunities

CMS stated its intent to broaden opportunities for clinicians to participate in Advanced APMs by retrofitting existing models to qualify as Advanced APMs and using the CMS Innovation Center to create new models, including those recommended by the Physician- Focused Payment Models Technical Advisory Committee.

One opportunity CMS is considering is testing a new ACO (Accountable Care Organization) Track 1+ model that would be a new Advanced APM in 2018 with lower risk levels than currently available to Medicare ACOs. The final rule also eases the risk criteria for Advanced APMs from the proposal, allowing a broader range of future models, including those tailored to small practices or specialties.

For the 2017 performance year, we estimate that approximately 70,000 to 120,000 clinicians will participate in Advanced APMs and qualify for the 5% incentive payment.

For the 2017 performance year, we anticipate that the following models will be Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Track 2
- Medicare Shared Savings Program Track 3
- Next Generation ACO Model

This list may change. We will publish a final list prior to January 1, 2017.

For the 2018 performance year, we estimate that more than 125,000 clinicians will participate in Advanced APMs and qualify for the 5% incentive payment.

For the 2018 performance year, we anticipate that the following models would be Advanced APMs (in addition to the list above).

ACO Track 1+	New Voluntary Bundled Payment Model	Advancing Cardiac Care Coordination through Episode Payment Models (Cardiac and Joint Care)

This list may change. We will publish a final 2018 performance year Advanced APM Model list before January 1, 2018.

For performance years 2026 and later, you may earn a 0.75% fee schedule update for sufficiently participating in an Advanced APM, while those clinicians who do not achieve sufficient participation in Advanced APMs will earn a 0.25% fee schedule update and may also be subject to MIPS reporting requirements and payment adjustments.

Physician-Focused Payment Model Technical Advisory Committee

The MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee. The final rule with comment period finalizes criteria for the committee to use in reviewing these proposals and providing recommendations to the Secretary of the Department of Health and Human Services (HHS). The criteria require that proposed Physician-Focused Payment Models are anticipated to reduce cost, improve care, or both. PTAC provides a unique opportunity for individuals and stakeholders to have a key role in the development of new APMs and to ensure that proposals recommended to the Secretary meet the established criteria and are well-developed.

We expect that the PTAC will assist HHS with improving the process for model development. By engaging with stakeholders early in the development of criteria and review processes, HHS anticipates that PTAC will encourage and facilitate submission of models that have a high likelihood of being implemented and represent the diversity of care provided by physicians across the country.

For more information on PTAC, information to support the development of proposals, and the proposal submission process, go to the PTAC website.

The Secretary is required to review the comments and recommendations submitted by the PTAC and post a detailed response to these recommendations. If CMS considers a physician-focused payment model, it will go through the CMS developmental process for APMs, including design changes as necessary, public announcement, and a request for applications. The decision to test a model recommended by the PTAC will not require stakeholders to submit a second proposal to CMS.

What is the Merit-Based Incentive Payment System (MIPS)?

If you decide to participate in traditional Medicare, rather than an Advanced APM, then you will participate in MIPS where you earn a performance-based payment adjustment to your Medicare payment. CMS estimates approximately 500,000 clinicians will be eligible to participate in MIPS in the first year of the program.

In MIPS, you earn a payment adjustment based on evidence-based and practice-specific quality data. Based on your performance in 2017, you will see a positive, neutral, or negative adjustment of up to 4% to your Medicare payments for covered professional services furnished in 2019. This adjustment percentage grows to a potential of 9% in 2022 and beyond. In addition, during the first six payment years of the program (2019-2024), MACRA allows for up to $500 million each year in additional positive adjustments for exceptional performance. In total, MACRA provides for up to $3 billion in additional positive adjustments to successful clinicians over six years.

MACRA replaced three Medicare reporting programs with MIPS (Medicare Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier). Under the combination of the previous programs, you would have faced a negative payment adjustment as high as 9% total in 2019, but the MACRA ended those programs, reduced the potential negative payment adjustments in the early years, and streamlined the overall requirements. While these three programs will end in 2018, if you have participated in these programs in the past, then you will have an advantage in MIPS because many of the requirements should be familiar.

MACRA defined four performance categories for MIPS, linked by their connection to quality and value of patient care.

What do you need to do for MIPS?

Category	What do you need to do?	2017 category weight
 **Quality** *Replaces the Physician Quality Reporting System (PQRS).*	**Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. **Groups using the web interface:** Report 15 quality measures for a full year. **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality.	
 **Improvement Activities** *New category.*	**Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days. **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days. **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit. **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model:** You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit. **Participants in any other APM:** You will automatically earn half credit and may report additional activities to increase your score.	

Category	What do you need to do?	2017 category weight
Advancing Care Information *Replaces the Medicare EHR Incentive Program also known as Meaningful Use.*	Fulfill the required measures for a minimum of 90 days: ✓ Security Risk Analysis ✓ e-Prescribing ✓ Provide Patient Access ✓ Send Summary of Care ✓ Request/Accept Summary of Care Choose to submit up to 9 measures for a minimum of 90 days for additional credit. OR You may not need to submit Advancing Care Information if these measures do not apply to you.	25%
Cost *Replaces Value-Based Modifier.*	No data submission required. Calculated from adjudicated claims.	Counted starting in 2018.

Should I participate in MIPS as an individual or a group?

Reporting as an Individual

If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

You'll send your individual data for each of the MIPS categories through a certified electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

Reporting as a Group

If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site.

