799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

Vizient Office of Public Policy and Government Relations
Regulatory Summary: CMS Proposed Rule for the Quality Payment Program Year 2

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On Tuesday, June 20, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to make payment and policy changes to the Quality Payment Program (QPP) for the second year of the program (2018), as well as future years.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the QPP for eligible clinicians. Under the QPP, eligible clinicians can participate via one of two tracks – the default Merit-based Incentive Payment System (MIPS), or the Advanced Alternative Payment Models (Advanced APMs). CMS began implementing the QPP through rulemaking for calendar year (CY) 2017, known as the transition year. This rule provides proposed updates for the second and future years of the Program. **The proposals will affect eligible clinicians' payment under the Medicare physician fee schedule (PFS) beginning in CY 2020.**

Comments are due August 21, 2017.

Background & Summary

Over the past two years, CMS has engaged with the health care community through a variety of ways. CMS notes that they have an explicit understanding that technology, infrastructure, physician support systems, and clinical practices will change over the next few years. CMS foresees that the QPP will continue to evolve over time.

Because the QPP brings significant changes to how clinicians are paid within Medicare, CMS acknowledges to moving slowly, so they can 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. As the QPP 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 QPP, similar to the 2017 "pick your pace" of participation, CMS continues to propose flexibilities that gradually prepare clinicians for full implementation. To provide unity and consistency across the two paths of the QPP, in this proposed rule CMS refers to the second year of the program as "Quality Payment Program Year 2".

This proposed rule addresses several aspects of the MACRA that were not included in the first year of the program – including virtual groups, facility-based measurement, and improvement scoring. The agency also includes proposals to implement elements of MACRA that will take effect in future years of the program.

Merit-based Incentive Payment System (MIPS) – Proposals

In the CY 2017 Quality Payment Program final rule, CMS defined a MIPS eligible clinician, as identified by a unique billing Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) combination used to assess performance, as any of the following: physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and a group that includes such clinicians. CMS established that the following are excluded from this definition: (1) Qualifying APM Participant (QPs); (2) Partial QPs who choose not to report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year; (3) low-volume threshold eligible clinicians; and (4) new Medicare-enrolled eligible clinicians. While there

were no change in the types of clinicians eligible to participate for the 2018 MIPS performance period, CMS noted that they may add other types for the 2019 performance period.

CMS approximates that 572,000 eligible clinicians will be required to participate in MIPS in the 2018 performance period – although this number could fluctuate due to eligible clinicians being excluded based on their status as QPs or Partial QPs. Furthermore, the new proposals to raise the low-volume threshold will exempt 585,560 clinicians from the QPP's 2018 performance period.

MIPS payment adjustments will be equally distributed between negative MIPS payment adjustments and positive MIPS payment adjustments to eligible clinicians, as required by the MACRA statute to ensure budget neutrality (assuming a participation of 90 percent of eligible clinicians in the program). Positive MIPS payment adjustments will be made for exceptional performance to eligible clinicians whose MIPS final composite score meets or exceeds the additional performance threshold of 70 points.

Within MIPS, CMS will assess eligible clinicians on four performance categories – quality, clinical practice improvement activities (referred to as "improvement activities"), meaningful use of CEHRT (referred to as "advancing care information"), and resource use (referred to as "cost"). Each category is weighted, and CMS takes the combined score across the categories to calculate the MIPS "final score". Based on their final score, eligible clinicians receive a performance-based payment adjustment under the Medicare Physician Fee Schedule (PFS).

For the QPP's 2018 performance year (MIPS payment year 2020), the composite score will be weighted as follows:

Category	Composite Score Weight
Quality	60%
Improvement Activities	15%
Advancing Care Information	25%
Cost	0%

- **Quality (60 percent)**
  For the 2018 MIPS performance period, CMS is proposing to maintain a 60 percent weight for the quality performance category (versus 50 percent, which CMS had previously finalized in prior rulemaking). Quality measures are selected annually through a call for measures – and the final list of quality measures is published in the Federal Register by November 1 of each year.

  CMS is proposing for the 2018 MIPS performance period to maintain the transition year data completeness threshold of 50 percent for data submitted on quality measures using Qualified Clinical Data Registries (QCDRs), qualified registries, EHR, or Medicare Part B claims to provide an additional year for individual MIPS eligible clinicians and groups to gain experience with the MIPS before increasing the data completeness threshold. CMS is proposing to increase the data completeness threshold to 60 percent for the 2019 MIPS performance period.

