COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Summary of CMS MACRA Proposed Rule

The following is summary of the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models*. The rule was officially proposed on May 9, 2016. Comments on the proposed rule are due on June 27, 2016.

CAHC is helping organizations better understand the rule. We are also assisting them to position their organizations strategically to maximally impact the final rule in ways that advantage their position. We are helping them to prepare and submit comments. If you would like to discuss the rule with CAHC experts, please let us know.

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MACRA Overview

On April 16, 2015, President Obama signed into law the *Medicare and CHIP Reauthorization Act of 2015* (MACRA). Its passage marked the end of Medicare's system of annual updates under the Sustainable Growth Rate (SGR) payment system. That system produced annual payment cuts for physicians and other health care providers that Congress regularly reversed. The law created powerful incentives to increase the volume of care while demoralizing physicians and other providers and doing little to improve patient outcomes.

MACRA sunsets the current Medicare reporting programs—Meaningful Use (MU), Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBM)—and creates a new, consolidated reimbursement scheme with updated measures, activities, and reporting standards.

The new reimbursement scheme provides two primary payment options for eligible clinicians:

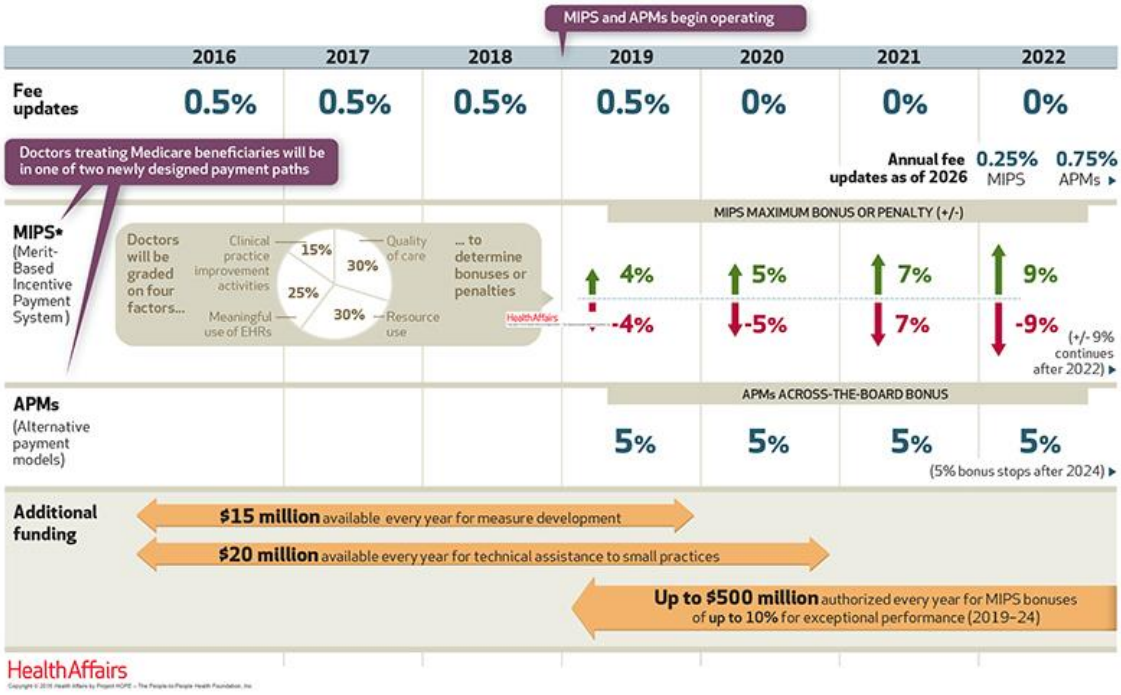
1) **Merit-Based Incentive Payment System (MIPS):** Provides annual updates to eligible clinicians under Medicare fee-for-service modified by bonuses or penalties based on performance in four categories of measurement: quality, clinical practice improvement activities, advancing care information, and resource use.