For groups to use the CMS Web Interface, you must register by June 30, 2017.

Your group will send in group-level data for each of the MIPS categories through the CMS web interface or a third-party data-submission service such as a certified electronic health record, registry, or a qualified clinical data registry. To submit data through our CMS web interface, you must register as a group by June 30, 2017.

Beginning in future years, you will also be able to participate in MIPS using "virtual groups." Individual clinicians, as well as groups of 10 or fewer clinicians, will be able to form virtual groups. You will be required to indicate that you will be reporting through a virtual group prior to the start of the applicable performance period. CMS will convene user groups to solicit input on establishing final requirements for virtual groups and will propose further policies for virtual groups in future rulemaking.

Support for Small Practices

Practices with 15 or fewer clinicians and practices in rural and health professional shortage areas are a crucial part of the health care system. The Quality Payment Program provides options designed to make it easier for you to report on your performance and qualify for incentives. Physicians in small practices who report their performance can do just as well as mid-sized or larger practices. We expect the number and percentage of small practices participating in the Quality Payment Program to increase and exceed participation in legacy programs (for example, PQRS) because of the reduced reporting burden, increasing usability of technology, and stepped-up technical assistance. There are a number of other flexibilities in the final rule with comment period to help small practices, including exemptions for low volume practices, allowances for patient-centered medical homes, and increased technical assistance.

Physicians in small practices who report their performance can do just as well as mid-sized practices.

MACRA also provides $20 million each year for 5 years to fund training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas. Beginning December 2016, local, experienced organizations will use this funding to help small practices select appropriate quality measures and health IT to support their unique needs, train clinicians about the new improvement activities and assist practices in evaluating their options for joining an Advanced APM. Providing these tools to help physicians and other clinicians in small practices and practices in underserved areas navigate new programs is key to making sure they are able to focus on what is most important: the needs of their patients.

Where do I go for help with the Quality Payment Program?

There is a new Quality Payment Program website, which will explain the new program and help clinicians easily identify the measures and activities most meaningful to their practice or specialty. This tool allows interested clinicians and practice managers to browse and explore the program options that best fit their practice.

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

If you're in an APM: The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.

We want to hear from you

Today's final rule with comment period incorporates input received to date, but it is only the next step in an iterative process for implementing the new law. We welcome additional feedback from patients, caregivers, clinicians, health care professionals, Congress and others on how to better achieve these goals. HHS looks forward to feedback on the final rule and will accept comments until 60 days after the date of filing for public inspection.

Comments may be submitted electronically through our e-Regulation website.

Quality Payment
PROGRAM

Proposed Rule for Quality Payment Program Year 2

The Quality Payment Program, established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), began in 2017, known as the transition year. The Program's main goals are to:

- Improve health outcomes.
- Spend wisely.
- Minimize burden of participation.
- Be fair and transparent.

The Quality Payment Program has 2 tracks: (1) The Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (Advanced APMs).

Because the Quality Payment Program brings significant changes to how clinicians are paid within Medicare, the Centers for Medicare & Medicaid Services (CMS) is continuing to go slow and use stakeholder feedback to find ways to streamline and reduce clinician burden, and make it easier for clinicians to participate and put their patients first. CMS has engaged more than 100 stakeholder organizations and over 47,000 people since January 1, 2017 to raise awareness, solicit feedback, and help clinicians prepare to participate. Based on stakeholder feedback, CMS established transition year policies from the clinician perspective, such as:

- Giving clinicians the option to choose how they'll participate. (For the 2017 transition year, MIPS eligible clinicians have the opportunity to "pick their pace" of participation in the performance period by submitting a minimum amount of data, 90-days of data, or a full year of data.)
- Having a low-volume threshold that exempts many clinicians with a low volume of Medicare Part B payments or patients.
- Allowing flexibilities for clinicians who are considered hospital-based or have limited face-to-face encounters with patients (referred to as non-patient facing clinicians).

As the Quality Payment Program moves into the second year, CMS wants to ensure that there is meaningful measurement and the opportunity for improved patient outcomes while minimizing burden, improving coordination of care for patients, and supporting a pathway to participation in Advanced APMs. In the second year of the Quality Payment Program, similar to "pick your pace," CMS is continuing to propose many flexibilities that make it easy for clinicians to participate and that gradually prepare clinicians for full implementation. Please note that CMS refers to the second year of program as "The Quality Payment Program Year 2" rather than "pick your pace."

Quality Payment Program Year 2 Proposals: MIPS

For the Quality Payment Program Year 2, CMS wants to keep what's working and use stakeholder and clinician feedback to improve the policies finalized in the transition year. Some prominent proposals include modestly increasing the performance period requirements to include a full year of data for the Quality and Cost performance categories, though CMS would not use Cost performance scores for final score determination. CMS is also proposing to

increase the performance period to 90-days of data for the Improvement Activities and Advancing Care Information performance categories. In an effort to continue to reduce burden and offer flexibilities to help clinicians to successfully participate, other proposals include:

- Offering the Virtual Groups participation option.
- Increasing the low-volume threshold so that more small practices and eligible clinicians in rural and Health Professional Shortage Areas (HPSAs) are exempt from MIPS participation.
- Continuing to allow the use of 2014 Edition CEHRT (Certified Electronic Health Record Technology), while encouraging the use of 2015 edition CEHRT.
- Adding bonus points in the scoring methodology for:
  - Caring for complex patients.
  - Using 2015 Edition CEHRT exclusively.
- Incorporating MIPS performance improvement in scoring quality performance.
- Incorporating the option to use facility-based scoring for facility-based clinicians.