  Going forward, as MIPS eligible clinicians gain experience, CMS expects to continue to increase the thresholds for data submitted on quality measures. For future performance periods, when the weight for the Cost performance category is eventually raised, the quality composite score weight is expected to decrease. Contingent on the final rule and future rulemaking, CMS plans to maintain the weight for Quality at 30 percent in the 2021 payment year and beyond

- **Improvement Activities (15 percent)**
  Improvement Activities support broad health care delivery goals – such as care coordination, beneficiary engagement, population management, and health equity. In response to comments, Improvement Activities were given relative weights of high and medium. For the 2018 MIPS performance period, the Improvement Activities performance category will comprise 15 percent of the final score, per the previously finalized CY 2017 QPP rule.

  CMS is proposing new Improvement Activities (Table F of the proposed rule) and Improvement Activities with changes (Table G) for the 2018 MIPS performance period and future years. Activities proposed in this

section would apply for the 2018 MIPS performance period and future performance periods unless further modified via notice and comment rulemaking.

CMS is proposing to expand the definition of how they will recognize an individual MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice by including eligible clinicians in practices that have been randomized to the control group in the Comprehensive Primary Care Plus (CPC+) model as a Medical Home Model.

For group reporters in the 2018 MIPS performance period and future performance periods, CMS is proposing to require that "at least 50 percent of the practice sites within a Tax Identification Number (TIN) must be recognized as a certified or recognized patient-centered medical home or comparable specialty practice" in order to receive full credit in this performance category.

Improvement Activities support the central mission of a "unified QPP"; thus, CMS is proposing to continue to designate activities in the Improvement Activities Inventory that will also qualify for the Advancing Care Information bonus score.

- **Advancing Care Information (25 percent)**
  The Advancing Care Information performance category objectives and measures are subsequent from stage 3 of the Electronic Health Record (EHR) Incentive Program; the transition objectives and measures are subsequent stage 2 of the EHR incentive program. For the QPP Year 2, the Advancing Care Information performance category comprises 25 percent of the final score.

  Enacted in 2016, the 21st Century Cures Act contains provisions affecting how Certified EHR Technology (CEHRT) impacts the Quality Payment Program's current transition year and future years. In this proposed rule, CMS implements these provisions, some of which will apply to the MIPS transition year. Additional details on these proposals are outlined further in this summary.

  CMS continues to "recommend that physicians and clinicians migrate to the implementation and use of EHR technology certified to the 2015 Edition so they may take advantage of improved functionalities, including care coordination and technical advancements such as application programming interfaces, or APIs". However, CMS recognizes that some practices may have ongoing challenges in adopting new certified health IT. Therefore, CMS is proposing that MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two for the CY 2018 performance period.

  CMS is also proposing to offer a one-time bonus of ten percentage points for MIPS eligible clinicians who report the Advancing Care Information Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT. The agency is proposing to expand the improvement activities that are eligible for the Advancing Care Information performance category bonus score in CY 2018 if they are completed using CEHRT functionality. Ten percentage points is the maximum bonus a MIPS eligible clinician would receive if they attest to using CEHRT for one or more of the activities CMS has identified as eligible for the bonus. CMS is seeking comments on if the percentage of the bonus is appropriate, and/or whether it should be limited to new participants in MIPS and small practices. The bonus is not available to MIPS eligible clinicians who use a combination of the 2014 and 2015 Editions.

CEHRT Edition	Advancing Care Information Reporting Option for 2018 Performance Period
2014 Edition	MIPS-eligible clinicians report transition objectives and measures
Combination of 2014 & 2015 Edition	Report transition objectives and measures
2015 Edition	Report objectives and measures, receive bonus points

Additionally, the agency is proposing modifications to the Advancing Care Information objectives and measures and the 2017 Advancing Care Information transition objectives and measures. CMS is also proposing to add an exclusion for the e-Prescribing and Health Information Exchange Objectives and

proposing to modify their scoring policy for the Public Health and Clinical Data Registry Reporting Objectives and Measures for the performance score and the bonus score.

- **Cost (Zero percent)**
  CMS is proposing to weight the cost performance category at zero percent of the final score for the 2020 MIPS payment year. As the agency continues their ongoing development of the episode-based measures that will eventually be used in this performance category, CMS notes that clinicians need additional time in order to gain better understanding of the new measures.

  However, CMS is proposing that cost measures would be weighted at 30 percent of the MIPS Final Score beginning with 2021 payment adjustments. CMS acknowledges that their proposal to assign a zero percent weight to the Cost performance category might not "provide a smooth enough transition for integrating cost measures into MIPS." The agency also considered that it might not promote or encourage clinicians enough to review their performance on these measures. Therefore, CMS is seeking comment on the alternative option of 10 percent weighting for the Cost performance category for the 2020 MIPS payment year.