2) **Advanced Alternative Payment Models (APMs):** Provides annual bonus payments to eligible clinicians participating in CMS-approved new models of payment and delivery based on quality performance and reimbursement, such as through risk-sharing arrangements and coordinated care.

The MIPS program is the antithesis of the SGR payment system it replaced. Where the SGR based the amount of updates (+/-) on total physician spending compared against a spending target, MIPS will base annual updates beginning in 2019 upon individual or group performance against a system of quality measurement. The updates can be positive or negative, and the system rewards exceptional performers and those who improve their score from the previous year. MIPS rewards or punishes performance.

A second payment track for clinicians under the law is designed to support participation in an APM. Individually or as a group, clinicians who adopt approved models of care would not be subject to MIPS requirements. Instead, they would receive a 5 percent annual update until 2026, after which they will receive a greater statutory update than clinicians who remain in the MIPS program. The APM model drives rapid evolution of payment innovation in the Medicare program.

Timeline for Payment Updates



Proposed Rule: Initial Key Takeaways

1) Value, defined as quality and efficiency, is no longer optional in Medicare. Both MIPS and APMs require value to be ingrained in the core payment systems. Failure or success in reporting and performance could lead to payment changes ranging from a negative 9 percent update to a maximum positive 27 percent update once the program is fully implemented.

2) Congress intended the law to reduce the overall burden on providers from various Medicare reporting programs by consolidating them into the MIPS program, and reducing reporting requirements overall. Much attention will be paid to how CMS uses the final rule to further reduce provider reporting burdens.

3) Overall confidence in the law will rest in part on how the provider professional organizations view the options available to their members. Many will be watching to see how CMS addresses the concerns of specialty medicine in the final rule with regards to the availability of practice-specific measures and APMs.

4) MACRA intended to provide new reporting avenues and more appropriate clinical quality measures, such as through quality registries tailored to specialty needs. Whether the proposed rule achieves this goal is subject to interpretation.

5) There are concerns that the rule advantages large group practices over small or individual physician practices, and will further lead to consolidation in health markets as more physicians could be incented to join hospital staff.

6) Some consider the requirements for Advanced APM models to be highly restrictive, and postulate few physicians will actually qualify for APM payments. Many in Congress anticipated most physicians

would be in Advanced APMs. How the final rule addresses this concern will be closely watched by lawmakers.

7) The timeline for implementation is very aggressive under the law, and implementation will not be easy. With the first MIPS performance period set to begin in 2017, the next few months will be crucial for the overall success of the program. Already, some groups are discussing implementation delay strategies.

The Merit-Based Incentive Payment System (MIPS)

MIPS is a payment system of annual updates based upon individual or group performance against a system of reporting measures. There is a two-year delay in the MIPS system from when providers' performance is evaluated to when payment is modified. For example, starting in 2017, physicians will report measures to be evaluated on quality and efficiency. CMS will collect and review these measures in 2018. In 2019, CMS will issue payment modifications based upon the first performance period of 2017.

The proposed rule, outlined below, begins to define the program with more specificity.

Eligible Clinicians

- **Definition of ECs:** Medicare Part B clinicians including physicians, physician assistants, nurse practitioners clinical nurse specialists, and certified registered nurse anesthetists.
  - Beginning in year 3 of the program, CMS can expand ECs to include additional clinicians, such as physician or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitian/nutrition professionals, etc.

- **Non-ECs:** CMS will allow ECs who are not MIPS-eligible to voluntarily report on applicable MIPS measures in order to gain experience. No payment adjustments will be made towards these volunteers.

- **Exemption:** Part B clinicians may be exempted from the MIPS payment adjustment if they:
  - Are newly enrolled in Medicare;
  - Have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients; or
  - Are significantly participating in an Advanced Alternative Payment Model (APM).

- **Non-patient-facing ECs:** Defined as an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period. Telehealth services are included in the definition of "patient-facing encounters."

How It Works

ECs seeking payment updates under the MIPS program will be graded on their performance against a set of measures. Performance against these measure sets will be used to set an update amount for individual ECs or groups of ECs. CMS is required to release an annual list of measures. ECs decide whether they will report as individuals or as part of a group. These measures will be drawn from four main categories: Quality, Resource Use, Clinical Improvement Activities, and Advancing Care Information (formerly the Meaningful Use program).

