The Centers for Medicare & Medicaid Services (CMS) late yesterday issued a proposed rule updating the requirements of the quality payment program (QPP) for physicians and other eligible clinicians mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The QPP includes two tracks – the default Merit-based Incentive Payment System and advanced alternative payment models (APMs). Data reporting for the QPP began on Jan. 1, 2017. The rule proposes what eligible clinicians must report for the QPP’s 2018 performance period, which will affect eligible clinicians’ payment under the Medicare physician fee schedule (PFS) in calendar year (CY) 2020. Select highlights of the proposed rule follow.

AHA View. The proposed rule continues the incremental, flexible implementation approach called for by hospitals, health systems and the more than 500,000 employed and contracted physicians with whom they partner to deliver care. We are encouraged by CMS’s proposal for a facility-based clinician reporting option, and applaud the agency’s proposal to extend the use of modified stage 2 meaningful use requirements through 2018. We will encourage CMS to provide the same relief to hospitals.

We also will encourage CMS to provide additional opportunities for clinicians to earn incentives for partnering with hospitals to provide better quality, more efficient care through advanced APMs.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The MIPS is the default payment system for eligible clinicians. The MIPS must assess eligible clinicians on four performance categories – quality measures, cost measures, improvement activities and advancing care information (ACI), which is a re-worked version of the Medicare EHR Incentive Program for eligible clinicians. Based on their MIPS performance, eligible clinicians will receive positive or negative payment adjustments of 5 percent in CY 2020, rising to a maximum of 9 percent in CY 2022 and beyond.
Eligible Clinicians and Group Reporting. As required by the MACRA, the CY 2020 MIPS will continue to apply to physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists that are billing under the Medicare PFS. CMS proposes to continue allowing eligible clinicians to participate in MIPS as individuals or as group practices. A group practice would be identified as a group of two or more clinicians who have reassigned their billing rights to a single tax identification number (TIN).

Several categories of clinicians are exempt from the MIPS, including qualifying APM participants, partially qualifying APM participants, clinicians in their first year of accepting Medicare patients, and clinicians who fall below a low-volume threshold during the performance period (described below).

Low-volume Threshold. In response to stakeholder concerns about the readiness of small and rural practices to meet MIPS requirements, CMS proposes to substantially increase the low-volume threshold. Specifically, the new threshold would exclude from MIPS participation clinicians billing $90,000 or less of Medicare charges, or that see 200 or fewer Medicare patients. CMS estimates this proposal would result in the exclusion of more than 565,000 clinicians from the MIPS in 2018.

Facility-based Measurement. The MACRA gives CMS the option to allow facility-based clinicians to be scored on the MIPS quality and cost categories using measures and results from CMS’s quality reporting and pay-for-performance programs for hospitals and other facilities. CMS proposes to implement a facility-based measurement option for the CY 2018 performance year. Those clinicians electing this option would have their MIPS quality and cost scores tied to their hospital’s CMS value-based purchasing (VBP) program performance. That is, CMS would convert a hospital’s total performance score in the hospital VBP program into scores for the MIPS quality and cost categories. Clinicians and groups using this option would not be required to submit separate quality and cost data for the MIPS.

The option would be available only to facility-based clinicians and groups that have at least 75 percent of their covered professional services provided in the inpatient hospital or emergency department settings, as identified by place of service (POS) codes 21 (for inpatient hospitals) and 23 (for emergency departments). Clinicians and groups that wish to use this option must elect to do so by the measure submission deadline; for the CY 2018 performance period, that is March 31, 2019. Clinicians and groups would be attributed to the hospital where they provide services to the most Medicare beneficiaries. While we continue to review the details of CMS’s proposal, the AHA applauds CMS for responding to our longstanding request to develop a facility-based measurement option for the MIPS.

Performance Period and Data Reporting Mechanisms. CMS proposes to use CY 2018 as the performance period for CY 2020 payment adjustments under the MIPS. CMS would require a full-year of data for the quality and cost categories, but only a 90-day reporting period for both the improvement activity and ACI categories. CMS further proposes that most CY 2018 performance data be submitted to the agency by March 31, 2019.
CMS also proposes that clinicians and groups would have multiple options for submitting data, including registries, electronic health record (EHR) reporting, Medicare claims-based reporting and attestation. In contrast to existing policy, CMS also proposes that clinicians and groups may use more than one submission mechanism for each MIPS performance category.

**Performance Categories and Requirements.** CMS proposes the measures, activities and data submission standards for each of the MIPS categories. In addition, CMS proposes the weights it will assign to each category in determining a MIPS Final Score. The Final Score will be used in determining payment adjustments in 2020. **Notably, in response to stakeholder concerns, CMS proposes to continue its policy of assigning a weight of zero percent to the cost category for CY 2020 payment adjustments.** However, the agency proposes that cost measures would comprise 30 percent of the MIPS Final Score starting with 2021 payment adjustments.

CMS’s proposed policies, and the proposed weights for each category for CY 2020, are briefly summarized below.