  "For the 2018 MIPS performance period, CMS is proposing to adopt for the Cost performance category the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period." Additionally, CMS is not proposing to use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Although data on the episode-based measures has been made available to clinicians in the past, the agency is in the process of developing (with clinician input) new episode-based measures, and believes it would be more practical to introduce these new measures over time. CMS will continue to provide performance feedback on episode-based measures prior to possible inclusion of these measures in MIPS – so that clinicians can gain familiarity with the new method as well as the specific episode-based measures.

  CMS will provide feedback to clinicians on these new episode-based cost measures in the fall of this year for informational purposes only. The agency will provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018. Additionally, CMS will offer feedback on another set of newly developed episode-based cost measures in 2018. Therefore, clinicians would have received feedback on cost measures at several different points prior to the Cost performance category being included in the final score.

The table below shows the proposed weighting for composite scores in the above performance categories for future MIPS payment years.

Category	CY 2020 Proposed	CY 2021 & Forward Proposed
Quality	60%*	30%
Improvement Activities	15%	15%
Advancing Care Information	25%	25%
Cost	0% (or 10%)	30%

*If the alternative option of 10 percent weighting for the Cost performance category for the 2020 MIPS payment year is finalized – the Quality performance category weight would decrease.

Performance Periods & Submission Mechanisms

In this proposed rule, for payment year 2021 and future years, CMS is proposing to increase the performance period requirements to include a full-year of data for the Quality and Cost performance categories, though they would not use Cost performance scores for final score determination. Additionally, CMS is proposing to increase the performance period to any continuous 90-day period of data for the Improvement Activities and Advancing Care Information performance categories. CMS is also proposing to retain the 90-day reporting period for the Advancing Care Information category in CY 2019.

CMS is proposing added flexibility for submitting data in CY 2018. Under their new proposal, individual MIPS eligible clinicians or groups will be able to submit measures and activities via as many mechanisms as necessary to

meet the requirements of the Quality, Improvement Activities, or Advancing Care Information performance categories. In other words, clinicians and groups could use more than one submission mechanism for each of the MIPS performance categories. The agency anticipates that this option will provide clinicians the ability to select the measures most relevant to them, regardless of the submission mechanism.

Following the close of the performance period, the data submission deadline for the qualified registry, Qualified Clinical Data Registry (QCDR), EHR and attestation submission mechanisms is March 31. If it is "technically feasible", following the close of the performance period – the submission period will begin prior to January 2. CMS provides an example: "For performance periods occurring in 2018, the data submission period will occur prior to January 2, 2019 through March 31, 2019. If it is not technically feasible to allow the submission period to begin prior to January 2 following the close of the performance period, the submission period will occur from January 2 through March 31 following the close of the performance period." **In any case, the final deadline to submit MIPS performance data will remain March 31, 2019.**

Low-Volume Threshold

The current policy excludes MIPS eligible clinicians or groups from the definition of a MIPS eligible clinician if they have less than or equal to $30,000 in Part B allowed charges OR provide care to equal to or fewer than 100 Part B beneficiaries, pursuant to the low-volume threshold. For Year 2, CMS is proposing to 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. CMS asserts that increasing the dollar amount and beneficiary count of the low-volume threshold will "further reduce the number of eligible clinicians that are required to participate in the MIPS, which would reduce the burden on individual MIPS eligible clinicians and groups practicing in small practices and designated rural areas".

In order to expand options for clinicians and offer them the ability to participate in MIPS if they are otherwise not included, for the purposes of the 2021 MIPS payment year, CMS is proposing to provide clinicians the choice to opt-in to the MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations, including as defined by dollar amount, beneficiary count or, if established, items and services. **CMS is seeking comment on this proposal.**

In order to expand the ways in which claims data could be analyzed for purposes of determining a more comprehensive assessment of the low-volume threshold, CMS is considering defining "items and services" by using the number of patient encounters or procedures associated with a clinician. Defining items and services by patient encounters would assess each patient per visit or encounter with the MIPS eligible clinician. CMS maintains that "defining items and services by using the number of patient encounters or procedures is a simple and straightforward approach for stakeholders to understand". However, the agency is concerned that using this unit of analysis could incentivize clinicians to focus on volume of services rather than the value of services provided to patients. Defining "items and services" by procedure would tie a specific clinical procedure rendered to a patient to a clinician. **CMS is seeking public comment on these methods of defining items and services furnished by clinicians – as well as alternate methods.**

In summary, starting with the 2019 MIPS performance period, CMS is proposing to let clinicians opt-in to MIPS if they meet or exceed one of the two 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 the third potential component – Part B items and services (as defined in future rulemaking).

Facility-Based Measurement

CMS is proposing to implement a facility-based measurement option for the 2018 MIPS performance period and future performance periods. This proposal will offer more flexibility for clinicians and groups to be assessed in the context of their respective facilities and specific work. CMS is proposing facility-based measure policies related to applicable measures, applicability to facility-based measurement, group participation, and facility attribution.