Performance against the selected individual measures will be tabulated by CMS into a composite score that will be compared with a CMS benchmark of performance to determine whether the update is positive or negative. Once determined, the ECs score is compared to all others and ranked to determine the exact amount of the update or penalty. Provider payments are modified based on this amount.

Specific details:

- ECs are required to choose from a menu of CMS-endorsed measures and activities.

- ECs are required to ensure that the measure set covers all four performance categories specified in statute (see MIPS – Performance Categories below for more information on performance categories).

- ECs are required to record performance data annually against a set of measures. (For more on the process of reporting, see MIPS Reporting Process below).

- EC performance against their set of measures will be used to determine an annual update amount.
  - A single MIPS composite performance score will be computed by totaling the performance scores of each measure.
  - The weights of each performance category differ so that performance against some measures is worth more in terms of a composite score than others (see MIPS – Performance Categories below for more info).

- Payments for ECs:
  - ECs in MIPS can receive a positive, downward, or neutral payment adjustment, starting at +/- 4 percent in 2019 and up to +/- 9 percent in 2022.
  - Additional Bonus: Those performing in the top 10 percent receive a bonus payment adjustment, up to a maximum of three times the positive MIPS payment adjustment for that year.
    - This bonus for excellence allows for up to a 27 percent max positive payment adjustment in 2022.

MIPS Base Adjustment Schedule

MIPS Score	2019	2020	2021	2022
100	+4x%	+5x%	+7x%	+9x%
PT to 100	Linear Increase from 0% to maximum bonus %			
Performance Threshold	0% Change			
25% of PT to PT	Linear Increase from 0% to maximum negative %			
0 to 25% of PT	-4%	-5%	-7%	-9%
"x" represents the budget-neutrality factor to ensure the national incentive $ pool is equal to the national penalty $ pool, "x" is capped at 3x the base adjustment (allowing a 27% maximum base adjustment in 2022)				

Performance Categories

Measures selected by ECs must cover all four performance categories: Quality; Clinical Practice Improvement Activities; Resource Use (cost); and Advancing Care Information.

The performance category weights are outlined in the table below.

Performance Category	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year and Beyond
Quality	50%	45%	30%
Clinical Practice Improvement Activities	15%	15%	15%
Resource Use	10%	15%	30%
Advancing Care Information	25%	25%	25%

Note that in the first payment adjustment year (2019), CMS assigns a weight of 50 percent on Quality Measures, 25 percent on Advancing Care Information, 15 percent on Clinical Practice Improvement Activities, and 10 percent on Resource Use. The weights for Quality Measures and Resource Use gradually shift, and in 2021 and beyond, CMS will weight Quality Measures at 30 percent and Resource Use at 30 percent.

The proposed rule allows the Secretary to re-weight categories based on certain factors such as measure availability or more targeted responses such as overwhelming provider compliance rates in the Advancing Care Information category.

Details of the four categories:

1) Quality Performance: Replaces the Physician Quality Reporting System and the quality component of the Value Modifier program.

- ECs must select at least six measures.
- There must be one cross-cutting measure and one outcome measure included, or another high priority measure if outcome measures are unavailable.
- High quality measures are measures related to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination.
- ECs need to select from individual measures or a specialty measure set:
  - There are more than 200 measures to pick from and more than 80 percent of the quality measures proposed are tailored to specialists.
  - Specialty measure sets help clinicians identify relevant measures.
  - Population measures are automatically calculated so no separate submission of information required.
    - For individual clinicians and small groups (2-9 clinicians), MIPS calculates two population measures based on claims data.
    - For groups with 10+ clinicians, MIPS calculates three population measures.
- **Key Changes from PQRS**
  - Reduced from 9 measures to 6 measures with no domain requirement.

- CMS is encouraging ECs choosing outcome measurement.