What are Virtual Groups?

The Year 2 proposed rule offers Virtual Group participation, which is another way clinicians can elect to participate in MIPS.

Virtual Groups would be composed of solo practitioners and groups of 10 or fewer eligible clinicians, eligible to participate in MIPS, who come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year.

Our goal is to make it as easy as possible for Virtual Groups to form no matter where the group members are located or what their medical specialties are. Generally, clinicians in a Virtual Group will report as a Virtual Group across all 4 performance categories and will need to meet the same measure and performance category requirements as non-virtual MIPS groups.

CMS is also proposing more flexibilities for clinicians in small practices that would:

- Add a new hardship exception for clinicians in small practices under the Advancing Care Information performance category.
- Add bonus points to the Final Score of clinicians in small practices.
- Continue to award small practices 3 points for measures in the Quality performance category that don't meet data completeness requirements.

Based on stakeholder and clinician feedback, CMS has proposed policies with respect to the use of Appropriate Use Criteria, and certain policies enacted under the 21st Century Cures Act that affect the Quality Payment Program.

Appropriate Use Criteria (AUC)

The AUC were first introduced in the calendar year (CY) 2016 Physician Fee Schedule Final Rule with Comment Period. More policies were added to the AUC in the CY 2017 Physician Fee Schedule Final Rule. The evidence-based AUC will help clinicians who order and furnish advanced diagnostic imaging services make the most appropriate treatment decisions for specific clinical conditions.

For the 2018 MIPS performance period, CMS proposes adding a new improvement activity that MIPS eligible clinicians could choose if they attest they're using AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered.

21st Century Cures Act

Enacted in 2016, the 21st Century Cures Act contains provisions affecting how CEHRT impacts the Quality Payment Program's current transition year and future years. The 21st Century Cures Act was enacted after the publication of the Quality Payment Program Year 1 Final Rule. In the Year 2 proposed rule, CMS is proposing to implement the provisions in the 21st Century Cures Act, some of which will apply to the MIPS transition year.

- Reweighting the Advancing Care Information performance category to 0% of the final score for ambulatory surgical center (ASC)-based MIPS eligible clinicians.
- Using the authority for significant hardship exceptions and hospital-based MIPS eligible clinicians for the Advancing Care Information performance category the 21st Century Cures Act grants CMS.

Quality Payment Program Year 2 Proposals: APMs

CMS is keeping many of the policies finalized for the transition year, and is proposing changes and updates, including:

- Extending the revenue-based nominal amount standard, which was previously finalized through performance year 2018, for two additional years (through performance year 2020). This standard allows an APM to meet the financial risk criterion to qualify as an Advanced APM if participants are required to bear total risk of at least 8% of their Medicare Parts A and B revenue.
- Changing the nominal amount standard for Medical Home Models so that the minimum required amount of total risk increases more slowly.
- Giving more detail about how the All-Payer Combination Option will be implemented. This option allows clinicians to become Qualifying APM Participants (QPs) through a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs. This option will be available beginning in performance year 2019.
- Giving more detail on how eligible clinicians participating in selected APMs will be assessed under the APM scoring standard. This special standard reduces burden for certain APMs (MIPS APMs) participants who do not qualify as QPs, and are therefore subject to MIPS.

Comparison of current policies to proposed policies:

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
MIPS POLICY		
Low-Volume Threshold	Exclude individual MIPS eligible clinicians or groups with ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries during a low-volume threshold determination period that occurs during the performance period or a prior period.	Increase the threshold to exclude individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries during a low-volume threshold determination period that occurs during the performance period or a prior period. Starting with 2019 MIPS performance period: let clinicians opt-in to MIPS if they exceed 1 or 2 of the low-volume threshold components: • Medicare revenue, or • Number of Medicare patients. Additionally, CMS is proposing that in 2019 the opt-in process would be allowable for 3 items, and is seeking comment on a 3rd potential component: • Number of Part B items and services
Non-Patient Facing	• Individual's ≤100 patient facing encounters. • Groups: > 75% NPIs billing under the group's TIN during a	There is no change in how CMS is defining non-patient facing clinicians, however;

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	performance period are labeled as non-patient facing.	CMS is proposing the same definition for Virtual Groups. • Virtual Groups: > 75% NPIs within a Virtual Group during a performance period are labeled as non-patient facing.
Submission Mechanisms	• MIPS eligible clinicians required to use only 1 submission mechanism per performance category.	• Allow individual MIPS eligible clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category as available and applicable to meet the requirements of the Quality, Improvement Activities, or Advancing Care Information performance categories.
Virtual Groups	Not available in current transition year.	Key Proposals: • Adding Virtual Groups as participation option for year 2, which would be composed of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		• In order for solo practitioners to be eligible to join a Virtual Group, they would need to meet the definition of a MIPS eligible clinician and not be excluded from MIPS based on one of the 4 exclusions (new Medicare-enrolled eligible clinician; Qualifying APM Participant; Partial Qualifying APM Participant who chooses not to report on measures and activities under MIPS; and those who do not exceed the low-volume threshold). In order for groups of 10 or fewer eligible clinicians to be eligible to participate in MIPS as part of a Virtual Group, groups would need to exceed the low-volume threshold at the group level. A group that is part of a Virtual Group may include eligible clinicians who do not meet the definition of a MIPS eligible clinician or may be excluded from MIPS based on one of the four exclusions. • Allow flexibility for solo practitioners and groups of 10 or fewer eligible clinicians to decide if they want to join or form a