For clinicians whose primary professional responsibilities are in an inpatient hospital or emergency department setting, CMS is proposing to implement an optional, voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing (VBP) Program. CMS notes that pay-for-performance programs, such as VBP programs, are more comparable to MIPS because they focus on performance and reporting. Thus, the agency asserts that facility-based measurement under MIPS should be based on pay-for-performance programs, rather than pay-for-reporting programs. Clinicians that elect this option would have their MIPS Quality and Cost scores tied to their hospital's VBP performance – and would not be required to submit separate Quality and Cost data

under MIPS. The facility-based measurement option converts a hospital's VBP Total Performance Score (TPS) into a MIPS Quality performance category and Cost performance category score. In other words, CMS will include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of Quality and Cost measures.

CMS is proposing the facility-based measurement available only to facility-based clinicians (of any specialty) who have at least 75 percent of their covered professional services supplied in the inpatient hospital setting or emergency department. **CMS is seeking comment on whether a higher or lower threshold of inpatient services would be more appropriate.**

While CMS is currently proposing to limit this opportunity to clinicians and groups who practice primarily in the hospital, they will consider expanding the program to other value-based payment programs in the future. **CMS is requesting comments on what other programs, if any, the agency should consider including for purposes of facility-based measurement under MIPS in future program years.**

For group practices, CMS proposes to require that at least 75 percent of clinicians in the group meet the facility-based eligibility criteria as individuals.

CMS does not propose to include POS code 22 – on-campus hospital outpatient – in determining whether a clinician is facility-based because many clinicians who bill for services using this POS code may work on a hospital campus, but "in a capacity that has little to do with the inpatient care in the hospital". CMS is requesting comments on whether POS 22 should be included in determining if a clinician is facility-based, and how they might differentiate those clinicians who contribute to inpatient care from those who do not. Further, CMS notes that the inclusion of any POS code in the definition is pending technical feasibility to link a clinician to a facility under the proposed method. CMS states that this more limited definition would mean that a clinician who is determined to be facility-based likely would also be determined to be hospital-based for purposes of the Advancing Care Information performance category.

To provide potential facility-based scores to clinicians and groups by the time the data submission period for the 2018 MIPS performance period begins (assuming that timeframe is operationally feasible), CMS suggests that the FY 2019 program year of the Hospital VBP Program, as well as the corresponding performance periods, is the most appropriate program year to use for purposes of facility-based measurement under the Quality and Cost performance categories for the 2020 MIPS payment year. This proposal is similar to the process CMS currently uses to identify clinicians below the low-volume threshold.

Participation in facility-based measurement is not required for clinicians that meet CMS's proposed definition – it is voluntary and optional. For clinicians and groups that choose to, they would be required to elect participation (opt-in or opt-out) by the measures submission deadline; for CY 2018, the date is March 31, 2019.

For MIPS eligible clinicians considering facility-based scoring, CMS expects that they "would generally be aware of their hospital's performance on its quality measures." However, the agency asserts that providing this information directly to clinicians gives additional assurance that clinicians will be "fully aware of the implications of their scoring elections under MIPS." CMS does note, however, that this could potentially give facility-based clinicians a competitive advantage over non-facility-based MIPS eligible clinicians – who do not have any way to obtain their MIPS measure scores in advance. The agency "views that compromise as a necessity to maximize transparency." CMS is seeking comment on appropriate timing to provide notification to facility-based clinicians – before the conclusion of the MIPS performance period, later in the performance period, or even after its conclusion. CMS notes that providing notification to facility-based clinicians after the MIPS performance period would mean that they cannot compare their expected performance scores under this option to the other options available to all MIPS eligible clinicians and simply pick the higher of the two scores. Higher performance category scores could ultimately result in a higher final total score – and thus a higher payment adjustment, and a substantial incentive for clinicians to choose to receive this comparison, which is not available to non-facility based clinicians.

Virtual Groups

CMS is proposing to implement the Virtual Group participation option – beginning with the 2018 MIPS reporting period. Virtual Groups are another way clinicians can elect to participate in MIPS. The agency proposes to define a virtual group as a combination of two or more Taxpayer Identification Numbers (TINs) composed of a solo practitioner (a MIPS eligible clinician who bills under a TIN with no other National Provider Identifiers (NPIs) billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. In other words, as long as the

Virtual Group members are all individual clinicians or group practices of 10 or fewer clinicians, they are permitted to form a virtual group.

CMS's 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. Likewise, Virtual Groups would have the same performance submission mechanisms available to non-virtual MIPS groups.