- **Quality (60 percent of MIPS Final Score).** CMS proposes to maintain its requirement that clinicians and groups report at least six measures. Among the six measures, CMS would require the reporting of at least one outcome measure. Alternatively, clinicians can choose to report all of the measures from a particular specialty measure set, even if that set includes fewer than six measures.

- **Improvement Activities (15 percent of MIPS Final Score).** The MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. CMS proposes a list of activities from which clinicians can select to fulfill this category. Each activity is assigned a weight towards the overall score. CMS proposes no significant changes to how improvement activities are scored.

- **Advancing Care Information (25 percent of MIPS Final Score).** CMS proposes to continue, as previously finalized, the minimum continuous 90-day reporting period for the ACI in CY 2018 and proposes a minimum continuous 90-day reporting period in CY 2019. CMS also proposes that eligible clinicians may use EHRs certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two for the CY 2018 performance period. With respect to reporting requirements, CMS proposes that eligible clinicians have the option to report the ACI "Transition Category" objectives and measures, derived from meaningful use modified stage 2 objectives and measures, for the 2018 performance period. CMS states that reporting the ACI category objectives and measures derived from meaningful use stage 3 is optional for 2018. The AHA applauds CMS for providing much-needed relief from unrealistic, unfunded mandates for EHR capabilities by extending the use of modified stage 2 meaningful use requirements through 2018. We will encourage CMS to provide the same relief to hospitals.
**Virtual Groups.** The MACRA permits individual clinicians and group practices of 10 or fewer clinicians to form “virtual groups” to participate jointly in the MIPS. CMS proposes to implement a virtual group participation option beginning with the 2018 reporting period. To participate in a virtual group, CMS proposes to require a formal written agreement among all members of the virtual group. Virtual groups also would be required to elect the option prior by Dec. 1 of the year prior to the performance period. Thus, to use the virtual group option for CY 2018, clinicians and groups would have to notify CMS by Dec. 1, 2017.

**INCENTIVES FOR PARTICIPANTS IN ALTERNATIVE PAYMENT MODELS (APMs)**

The MACRA provides incentives for clinicians who participate in advanced APMs. These include a bonus payment of 5 percent of payments for professional services in 2019 through 2024; exemption from MIPS reporting requirements and potential payment cuts; and higher base payment updates beginning in 2026. In 2016, CMS finalized the initial criteria by which physicians and other professionals will qualify for these incentives. In this rule, CMS proposes to modify certain existing policies and establish new policies related to advanced APMs.

**Comprehensive Primary Care Plus (CPC+).** In 2016, CMS finalized a policy that limited advanced APM “credit“ for participation in the CPC+ program to medical homes owned and operated by organizations with fewer than 50 clinicians, beginning in 2018. CMS proposes to exempt from this policy organizations that enrolled in the first round of CPC+, which began Jan. 1, 2017. The AHA is pleased with this proposal, which would allow clinicians in hospital-affiliated CPC+ practices to receive credit for participation in advanced APMs.

**Nominal Financial Risk.** In last year’s rulemaking, CMS established two standards for calculating the amount of financial risk an entity must accept for a model to qualify as an advanced APM. Specifically, an APM entity that demonstrates annual losses must potentially owe a total amount equal to either:

- 8 percent of the average estimated total Medicare Parts A and B revenues of the APM entity (the “revenue standard”), or
- 3 percent of the expected expenditures (i.e., the benchmark or target price set under the model) for which the APM entity is responsible (the “benchmark-based standard”).

CMS had previously made the revenue standard option only available for performance years 2017 and 2018, while the benchmark-based standard is applicable for all performance years. However, the agency now proposes to extend the revenue standard to performance years 2019 and 2020.

Additionally, CMS proposes to limit planned increases in the amount of risk required for medical homes. To qualify as an advanced APM under a medical home model, CMS proposes that the amount the APM entity potentially forgoes or owes CMS must be at least the following percent of the entity’s total Medicare Parts A and B revenue:
• 2018 – 2 percent (reduced from 3 percent)
• 2019 – 3 percent (reduced from 4 percent)
• 2020 – 4 percent (reduced from 5 percent)
• 2021 and beyond – 5 percent

**Other Payer Advanced APMs.** The MACRA allows clinicians to earn advanced APM incentives only for participation in Medicare advanced APMs in 2017 and 2018. Beginning in 2019, clinicians will be able to earn incentives for combined participation in Medicare advanced APMs and “other payer advanced APMs” with non-Medicare payers (i.e., Medicare Advantage, Medicaid and private payers). In 2016, CMS finalized the criteria for determining whether a payment arrangement is an advanced APM. The agency now proposes a process for payers, entities participating in APMs or clinicians to request such a determination. CMS also proposes requirements for the information that must be submitted by payers and clinicians to make other payer advanced APM determinations and evaluate clinician participation in these arrangements.

**Next Steps**

Comments on the [proposed rule](https://www.aha.org/MACRA) will be accepted through Monday, Aug. 21. The final rule is expected no later than Nov. 1. Watch for more detailed AHA analysis of the proposed rule in the coming weeks. Additional resources on the MACRA QPP can be found at [www.aha.org/MACRA](https://www.aha.org/MACRA).

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