- **SCORING**: The measures would each be worth up to 10 points for a total of 80-90 possible points depending on group size.

2) Clinical Practice Improvement Activities (CPIA): Does not replace any functions of the VM, PQRS, or MU reporting programs.

- CPIAs are activities focused on such things as care coordination, beneficiary engagement, and patient safety.

- Clinicians would select activities from a list of more than 90 options, including.
  - Expanded Practice Access
  - Beneficiary Engagement
  - Achieving Health Equity
  - Population Management
  - Patient Safety and Practice Assessment
  - Emergency Preparedness and Response
  - Care Coordination
  - Participation in an APM, including a medical home model
  - Integrated Behavioral and Mental Health.

- Clinicians who are not patient-facing (e.g., radiologists) will only need to report on one activity.

- **SCORING**: Up to 60 points. CMS will weight the activities on which a clinician reports. Highly weighted activities would be worth 20 points and other activities would be worth 10 points.

3) Advancing Care Information (ACI)*:* Replaces the Medicare EHR Incentive Program known as "Meaningful Use."

- Clinicians must report a customizable set of measures that reflect how they use Certified Electronic Health Record Technology (CEHRT) in their day-to-day practice, with a particular emphasis on interoperability and information exchange.

- Clinicians must provide the numerator/denominator or yes/no for each objective and measure.

- ECs are required to report on measures that meet these three categories:
  - Patient Electronic Access
  - Coordination of Care through Patient Engagement
  - Health Information Exchange

- *CMS proposes six measures.* CPs must provide the numerator/dominator (or yes/no) for each.
  - Protect Patient Health Information (yes/no). Clinicians MUST achieve this objective to receive any score.
  - Patient Electronic Access (numerator/denominator)
  - Coordination of Care through Patient Engagement (numerator/denominator)
  - Electronic Prescribing (numerator/denominator)
  - Health Information Exchange (numerator/denominator)
  - Public Health and Clinical Data Registry Reporting (yes/no)

- *Public Health Registry Bonus*: Immunization registry reporting is required. In addition, clinicians may choose to report on more than one public health registry, and will receive one additional point for reporting beyond the immunization category.

- **Key Changes to Meaningful Use:**
  - No longer require all-or-nothing EHR measurement or quality reporting.
  - No longer require reporting on the Clinical Decision Support and Computerized Provider Order Entry objectives.

- ***SCORING**:* The clinician's base score, performance score, and bonus point (if applicable) are added for a total of up to 131 points. If clinicians earn 100 points or more, they receive the full 25 points towards MIPS. If they earn less than 100 points, their overall score in MIPS declines proportionately.

4) Resource Use: Replaces the cost component of the Value Modifier, otherwise known as resource use.

- No separate data submission required, resource use calculated based on Medicare claims submitted by EC.

- Assessment under all available resource use measures, as applicable to the clinician.

- Each cost measure worth up to 10 points. Clinicians must see a sufficient number of patients in each cost measure to be scored (generally minimum of a 20-patient sample).
  - If a clinician does not have enough patient volume for any cost measures, then a cost score would not be calculated.

  - **SCORING**: Clinician's cost score based on the average score of all cost measures that can be attributed to the clinician.

<u>Reporting Provisions</u>

The proposed rule expands options for reporting of data by allowing ECs to utilize current vendors or platforms such as qualified registries to ease the reporting burden. In addition, the proposed rule defines the rules for group reporting under the MIPS program, including virtual groups. The process for reporting varies based on the method used.

Details of reporting requirements and options:

Data Reporting: CMS will use claims processed within 90 days after the end of the performance period for purposes of assessing performance and computing the MIPS payment adjustment.

- If CMS determines that it is not operationally feasible to have a claims data run-out for the 90-day timeframe, then they would utilize a 60-day timeframe.

- CMS proposes to use the 2017 performance year for the 2019 payment adjustment, which is consistent with other CMS programs.

- Individuals and groups would be required to report all partial year performance data even if they did not practice for a full reporting year.

- Under this approach, MIPS ECs with partial year performance data could achieve a positive, neutral, or negative MIPS adjustment based on their performance data.