CMS acknowledges that virtual groups would each have unique characteristics and varying patient populations, and statute provides the Secretary with discretion to establish classifications regarding the composition of virtual groups (e.g., by geographic area or specialty). However, CMS asserts that it is important for virtual groups to have the flexibility to determine their own composition at this time, and, as a result, is not proposing to establish any such classifications regarding virtual group composition at this time. However, CMS is currently considering an approach to limit virtual group size – such as limiting the number of TINs that may form a group – in future rulemaking.

CMS asserts that qualifications as a Virtual Group for purposes of MIPS do not change the application of the physician self-referral law to a financial relationship between a physician and an entity furnishing designated health services, nor does it change the need for such a financial relationship to comply with the physician self-referral law. The agency proposes to require a formal written agreement between all group members to demonstrate that they intend to participate in MIPS as a Virtual Group. CMS will define a "Model Agreement" and will provide a template through additional communications guidance for Virtual Groups that choose to use it.

Virtual Groups must elect to participate in MIPS as a Virtual Group prior to the beginning of a performance period, and election cannot be changed once the performance period starts. If TIN/NPIs move to an APM, CMS proposes to utilize the agency's waiver authority to use the APM score over the virtual group score.

To provide support and reduce burden, CMS will make technical assistance (TA) available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group for the first 2 years of virtual group implementation. Clinicians can access the TA infrastructure that they may be already utilizing. For Quality Payment Program Year 3, CMS will provide an electronic election process (if technically feasible). Clinicians who do not elect to contact their designated TA representative would still have the option of contacting the QPP Service Center for support.

CMS is proposing to modify the definition of a non-patient facing MIPS eligible clinician to apply to virtual groups. The agency is also proposing to specify that groups considered to be non-patient facing (more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician) during the non-patient facing determination period would automatically have their Advancing Care Information performance category reweighted to zero.

Complex Patients Bonus

CMS is proposing to apply an adjustment of up to three bonus points by adding the average Hierarchal Conditions Category (HCC) risk score to the final score. Generally, this will award between one to three points to clinicians based on the medical complexity of the patients they see.

CMS is seeking comments on the option of including dual-eligibility (as a proxy for social risk factors) as a method of adjusting scores as an alternative to the HCC risk score, or in addition to the HCC risk score. Under the agency's alternative proposal, CMS would multiply the proportion of dually eligible patients by five points to determine the number of bonus points it would award.

Additionally, CMS is seeking comments on whether the available small practice bonus (adding 5 points to MIPS scoring) should be extended to those who practice in rural areas as well.

Performance Threshold & Payment Adjustment

The MACRA requires CMS to identify final score thresholds to calculate MIPS final scores into payment adjustments. CMS must publish the performance threshold prior to the start of the performance period; for CY 2020 MIPS payment adjustments, the performance period is CY 2018.

CMS is proposing to set the performance threshold for the 2018 performance period (2020 payment year) at 15 points – a substantial increase over the previous threshold of 3 points – and is requesting feedback on whether it should be lower (or higher). The additional performance threshold will remain at 70 points; eligible clinicians with a final score that meets or exceeds 70 points will receive a bonus in addition to their positive MIPS payment adjustments for exceptional performance.

Final Score (Year 2)	Proposed Payment Adjustment (Year 2)
≥ 70 points	- Positive adjustment - Eligible for exceptional performance bonus – minimum of additional 0.5%
16 – 69 points	- Positive adjustment - Not eligible for exceptional performance bonus
15 points	- Neutral payment adjustment
0 points	- Negative payment adjustment of -5% - 0 points = does not participate

The MIPS payment adjustment is applied to the amount otherwise paid under Part B with respect to the items and services furnished by a MIPS eligible clinician during a year. The payment adjustment for the 2020 payment year ranges from -5% to + (5% x scaling factor) as statutorily required. The scaling factor is determined in a way so that budget neutrality is achieved.

If a MIPS eligible clinician furnishes items and services in an Ambulatory Surgical Center (ASC), Home Health Agencies (HHA), Hospice, and/or Hospital Outpatient Department (HOPD) and the facility bills for those items and services (including prescription drugs), the MIPS adjustment would not apply to the facility payment itself. However, if a MIPS eligible clinician furnishes other items and services in an ASC, HHA, Hospice, and/or HOPD and bills for those items and services separately, such as under the PFS, the MIPS adjustment would apply to payments made for these items and services (they would also be considered in applying the low-volume threshold).

CMS is proposing that services rendered by an eligible clinician that are payable under the ASC, HHA, Hospice, or HOPD methodology would not be subject to the MIPS payments adjustments. However, the agency is proposing that these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS, in which the data received would not be used to assess their performance for the purpose of the MIPS payment adjustment. CMS emphasizes that eligible clinicians who bill under both the PFS and one of these other billing methodologies may be required to participate in MIPS if they exceed the low-volume threshold and are otherwise eligible clinicians; in which case, data reported would be used to determine their MIPS payment adjustment.