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		Virtual Group with other solo practitioners or groups of 10 or fewer eligible clinicians, regardless of location or specialties. • If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would be part of the Virtual Group. • CMS proposes various components that would need to be included in a formal written agreement between each member of the Virtual Group. • Virtual Groups that choose this participation option would need to make an election prior to the 2018 performance period (as outlined in the MACRA legislation). • If/when TIN/NPIs move to an APM, CMS proposes to exercise waiver authority so that CMS can use the APM score instead of the Virtual Group score. • Generally, policies that apply to groups would apply to Virtual Groups, except the following group-related policies: ○ Definition of non-patient facing MIPS eligible clinician.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		○ Small practice status. ○ Rural area and Health Professional Shortage Area designations.
Facility-Based Measurement	Not available in current transition year.	• Implement an optional voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. • Available only for facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital setting or emergency department. • The facility-based measurement option converts a hospital Total Performance Score into a MIPS Quality performance category and Cost performance category score.
Quality	**Weight to final score:** • 60% in 2019 payment year. • 50% in 2020 payment year. • 30% in 2021 payment year and beyond. **Data completeness:** • 50% for submission mechanisms except for Web Interface and CAHPS.	**Weight to final score:** • 60% in 2020 payment year. • 30% in 2021 payment year and beyond. **Data completeness:** • No change, but CMS proposes to increase the data completeness threshold to 60% for the

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	• Measures that do not meet the data completeness criteria receive 3 points. **Scoring:** • 3-point floor for measures scored against a benchmark. • 3 points for measures that don't have a benchmark or don't meet case minimum requirements. • 3 points for measures that do not meet data completeness. • Bonus for additional high priority measures up to 10%. • Bonus for end-to-end electronic reporting up to 10%.	2019 MIPS performance period. • Measures that do not meet data completeness criteria will get 1 point instead of 3 points, except that small practices will continue to get 3 points. **Scoring:** • Keep 3-point floor for measures scored against a benchmark. • Keep 3 points for measures that don't have a benchmark or don't meet case minimum requirement. • Measures that do not meet data completeness requirements will get 1 point instead of 3 points, except that small practices will continue to get 3 points. • No change to bonuses. • Proposed changes to the CAHPS for MIPS survey collection and scoring.
Quality/ Topped Out Quality Measures	No policies established in the current transition year.	• Starting with the 2018 MIPS performance year, in the second consecutive year, or beyond, CMS proposes to use a cap of 6 points for a select set of 6 topped out measures. • CMS proposes to identify topped out measures, and after 3 years, to consider

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		removal from the program through rulemaking in the 4th year. • This policy on topped out measures wouldn't apply to CMS Web Interface measures.
Cost	**Weight to final score:** • 0% in 2019 payment year. • 10% in 2020 payment year. • 30% in 2021 payment year and beyond. **Measures:** • Will include the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures. • 10 episode-based cost measures. • Measures do not contribute to the score, feedback is provided for these measures.	**Weight to final score:** • CMS proposes 0% in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at 10%. • 30% in 2021 MIPS payment year and beyond. **Measures:** • 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. However, these measures will not contribute to the 2018 final score if the Cost performance category is finalized to be weighted at 0%. • CMS expects to replace previous episode-based cost measures are developed in collaboration with expert clinicians and other stakeholders.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
Improvement Scoring for Quality and Cost	• Not applicable in the current transition year.	• Rewards improvement in performance (applicable to the Quality and Cost performance categories only) for an individual MIPS eligible clinician or group for a current performance period compared to the prior performance period. **For Quality:** • Improvement scoring will be based on the rate of improvement so that higher improvement results in more points, particularly for those improving from lower performance in the transition year. ○ Improvement is measured at the Quality performance category level. ○ Up to 10 percentage points available in the Quality performance category. **For Cost:** • Improvement scoring will be based on statistically significant changes at the measure level. • CMS proposes an improvement scoring methodology for Cost, but

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		it wouldn't affect the MIPS final score for the 2020 MIPS payment year if the Cost performance category weight is finalized at 0%. CMS will add improvement percentage points to the Quality performance category and Cost performance category scores (beginning in the 2021 payment year for cost), but the performance category scores can't exceed 100%.
Improvement Activities	**Weight to final score:** • 15% and measured based on a selection of different medium and high-weighted activities. **Number of activities:** • No more than 2 activities (2 medium or 1 high-weighted activity) are needed to receive the full score for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians. • No more than 4 activities (4 medium or 2 high-weighted activities, or a combination) for all other MIPS eligible clinicians. • Total of 40 points. • 92 activities were included in the Inventory.	**Weight to final score:** • No change. **Number of 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 a rural areas will keep reporting on no more than 2 medium or 1 high-weighted activity to reach the highest score.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	Definition of certified patient-centered medical home: • Includes accreditation as a patient-centered medical home from 1 of 4 nationally-recognized accreditation organizations; a Medicaid Medical Home Model or Medical Home Model; NCQA patient-centered specialty recognition; and certification from other payer, state or regional programs as a patient-centered medical home if the certifying body has 500 or more certified member practices. • Only 1 practice within a TIN has to be recognized as a patient-centered medical home or comparable specialty practice for the TIN to get full credit in the category. **Scoring:** • All APMs get at least 1/2 of the highest score, but CMS will give MIPS APMs an additional score to reach the highest score based on their model. All other APMs must choose other activities to get additional points for the highest score. • Designated specific activities within the performance category that also qualify for Advancing Care Information bonus. • For group reporting, only 1 MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to get credit.	**Definition of certified patient-centered medical home:** • CMS proposes to expand the definition of certified patient-centered medical home to include the CPC+ APM model. • CMS proposes to make it clear that the term "recognized" is the same as the term "certified" as a patient-centered medical home or comparable specialty practice. • CMS proposes a threshold of 50% for 2018 for the number of practices within a TIN that need to be recognized as patient-centered medical homes for the TIN to get the full credit for the Improvement Activities performance category. **Scoring:** • No change to the scoring policy for APMs and MIPS APMs. • Keep designated activities within the performance category that also qualify for an Advancing Care Information bonus. • For group participation, only 1 MIPS eligible