- ECs who fall under a low-volume threshold would be excluded from payment adjustments.

- CMS will not publish any data submission requirements for certain categories that do not require additional data submission, including for the resource use performance category, certain quality measures used to assess performance on the quality performance category, and certain activities in the CPIA performance category.

- Each individual MIPS EC's and group's resource use performance would be calculated using administrative claims data.

- CMS would also use administrative claims data to calculate performance on a subset of the MIPS quality measures and the CPIA performance category.

- For individual clinicians and groups that are not MIPS ECs (such as physical therapists), but who elect to report to MIPS, CMS would calculate administrative claims resource use measures and quality measures, if data are available.

Group Reporting: To be eligible, groups must meet the proposed definition of a group at all times during the performance period for the MIPS payment year.

- Individual MIPS eligible clinicians within a group must aggregate their performance data across the group TIN.

- Groups are assessed across all four MIPS performance categories.

- When groups submit data utilizing third party entities, such as a qualified registry, health IT vendor, or data registry, CMS is able to obtain group information from the third party entity and discern whether the data submitted represents group submission or individual submission.

- Group must adhere to an election process:
    - Only groups submitting data on performance measures via participation in the CMS Web Interface or groups electing to report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey for the quality performance category will be required to register.
        - ECs may register as a virtual group, which is a process whereby unaffiliated providers can report and be graded as a group. During the election process, individual MIPS ECs and groups electing to be a virtual group would be required to register in order to submit reportable data.
        - Virtual groups would be assessed across all four MIPS performance categories.
        - CMS has determined implementation of virtual groups for the 2017 calendar year is unfeasible, but plans to implement virtual groups in the future.

Submission Requirements & Mechanisms: Individual MIPS ECs and groups would be required to submit data on measures and activities for the Quality, CPIA, and Advancing Care Information performance categories.

The proposed data submission mechanisms for MIPS ECs reporting individually are outlined in the table below.

Quality	Claims
	QCDR
	Qualified registry
	EHR
	Administrative claims (no additional submission required)
Resource Use	Administrative claims (no additional submission required)
Advancing Care Information	Attestation
	QCDR
	Qualified registry
	EHR
Clinical Practice Improvement Activities	Attestation
	QCDR
	Qualified registry
	Administrative claims (no additional submission required)

The proposed data submission mechanisms for MIPS ECs reporting as a group are outlined in the table below. Processes in red are reporting venues not available to individual ECs.

Quality	QCDR
	Qualified registry
	EHR
	CMS Web Interface (25+)
	CMS-approved survey vendor for CAHPS for MIPS
	Administrative claims (no additional submission required)
Resource Use	Administrative claims (no additional submission required)
Advancing Care Information	Attestation
	QCDR
	Qualified registry
	EHR
	CMS Web Interface (25+)
Clinical Practice Improvement Activities	Attestation
	QCDR
	Qualified registry
	CMS Web Interface (25+)
	Administrative claims (no additional submission required)

Submission Deadlines:

- The data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms is March 31 following the close of the performance period.

- For the Medicare Part B claims submission mechanism, the submission deadline would occur during the performance period with claims required to be processed no later than 90 days following the close of the performance period.

- For the CMS Web Interface submission mechanism, the submission deadline will occur during an eight-week period following the close of the performance period that will begin no earlier than January 1 and end no later than March 31.

Additional Provisions

The proposed rule covers additional policy objectives that support the use of new technologies and data policies to improve the quality of care provided to Medicare beneficiaries.

- **ONC Surveillance Attestation:** The proposed rule seeks to help reduce medical errors and improve security for personal health information by requiring ECs to attest that they have cooperated with the surveillance of certified EHR technology under the ONC Health IT Certification Program.