Performance Feedback & Targeted Review Process

CMS is proposing to provide QPP performance feedback to eligible clinicians and groups. Initially, the agency would provide performance feedback on an annual basis. In future years, CMS aims to provide performance feedback on a more frequent basis, which is “in line with clinician requests for timely, actionable feedback that they can use to improve care”.

In the CY 2017 Quality Payment Program final rule, CMS finalized (and is not proposing any changes to) a targeted review process under MIPS wherein a MIPS eligible clinician or group may request that the agency review the calculation of the MIPS payment adjustment factor and, as applicable, the calculation of the additional MIPS payment adjustment factor applicable to such MIPS eligible clinician or group for a year.

21st Century Cures Act Provisions

The 21st Century Cures Act, enacted last year, contains provisions affecting how use of certified electronic health record (EHR) technology (CEHRT) impacts the QPP’s current transition year and future years. CMS is proposing to implement the provisions in the 21st Century Cures Act, some of which will apply to the MIPS transition year, including:

- Reweighting the Advancing Care Information performance category to 0% of the final score for ambulatory surgical center (ASC)-based MIPS eligible clinicians; and

- Using the authority for significant hardship exemptions and hospital-based MIPS eligible clinicians for the Advancing Care Information performance category the Act grants CMS.

To align with their hospital-based MIPS eligible clinician policy, CMS is proposing to define an ambulatory surgical center (ASC)-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) code 24 used in the HIPAA standard transaction based on claims for a period prior to the performance period as specified by the agency. CMS is requesting comments as to whether other Place of Service (POS) codes should be used to identify a MIPS eligible clinician's ASC-based status or if an alternative methodology should be used. The ASC-based determination will be made independent of the hospital-based determination.

To determine a MIPS eligible clinician's ASC-based status, CMS is proposing to use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period. If it is not operationally feasible to use claims from this time period, the agency would use a 12-month period as close as practicable. CMS provides this example: "For the 2018 performance period (2020 MIPS payment year), [they] would use the data available at the end of October 2017 for Medicare claims with dates of service between September 1, 2016 through August 31, 2017, to determine whether a MIPS eligible clinician is considered ASC-based under their proposed definition." CMS is proposing this timeline to allow the agency to notify MIPS eligible clinicians of their ASC-based status before the performance period begins, and to align with the hospital-based MIPS eligible clinician determination period. For the 2019 MIPS payment year, CMS would not be able to notify MIPS eligible clinicians of their ASC-based status until after the final rule is published, which they anticipate would be later in 2017. CMS expects that they would provide this notification through QPP.cms.gov. The agency is proposing that these ASC-based policies apply beginning with the 2017 performance period (2019 payment year).

CMS is not proposing changes to the definition of hospital-based MIPS eligible clinicians or previously finalized policy; however, as a result of the changes in the law made by the 21st Century Cures Act discussed above, CMS would assign a zero percent weighting to the Advancing Care Information performance category in the MIPS final score for a MIPS payment year for hospital-based MIPS eligible clinicians (as previously defined). A hospital-based MIPS eligible clinician would have the option to report the advancing care information measures for the performance period for the MIPS payment year for which they are determined hospital-based. However, if a MIPS eligible clinician who is determined hospital-based chooses to report on the advancing care information measures, they would be scored on the Advancing Care Information performance category like all other MIPS eligible clinicians, and the category would be given the weighting prescribed under statute, regardless of their score.

Under the Medicare EHR Incentive Program, an approved hardship exception exempted an EP from the payment adjustment. **CMS maintains that weighting the Advancing Care Information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category, and requests comments on this proposed use of the authority provided in the 21st Century Cures Act as it relates to hospital-based MIPS eligible clinicians.**

Hospital-based MIPS Eligible Clinicians

In the CY 2017 Quality Payment Program final rule, CMS defined a hospital-based MIPS eligible clinician as "a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of services identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22) or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by the agency."

CMS is proposing to modify their policy to include "covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19)" in the definition of hospital-based MIPS eligible clinician. POS 19 was developed in 2015 in order to "capture the numerous physicians that are paid for a portion of their services in an off campus-outpatient hospital versus an on campus-outpatient hospital" (POS 22). CMS also believes that these MIPS eligible clinicians do not generally have control over development and maintenance of their EHR systems, similar to those who bill using POS 22. Beginning with the 2018 performance period, CMS proposes to add POS 19 to their existing definition of a hospital-based MIPS eligible clinician.