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	• Allow simple attestation of Improvement Activities.	clinician in a TIN has to perform the Improvement Activity for the TIN to get credit. CMS is soliciting comments on alternatives for a future threshold. • Keep allowing simple attestation of Improvement Activities.
Advancing Care Information	• Allow clinicians to use either the 2014 or 2015 CEHRT Edition for the 2017 transition year and require use of 2015 CEHRT edition for 2018. • Performance points awarded for reporting both required and optional measures (up to 10 points each). • Bonus (5%) for reporting to 1 or more additional public health and clinical data registries. • Bonus (10%) for completion of at least 1 of the specified Improvement Activities using CEHRT. • Allowed reweighting of the Advancing Care Information category to 0, if there are insufficient measures applicable and available to MIPS eligible clinicians.	**Key Proposals:** • Allow MIPS eligible clinicians to use either the 2014 or 2015 Edition CEHRT in 2018; grants a bonus for using only 2015 Edition CEHRT. • Add exclusions for the E-Prescribing and Health Information Exchange Measures. • Adds more Improvement Activities that show the use of CEHRT to the list eligible for an Advancing Care Information bonus. • Allow a MIPS eligible clinician to not report on the Immunization Registry Reporting measure and potentially earn 5% each for reporting any of the Public Health and Clinical Data Registry Reporting measures as part of the performance score, up to 10%, and awarding an additional 5% bonus for reporting to an additional

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		registry not reported under the performance score. • Add a decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017. • Change the deadline for the exception application submission for 2017 and future years to be December 31 of the performance year. • For small practices (15 or fewer clinicians), add a new category of hardship exceptions to reweight Advancing Care Information performance category to 0 and reallocate the Advancing Care Information performance category weight of 25% to the Quality performance category. • Proposes 2 policies retroactive to the transition year based on the 21st Century Cures Act, which was passed after publication of the Year 1 Final Rule: ○ Ambulatory surgical center (ASC)-based MIPS eligible clinicians will be automatically reweighted to 0.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		○ Clarifying policies on hardship exceptions for the Advancing Care Information performance category, using the authority of the 21st Century Cures Change time period for the application of the potential modifications to the weight of the Advancing Care Information performance category.
Complex Patients Bonus	• Not available in the current transition year.	• Apply an adjustment of up to 3 bonus points by adding the average Hierarchical Conditions Category (HCC) risk score to the final score. • Generally, this will award between 1 to 3 points to clinicians based on the medical complexity of the patients they see. • Ask for 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.
Small Practice Bonus	• Not available in current transition year.	• Adjust the final score of any eligible clinician or group who's in a small practice (defined in the regulations as 15 or fewer clinicians) by adding 5

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		points to the final score, as long as the eligible clinician or group submits data on at least 1 performance category in an applicable performance period. • Ask for comments on whether the small practice bonus should be given to those who practice in rural areas as well.
Final Score	• If no Advancing Care Information performance category, then reassign to the Quality performance category. • If no Quality performance category, then reassign 50% to Improvement Activities and 50% to Advancing Care Information. • The Quality performance category weight isn't lowered if there are only 1 or 2 scored measures.	**2018 MIPS performance year final score:** • Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%. • Keep reweighting the Advancing Care Information performance category to the Quality performance category for participants who meet exclusions. • Make new extenuating circumstances for all performance categories. • Add up to 5 bonus points for small practice bonus. • Add up to 3 bonus points to the final score for caring for complex patients.
Performance Threshold/ **Payment Adjustment**	• Performance threshold is set at 3 points. • Additional performance threshold set at 70 points for exceptional performance bonus.	• Performance threshold set at 15 points. Comments are solicited on whether it should be higher or lower.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	• Payment adjustment for the 2019 payment year ranges from - 4% to + (4% x scaling factor not to exceed 3) as required by law. (The scaling factor is determined in a way so that budget neutrality is achieved.) • Additional performance threshold starts at 0.5 and goes up to 10% x scaling factor not to exceed 1.	• Additional performance threshold stays at 70 points for exceptional performance. • Payment adjustment for the 2020 payment year ranges from - 5% to + (5% x scaling factor) as required by law. (The scaling factor is determined in a way so that budget neutrality is achieved.) • Additional performance threshold range doesn't change. • The payment adjustment is applied to the amount Medicare paid for Part B claims.
Performance Period	• Minimum 90-day performance period for Quality, Advancing Care Information, and Improvement Activities. Exception: measures through CMS Web Interface, CAHPS, and the readmission measure are for 12 months. Cost is measured for 12 months.	• Quality and Cost: 12-month calendar year performance period. • Advancing Care Information and Improvement Activities: 90 days minimum performance period.
ADVANCED APM POLICY		
Generally Applicable Nominal Amount Standard	• Total potential risk under the APM must be equal to at least: either 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018 (the revenue-based	• 8% revenue-based standard is extended for two additional years, through performance year 2020.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	standard), OR 3% of the expected expenditures for an APM Entity is responsible for under the APM for all performance years.	
Medical Home Model Financial Risk Standard	• In order for an APM to meet the medical home standard, the APM Entity must, if actual expenditures exceed expected expenditures or performance on specified performance measures doesn't meet or exceed expected performance, be subject to: ○ Withheld payment for services to the APM Entity and/or the APM Entity's eligible clinicians; ○ Lower payment rates to the APM Entity and/or the APM Entity's eligible clinicians; ○ Repayments to CMS; or ○ Loss of the right to all or part of an otherwise guaranteed payment or payments. • Starting in the 2018 QP performance period, the Medical Home Model Advanced APM financial risk standard wouldn't apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians.	• 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	• The total potential risk for an APM Entity under the Medical Home Model Standard must be equal to at least: ○ 2.5% of the estimated average total Parts A and B revenue of	• Minimum total potential risk for an APM Entity under the Medical Home Model Standard is adjusted to: ○ 2% of the estimated average total Medicare