- **Information Blocking Attestation:** An EC must demonstrate that he/she did not knowingly and willfully take action to limit or restrict the compatibility or interoperability of the CEHRT via a three-part attestation:

    - First, the EC, eligible hospital, or Critical Access Hospital (CAH) must attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
    - Second, the eligible clinician, EC, eligible hospital, or CAH must attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the CEHRT was, at all relevant times:
        - connected in accordance with applicable law;
        - compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted under Meaningful Use regulations;
        - implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information); and
        - implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 USC 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.
    - Third, the eligible clinician, EC, eligible hospital, or CAH must attest that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers, and other persons, regardless of the requestor's affiliation or technology vendor.

Advanced Alternative Payment Models (APM)

APMs are models of care intended to promote better quality at lower cost. Shared risk and savings, partial capitation, and other alternative payment arrangements can better align incentives between providers, producing better outcomes for patients and lower costs for taxpayers and consumers alike. Examples of such models include medical homes, ACOs, and episodic bundled payment arrangements.

When writing the law, Congress held the view that APMs espoused the same quality and cost objectives intended under the MIPS program and therefore clinicians who practiced in such models should be exempt from the MIPS program. In lieu of the MIPS annual update process, QPs are given a flat 5 percent increase for practicing in an APM from 2019-2024.[1]

In order to qualify for this option, clinicians must participate in an *Advanced APM*, with the following requirements:

- APM requires participants to use CEHRT.
- APM bases payments on quality measures comparable to those in the MIPS quality performance category.

- APM either 1) requires APM Entities to bear more than nominal financial risk for monetary losses; OR 2) is a Medical Home Model expanded under CMMI authority.

Current APMs that would qualify as Advanced APMs in 2017, as outlined by CMS in the proposed rule, include:

- Medicare Shared Savings Program (ACOs Tracks 2 and 3).
- Next Generation ACO Model.
- Comprehensive ESRD Care (CEC) (large dialysis organization arrangement).
- Comprehensive Primary Care Plus (CPC+).
- Oncology Care Model (OCM) (two-sided risk track available in 2018).

The proposed rule also provides additional opportunities for providers to advance model consideration and vetting than provided under CMMI today. The Technical Advisory Committee (TAC) was created as a venue outside of the CMMI process where experts in the development and operation of successful payment models will be able to advance recommendations to CMS on areas of model development or specific models that are deemed worthy of testing through the CMMI process. New models for consideration must demonstrate that they do not increase costs and/or decrease quality of care, among the other requirements outlined below.

Qualifying Participants

Definition: Those who participate in Advanced APMs may be determined to be qualifying APM participants (QPs) or Partial QPs based on whether they meet the QP Threshold for a particular year.

- QPs:
  - Not subject to MIPS;
  - Receive a 5 percent lump sum bonus for years 2019-2024; and
  - Receive a higher fee schedule update for 2026 and onward.

[1] After 2026, the 5% increase converts to a 0.75% annual increase.

- CMS will identify eligible clinicians who do not meet the QP Threshold but reach the Partial QP Threshold for a year to be Partial QPs.

- Partial QPs would:
  - Not receive a 5 percent lump sum bonus for years 2019-2024;
  - Not receive higher fee schedule update for 2026 and onward; and
  - Have the opportunity to decide whether they wish to be subject to MIPS.

How are QPs Determined? QPs are ECs who have a certain percentage of their patients or payments provided through an eligible Advanced APM.

- **Medicare Option:** Initially, this threshold percentage can only be reached for patients or payments provided through Medicare APM arrangements.

- **All-Payer Combination Option:** Beginning in 2021, this threshold percentage may be reached for patients or payments provided through a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid.

Process for QP Determination: ECs can become QPs in 4 STEPS:

1) QP determinations are made at the Advanced APM Entity level (see figure below).

2) CMS calculates a "Threshold Score" for each Advanced APM Entity.

3) The Threshold Score for each method is compared to the corresponding QP Threshold.

4) All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.
   a. The period of assessment (QP Performance Period) for each payment year will be the full calendar year that is two years prior to the payment year, in alignment with the MIPS performance period (e.g., 2017 performance for 2019 payment).

- *STEP 1: APM Entity Level*

  - QP determinations are made at the Advanced APM Entity level.
  - All participating eligible clinicians in the Advanced APM Entity are assessed together. These eligible clinicians will, or will not become QPs, as a unit.