Public Reporting

CMS is proposing public reporting of certain eligible clinician and group Quality Payment Program information, including MIPS and APM data in an easily understandable format as required under the MACRA.

MIPS Alternative Payment Models (APMs)

Certain Alternative Payment Models (APMs) include MIPS eligible clinicians as participants and hold them accountable for the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a "MIPS APM," and participants in MIPS APMs have MIPS different reporting requirements, and receive different MIPS scoring under the "APM scoring standard." Most Advanced APMs are also MIPS APMs, so that if an eligible clinician participating in the Advanced APM does not meet the threshold of having sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM. For example, the APM scoring standard eliminates the need for MIPS clinicians to duplicate submission of Quality and Improvement Activity performance category data and "allows them to focus instead on the goals of the APM".

MIPS APMs are APMs that meet these three criteria:

- The APM Entities participate in the APM under an agreement with CMS;
- The APM requires that APM Entities include at least one MIPS clinician on a Participation List; and
- The APM bases payment incentives on performance (either at the APM Entity or clinician level) on cost/utilization and quality measures.

For 2018 CMS is proposing to align weighting across all MIPS APMs, and assess all MIPS APMs on quality:

Category	Composite Score Weight
Quality	50%
Improvement Activities	20%
Advancing Care Information	30%
Cost	0%

CMS is proposing additional details on how the Quality performance category will be scored under the MIPS APM scoring standard for non-ACO models, which had quality weighted to zero in 2017. In 2018, participants in these models will be scored under MIPS using the quality measures that they are already required to report on as a condition of their participation in their APM. A fourth "snapshot date" of December 31st would be added for full TIN APMs for determining which eligible clinicians are participating in a MIPS APM for purposes of the APM scoring standard. This would allow participants who joined certain APMs between September 1st and December 31st of the performance year to utilize from the MIPS APM scoring standard.

Incentives for Participants in Advanced Alternative Payment Models (APMs) – Proposals

Advanced Alternative Payment Models (APMs) are a subset of APMs. To be an Advanced APM, a model must meet the following three criteria:

- Require participants to use certified electronic health record technology (CEHRT);
- Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
- Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Advanced APMs receive a 5 percent incentive payment in 2019 for participation in 2017 if they a) receive 25% of their Medicare Part B payments through an Advanced APM or b) see 20% of Medicare patients through an Advanced APM.

Qualifying APM Participants (QP) and Partial QPs

CMS finalized that the QP Performance Period will run from January 1 through August 31 of the calendar year that is 2 years prior to the payment year, and refers to this time period for the Medicare Option as the "Medicare QP Performance Period". Clinicians who participate in Advanced APMs and become Qualifying Participants (QPs) are exempt from MIPS participation (i.e., reporting requirements and payment adjustments). Clinicians in an Advanced APM who become Partial QPs may choose whether or not to report on MIPS measures and activities. If Partial QPs

do not choose to participate in MIPS, they are exempt from MIPS reporting and will not receive a MIPS payment adjustment.

CMS proposes that the generally applicable revenue-based nominal amount standard remain at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities for the 2019 and 2020 Medicare QP Performance Periods, and will address the standard for Medicare QP Performance Periods after 2020 through subsequent rulemaking. CMS is requesting comment on whether the agency should consider either a lower or higher revenue-based nominal amount standard for the 2019 and 2020 Medicare QP Performance Periods, and on the amount and structure of the revenue-based nominal amount standard for Medicare QP Performance Periods 2021 and later. CMS states that "maintaining the revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities will provide stability and clarity for eligible clinicians and APM Entities". CMS also continues to assert that 8 percent represents a reasonable standard to determine what constitutes a more than nominal amount of financial risk. The agency notes that the continued testing and evaluation of APMs with two-sided risk will provide essential information about the best way to structure financial incentives and financial risk, and in the future – this information may have bearing on what constitutes a more than nominal amount of risk. CMS will continue to evaluate the revenue-based nominal amount standard in light of participation in Advanced APMs before considering any increase in later years.

Medical Home models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Advanced APM. CMS notes that it is important to maintain the distinction between Medical Home Models and other APMs because Medical Home Models are categorically different than other types of APMs. Thus, CMS previously finalized special standards for Medical Home Models that are exceptions to the generally applicable financial risk and nominal amount standards.