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	participating APM Entities for performance year 2017. ○ 3% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2018. ○ 4% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2019. ○ 5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2020.	Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2018. ○ 3% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for the QP performance period in 2019. ○ 4% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2020. ○ 5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance years 2021 and after.
Qualifying APM Participant (QP) Performance Period and QP and Partial QP Determination	• Beginning in 2017, the QP performance period will be January 1 – August 31 each year. • CMS will make 3 QP determinations using data available through March 31, through June 30, and through the last day of the	• The QP performance period stays the same but will be called the Medicare QP performance period (creating a term for the All-Payer QP performance period).

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
	QP performance period, respectively.	• The period the payment/patient threshold calculations are based on is modified for certain Advanced APMs. For Advanced APMs that start or end during the 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 QP performance period. •
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
Generally Applicable Nominal Amount Standard	• Nominal amount of risk must be: ○ Marginal Risk of at least 30%; ○ Minimum Loss Rate of no more than 4%; and ○ Total Risk of at least 3% of the expected expenditures the APM Entity is responsible for under the APM.	• In addition to the existing Total Risk standard, an additional revenue-based nominal amount standard of 8% is added. 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.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
All-Payer Combination Option QP Performance Period	• Beginning in 2019, the QP performance period will be January 1 – August 31 each year. • CMS will make 3 QP determinations (Q1, Q2, and Q3) using data available through March 31, through June 30, and through the last day of the QP performance period, respectively.	• A separate All-Payer QP Determination Period is created, 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.
Payer-Initiated Determination of Other Payer Advanced APMs	• Not addressed in the CY 2017 Final Rule.	• Starting in performance year 2019, payers would be able 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 made at either the APM Entity or individual eligible clinician level, depending on the circumstances.	• 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

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
		individual eligible clinician, CMS will make the QP determination under the All-Payer Combination Option using a weighted Medicare Threshold Score that will be factored into 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 and Making All-Payer Combination Option QP Determinations	• To be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians would be required to provide CMS with the following information: ○ Payment arrangement information needed to assess the other payer arrangement on all Other Payer Advanced APM criteria. ○ For each other payment arrangement, the amount of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement, and the total numbers of patients furnished any service through the payer. ○ An attestation from the payer that the submitted information is correct.	• APM Entities or eligible clinicians may submit information regarding their payment arrangement to and request that CMS make Other Payer Advanced APM determinations, when the determination had not already been made through the Payer-Initiated process. ○ The requirement for attestation from the payer is eliminated; APM Entities or eligible clinicians would need to certify information they submit.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
MIPS APM/APM SCORING STANDARD POLICY		
Identifying MIPS APM Participants	• If a MIPS eligible clinician is on an APM Participation List on at least one of the APM participation assessment (Participation List ''snapshot'') dates, the MIPS eligible clinician will be included in the APM Entity group for purposes of the APM scoring standard for the applicable performance year. If the MIPS eligible clinician is not on the APM Entity's Participation List on at least one of the snapshots dates (March 31, June 30, or August 31), then the MIPS eligible clinician will need to submit data to MIPS using the MIPS individual or group reporting option and adhere to all generally applicable MIPS data submission requirements to avoid a negative payment adjustment.	• A fourth snapshot date of December 31 will be added for the purpose of determining participation in full TIN MIPS APMs. • This fourth snapshot date will not be used to make QP determinations and will not extend the QP performance period beyond August 31.
Virtual Groups and MIPS APMs	• No previously finalized policy.	• CMS is proposing to waive sections of the statute that would require that all participants in a Virtual Group receive their MIPS payment adjustment based on the Virtual Group score, so that participants in APM Entities in MIPS APMs may receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
Quality performance category	• Use quality measure data reported through APM. • 50% weight for MSSP, Next Generation ACO Model in the first year. • 0% weight for other MIPS APMs in the first year.	• Use quality data reported through the APM. • Performance Category weight = 50%. • Quality Improvement points will be available beginning in the 2018 performance year for any APM Entity for which 2017 quality performance data are available.
Improvement Activities performance category	• 20% weight for MSSP, Next Generation ACO Model. • 25% weight for other MIPS APMs for first year. • Automatic assignment of Improvement Activity scores based on APM design (no reporting activity required). CMS will review each MIPS APM on a case-by-case basis, identify activities inherent to the design of those APMs that correlate to Improvement Activities, and assign the correlating Improvement Activity score to the APM Entity group.	• CPC+ practices that are assigned to a control group will receive full credit in the Improvement Activities performance category. • The improvement activities performance category weight = 20%.
Advancing Care Information performance category	• The Advancing Care Information performance category for the 2017 performance period is weighted at 30% for the Medicare Shared Savings Program and the Next Generation ACO model MIPS APMs. • For all other MIPS APMs this performance category is weighted at 75% for the 2017 performance period.	• The Advancing Care Information performance category weight = 30%