- *STEP 2: Threshold Score & APM Eligibility Calculation Methods*

  - CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).
  - Definitions for calculating Threshold Scores:
    - Attributed (Numerator): beneficiaries for whose cost and quality of care the APM Entity is responsible.
    - Attribution-eligible (Denominator): all beneficiaries who could potentially be attributed.
  - The two methods for calculation are the Payment Amount Method and the Patient Count Method.
    - Payment Amount Method:(**$$$** for Part B professional services to **attributed beneficiaries**) / (**$$$** for Part B professional services to **attribution-eligible beneficiaries**) = Threshold Score %

    - Patient Count Method: (# of **attributed beneficiaries** given Part B professional services) / (# of **attribution-eligible beneficiaries** given Part B professional services) = Threshold Score %
  - CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

- *STEP 3: QP Thresholds*

  - The Threshold Score for each method is compared to the corresponding QP Threshold table (see tables below) and CMS takes the better result.
  - Payment Amount QP Thresholds are set in MACRA statute.
  - CMS proposed Patient Count QP Thresholds in the rule.
  - All the eligible clinicians in the Advanced APM Entity reach a QP determination for the payment year together.
  - Threshold Scores above the QP Threshold = All eligible clinicians attain QP status.
  - Threshold Scores below the QP Threshold = No eligible clinicians attain QP status.

Medicare Option: Payment Amount Thresholds for APM Qualification by Year						
Payment Year	2019	2020	2021	2022	2023	2024+
QP Payment Amount Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Amount Threshold	20%	20%	40%	40%	50%	50%

Medicare Option: Patient Amount Thresholds for APM Qualification by Year						
Payment Year	2019	2020	2021	2022	2023	2024+
QP Payment Amount Threshold	20%	20%	35%	35%	50%	50%
Partial QP Payment Amount Threshold	10%	10%	25%	25%	35%	35%

All-Payer Combination Payer Option – QP Thresholds. Starting in 2021, some arrangements with non-Medicare payers can count towards becoming a QP.

- If the other "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs."

- All-Payer Combination Option QP Thresholds for both the Payment Amount Method and the Patient Count Method are outlined below (see table).

All-Payer Combination Option: Payment Amount Thresholds for APM Qualification by Year										
Payment Year	2019	2020	2021		2022		2023		2024+	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total Share	Medicare Share	Total Share	Medicare Share	Total Share	Medicare Share	Total Share	Medicare Share

All-Payer Combination Option: Patient Amount Thresholds for APM Qualification by Year										
Payment Year	2019	2020	2021		2022		2023		2024+	
QP Payment Amount Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Payment Amount Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total Share	Medicare Share	Total Share	Medicare Share	Total Share	Medicare Share	Total Share	Medicare Share

APM Incentive Payments

Method of Calculating and Distributing APM Incentive Payment. CMS will make an annual APM incentive Payment to eligible clinicians that achieve QP status during 2019-2024.

- The incentive payment will equal five percent of the estimated aggregate amounts paid for Medicare Part B covered professional services conducted by the eligible clinician from the preceding year across all billing TINs associated with the QP's national provider identifier (NPI).

- CMS proposes to use the full calendar year preceding the QP payment year as the basis for the incentive payment and requests comments concerning the time period for the incentive payment base period.

- Timeframe for Claims:
  - CMS proposes to calculate the APM Incentive Payment based on data available three months after the end of the incentive payment base period. (i.e., For the 2019 payment year, CMS would capture claims submitted from Jan. 1, 2018 - Dec. 1, 2018, and processing dates of Jan. 1, 2018 - March 31, 2019).

  - CMS notes that several current APMs apply the 3-month claims run-out in conjunction with a completion factor.

  - Although CMS estimates that incentive payments could be made about six months after the end of the incentive payment based period, it proposes that the APM Incentive Payment be made no later than one year from the end of the incentive payment base period. CMS requests comments on the proposed timing of the incentive base period.