Policy Topic	Current Transition Year (Final Rule CY 2017)	Year 2 (Proposed Rule CY 2018)
Cost performance category	• The cost performance category weight = 0%	• The cost performance category weight = 0%

Continuing the dialogue

Continuing our user-centered approach, CMS wants to hear from the health care community on the proposed policy and the implications for clinicians in Year 2, as well as on our message and education delivery. To give feedback or host a listening session, please contact us at QPP@cms.hhs.gov.

How to comment on the proposed rule

Please see the proposed rule for how to submit comments by the close of the 60-day comment period on August 21, 2017. When commenting refer to file code CMS 5522-P.

Instructions for submitting comments are in the proposed rule; FAX transmissions won't be accepted. Use 1 of the following ways to officially submit comments:

- Electronically through Regulations.gov
- Regular mail
- Express or overnight mail
- Hand or courier

For more information, go to: qpp.cms.gov

Contact us

The Quality Payment Program can be reached at 1-866-288-8292 (TTY 1-877-715- 6222), Monday through Friday, 8:00 AM-8:00 PM Eastern time or by email at: QPP@cms.hhs.gov.

MACRA Glossary of Acronyms and Terms

This glossary attempts to cut through all the alphabet soup of commonly used terms of/or related to the MACRA legislation, including the term "MACRA" itself.

Some of the words or acronyms pre-date the MACRA legislation but all are related in some way to the law and its future implementation. The terms are listed in alphabetic order (based on the letters in the acronym itself, not the words for which the acronym stands). If one term refers to another term or acronym, it will be included in this glossary. Where available, links are provided to CMS web pages that provide further details.

ACA (Affordable Care Act) - Officially called the Patient Protection and Affordable Care Act of 2010, and also known as "Obamacare," this massive legislation effective included many parts, some of which are defined herein.

ACI (Advancing Care Information) - This is what was formerly known as Meaningful Use and covers the technological aspects of MIPS.

ACO (Accountable Care Organization) - ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Some ACOs participating in CMS programs will qualify as APMs or Advanced APMs if they meet the criteria. Most will not, at least not initially.

APM (Alternative Payment Models) - New approaches to paying for medical care of Medicare patients that incentives quality and value. ACP hopes that the final rule will provide more clarity of the definitions and flexibility in types of APMs.

- **Advanced APM** – Not all APMs will qualify as "advanced." In order to be considered an "Advanced APM" the following criteria must be met: it must meet the legislative definition of an APM, at least 50% of participants must use a certified EHR, payment must be based on quality measures comparable to those used in MIPS (of which one must be an outcome measure), and it must bear more than nominal financial risk (or is a CMMI Medical Home Model expanded by the Secretary of DHHS).
- **MIPS APM** – A sub-set of APMs whose APM clinicians otherwise would be subject to the full range of MIPS requirements in addition to their APM

obligations. In other words, they are APMs that meet the following criteria: (1) the APM entity participates in under an agreement with CMS; (2) the APM Entity includes one or more MIPS eligible clinicians on a participation list; and (3) the APM bases payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures. Because the criteria for the identification of MIPS APMs are independent of the criteria for Advanced APM determinations, a MIPS APM may or may not also be an Advanced APM. Thus, it is possible that an APM meets all three proposed criteria to be a MIPS APM, but does not meet the Advanced APM criteria. Conversely, it would be possible, that an Advanced APM does not meet the criteria because it does not include MIPS eligible clinicians as participants.

CAHPS (Consumer Assessment of Healthcare Providers and Systems) - A survey that measures patient experience. Voluntary participating in CAHPS for MIPS surveys would count as a cross-cutting or patient experience measure for Quality scoring purposes.

CEC (Comprehensive ESRD Care Model) - Large Dialysis Organization (LDO) arrangement or non-LDO arrangement. Only the LDO arrangement qualifies as an Advanced APM. The non-LDO does not qualify because it does not bear financial risk.

CEHRT (Certified EHR Technology) - Certification of EHR products is done by the Office of the National Coordinator of Health Information Technology (ONC).

CHIP (Children's Health Insurance Program) - This program provides health coverage to eligible children, both through Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements and is funded jointly by states and the federal government.

CMMI (Center for Medicare and Medicaid Innovation) - This is the department within CMS that oversees programs such as MSSP, TCPI, ACOs, and other demonstration projects.

CPCI (Comprehensive Primary Care Initiative or **CPC Classic**) - This is a four-year multi-payer initiative designed to strengthen primary care. It launched in October 2012 and expires in October 2016. It will be replaced by CPC+ beginning in January 2017. CPC Classic is a collaboration between CMS and commercial and State health insurance plans in 7 markets to offer population-based care management fees and

shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions. These five functions are: (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood.

CPC+ (Comprehensive Primary Care Plus) - CPC+ is a five-year model that will begin in January 2017 and replaces CPC Classic. CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment.

CPIA (Clinical Practice Improvement Activities) - One component of the total MIPS Composite Score. There are over 90 proposed activities from which practices can choose to implement. Some of the categories include expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, emergency preparedness, and behavorial health integration.

CPS (Composite Performance Score) - The sum of the 4 MIPS categories Quality + Resource Use + Advanced Care Information + CPIA. It was previously referred to as the MIPS Composite Score.

CQM (Clinical Quality Measure) - CQMs measure and track quality of services provided by ECs. They measure aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of resources, care coordination, patient engagement, population health, and adherence to clinical guidelines.

EC (Eligible Clinician, formerly EP or eligible professional) - A term used to indicate which professionals are qualified to participate. "Eligible" is defined by each program.

FFS (Fee for Service) - Most Medicare payments are based on services provided. Traditional Medicare (Part B) is based on FFS payments.

MACRA (Medicare Access and CHIP Reauthorization Act of 2015) - This is the law that sunsets the volume-based SGR and replaces the payment system with one that is value-based. The goal is to create a sustainable payment system for

physicians. The new payment system begins in 2019 and will be phased in over several years.

MIPS (Merit-based Incentive Payment System) - MIPS is the 1st option. This path will pay based on quality, technology, resource use (cost), and practice improvement. PQRS, MU, and VBM will cease to exist individually, but will be consolidated into MIPS beginning in 2019.

- **MIPS Composite Score** – The MIPS score (in Year 1) will be based on performance in 4 categories: Quality (50%), Advancing Care Information (25%), Clinical Practice Improvement Activities (15%), and Resource Use or Cost (10%). This is now referred to as the Composite Performance Score.

MSSP (Medicare Shared Savings Program) - MSSP was established by the ACA to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. MSSP aims to improve beneficiary outcomes and increase value of care by providing better care for individuals, better health for populations, and lowering growth in expenditures. The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.

MU (Meaningful Use) - The Affordable Care Act created incentives for physicians to adopt EHR and use them "meaningfully" in practice. The EHR Incentive Program was set up in 3 stages, but the program will be rolled into MACRA as part of MIPS. *The new term for MU is "Advancing Care Information."*

OCM (Oncology Care Model) - There are two types of Oncology Care Models: 1-sided risk and 2-sided risk arrangements. Those that are 2-sided risk arrangements will qualify as Advanced APMs.

PCMH (Patient-Centered Medical Home) - The PCMH is a model of care delivery whereby the physician practice coordinates all the care of the patient, even those with chronic conditions. Nationally recognized patient-centered medical homes are accredited by (1) the Accreditation Association for Ambulatory Health Care, (2) the National Committee for Quality Assurance (NCQA) PCMH Recognition, (3) the Joint Commission Designation, or (4) the Utilization Review Accreditation Commission (URAC).

PFPM (Physician Focused Payment Models) - These are Alternative Payment Models wherein Medicare is a payer, which includes physician group practices or individual physicians as APM Entities and targets the quality and costs of physician services.

- **PTAC** (Physician-focused Payment Model Technical Advisory Committee) - The body that will review and provide comments and recommendations on PFPMs submitted by stakeholders. The Secretary must establish, through notice and comment rulemaking, criteria for PFPMs, including models for specialist physicians, that could be used by the PTAC for making its comments and recommendations.

PQRS (Physician Quality Reporting System) - PQRS is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. PQRS will be consolidated into the new MIPS program.

QCDR (Qualified Clinical Data Registries) - A QCDR is a CMS-approved entity that collects and submits PQRS quality measures data on behalf of eligible professionals (EPs). To be considered a QCDR for purposes of PQRS, an entity must self-nominate and successfully complete the qualification process.

QP (Qualified Professional) - This represents the subset of professionals who participate in Advanced APMs.

QPP (Quality Payment Program) - This is the name of the new payment program to implement MACRA in the proposed rule released on April 27, 2016.

QRUR (Quality and Resource Use Report) - Under the Value-Based Payment (see VBP below) program, QRURs provide information about the resources used and the quality of care furnished to a group's or solo practitioner's Medicare FFS beneficiaries. The 2015 QRURs will be generated for all groups and solo practitioners nationwide, as identified by their Medicare-enrolled TIN, regardless of whether the 2017 Value Modifier will apply to them. They can use their QRURs to see how their TIN compares with other TINs caring for Medicare beneficiaries.

SGR (Sustainable Growth Rate) - This is the formula on which fee-for-service Medicare Part B payments are based through 2017. This payment system is effectively replaced by MACRA (MIPS and APM).

TCPI (Transforming Clinical Practice Initiative) - This is an initiative within CMMI that is designed to help practices implement changes and improvements so that they can participate in APMs. The initiative is designed to support practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies.

TIN (Tax Identification Number) - This the number that identifies the billing entity. The TIN will be used to connect each EC to the entity under which they bill for purposes of calculating MIPS scores or APM participation.

VBP/VBMP/VM (Value-based payment modifier) - This program provides differential payment to a physician or group under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period. VM will also be consolidated into MIPS.