  - CMS proposes to exclude the MIPS, VM, MU, and PQRS payment adjustments when calculating the estimated aggregate payment amount for covered professional services upon which the APM

incentive Payment amount is based. (i.e., a QP who receives a fee adjustment during 2018 in VM would not see that adjustment reflected in the estimated aggregate payment amount for covered professional services used to calculate his or her APM Incentive Payment in 2019).

Treatment of Payments for Services Paid on a Basis Other Than Fee-For-Service CMS recognizes in the proposed rule that APMs use incentives and financial arrangements that differ from usual fee schedule payments, including financial risk payments, supplemental service payments, and cash flow mechanisms.

- CMS proposes to exclude financial risk payments, such as shared savings payments or net reconciliation payments, when calculating the estimated aggregate payment amount.

- CMS proposes to include a supplemental service payment in the calculation of the Incentive Payment Amount if it meets all of the following four criteria:
  1) Payment is for services that constitute physician services;
  2) Payment is made for only Part B services under the first criterion;
  3) Payment is directly attributable to services furnished to an individual beneficiary; and
  4) Payment is directly attributable to an eligible clinician.

- CMS proposes to create a process to notify the public of supplemental service payments in all APMs and identify the supplemental service payments that meet the proposed criteria and would be included in the APM Incentive Payment calculations – and suggests posting an initial list on the CMS website.

- For expenditures affected by cash flow mechanisms, CMS proposes to calculate the estimated aggregate payment amount using the payment amounts that would have occurred for Part B covered professional services if the cash flow mechanism had not been in place.

- CMS recognizes that payment methods and financial arrangements may evolve over time, which would need to be addressed in future rule making.

Treatment of Other Incentive Payments in Calculating the Amount of APM Incentive Payments

- CMS notes that it will not include certain existing Medicare Incentive Payments, such as the HPSA Physician Bonus Program, in the calculation of the APM Incentive Payment.

Notification of APM Incentive Payment Amount

- Notification of the APM Incentive Payment will not occur at the same time as the notification of QP status. Instead, notification will occur later in the year to allow for accurate calculations and validation.

- CMS proposes to send notification of APM Incentive Payment amounts to both Advanced Payment Entities and their individual participating QPs as soon as amounts have been calculated and validated.

- CMS proposes that APM Incentive Payment amount notification would be made directly to QPs in combination with a general public notice.

- QP notification would include the amount of the APM Incentive Payment and the TIN to which the incentive payment will be made.

QP Determination and APM Incentive Payment Timeline

The QP Determination and APM Incentive Payment Timelines are outlined visually below (see tables).

2017	2018	2019
QP Performance Period	**Incentive Payment Base Period**	**Payment Year**
QP status based on Advanced APM participation.	Add up payments for a QP's services.	+5% lump sum payment made (and excluded from MIPS adjustments).

2018	2019	2020
QP Performance Period	**Incentive Payment Base Period**	**Payment Year**
Repeat the cycle each year…		

Conclusion

The law's focus on rewarding individual achievement through the MIPS program or accelerating payment innovation through Advanced APMs provide for a system of incentives that may produce meaningful change if implemented carefully. Through both the statute and implementing regulations, providers have tools that may ultimately lead to innovations in practice that improve the quality of care to Medicare beneficiaries. Whether such opportunities will be realized will play a large part in how medical providers, Congress, and the public view the law. To be successful, known problems must be addressed, including tight statutory timelines, wide variances in the availability and quality of measures across provider types, a narrow availability of CMS-approved Advanced APMs, and the burden the new measurement and payment system may place on providers.

To assist stakeholders, the law provides resources to support implementation of the program, including dollars for quality measures and model analytics. To date CMS has embraced using these resources. Through the proposed rule and other means, the Agency is actively seeking advice and ideas on ways to improve implementation. The results of such solicitations will be addressed in the final rule and beyond, but it is clear that efforts to improve administration will continue for years to come.

Whether the law ultimately succeeds in large part now rests upon the shoulders of those at CMS implementing the law, and the people watching and influencing the outcome via regulatory advocacy.