For the CY 2017 Quality Payment Program, CMS finalized that beginning in the 2018 Medicare QP Performance Period, the Medical Home Model financial risk standard would only apply to APM Entities that participate in Medical Home Models and that have fewer than 50 eligible clinicians in the organization through which the APM Entity is owned and operated. Under this policy, in a Medical Home Model that otherwise meets the criteria to be an Advanced APM, the Medical Home Model financial risk standard would be applicable only for those APM Entities owned and operated by organizations with fewer than 50 eligible clinicians (note: this policy does not apply to Medical Home Models expanded under section 1115A of the Act). CMS is proposing to exempt from this requirement any APM Entities enrolled in Round 1 of the Comprehensive Primary Care Plus Model (CPC+). In other words, CMS is proposing to exempt Round 1 of the CPC+ Model from the requirement that beginning in the 2018 Medicare QP Performance Period, the Medical Home Model financial risk standard applies only to an APM Entity that is participating in a Medical Home Model if it has fewer than 50 eligible clinicians in its parent organization.

Additionally, CMS is proposing to lower the minimum total potential risk for an Advanced APM Entity under the Medical Home Model Standard, so that it must be equal to at least:

Performance Year	Estimated Average Total Medicare Parts A and B Revenues of All Providers and Suppliers in Participating APM Entities
2018	2%
2019	3%
2020	4%
2021 & after	5%

CMS proposes to modify policies regarding the timeframe(s) for which payment amount and patient count data are included in the QP payment amount, and patient count threshold calculations for Advanced APMs that start after January 1 or end before August 31 in a given Medicare QP Performance Period. In these situations, CMS would calculate QP Threshold Scores using only data in the numerator and denominator for the dates that APM Entities were able to participate in active testing of the Advanced APM, per the terms of the Advanced APM, so long as APM Entities were able to participate in the Advanced APM for 60 or more continuous days during the QP

Performance Period. This proposed change would not affect how CMS makes QP and Partial QP determinations for eligible clinicians who participate in multiple Advanced APMs. Further, CMS proposes to make these calculations using the full Medicare QP Performance Period, even if the eligible clinician participates in one or more Advanced APMs that start or end during the same period.

All-Payer Combination Option

For QPP Year 2, CMS provides additional details about how the All-Payer Combination Option will be implemented. This option allows clinicians to become 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.

The proposed rule would establish:

- A voluntary Payer-Initiated Process that would allow payers to report payment arrangements and request that CMS can determine whether they qualify as Other Payer Advanced APMs.
- An Eligible Clinician-Initiated Process in which eligible clinicians would report payment arrangements that had not previously been reported by payers.

In addition to the existing Total Risk standard, an additional revenue-based nominal amount standard of 8 percent 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. CMS is proposing a separate All-Payer QP Determination Period, which 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.

Prior to each All-Payer QP Performance Period, CMS would make Other Payer Advanced APM determinations based on information voluntarily submitted by payers. This payer-initiated process would be available for Medicaid, Medicare Advantage, and the Centers for Medicare and Medicaid Innovation (CMMI) multi-payer models for performance year 2019. CMS intends to add remaining payer types in future years. APM Entities and eligible clinicians would also have the opportunity to submit information regarding the payment arrangements in which they were participating – in the event that the payer had not already done so. Guidance and submission forms for both payers and clinicians would be made available for each Other Payer type early in the calendar year prior to each All-Payer QP Performance Period. CMS notes that the specific deadlines and processes for submitting payment arrangements will vary by payer type (Medicaid, Medicare Advantage, etc.) in order to align with pre-existing processes and meet statutory requirements.

CMS is proposing to calculate QP determinations under the All-Payer Combination Option at the individual eligible clinician level only. This proposal aims to account for the fact that participation in APMs will vary across payer; the eligible clinicians participating in an APM in Medicare may not be identical to eligible clinicians who participate in an APM in a commercial payer or Medicaid. "If the Medicare Threshold Score for an eligible clinician is higher when calculated for the APM Entity group than when calculated for the 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".

When the determination has not already been made through the Payer-Initiated process – APM Entities or eligible clinicians can submit information in regard to their payment arrangement, and request that CMS make Other Payer Advanced APM determinations. CMS is proposing to eliminate the requirement for attestation from the payer; APM Entities or eligible clinicians would need to certify information they submit.

Additional Advanced APM Proposals and Future Advanced APMs

For the 2020 payment year, based on Advanced APM participation in 2018 performance period, CMS estimates that "approximately180,000 to 245,000 clinicians will become QPs – and therefore be exempt from MIPS and qualify for lump sum incentive payments based on 5 percent of their Part B allowable charges for covered professional services". CMS estimates that "the total lump sum incentive payments will be between approximately $590 and $800 million for the 2020 QPP payment year". This expected growth in QPs between the first and second year of the program is due in part to reopening of CPC+ and Next Generation ACO for 2018, and the ACO Track 1+ which is projected to have a large number of participants, with a majority reaching QP status.

The table below displays the Alternative Payment Models (APMs) of which CMS has determined to be Advanced APMs, unless otherwise noted.

The information presented in this table applies the Advanced APM criteria adopted in the previous QPP final rule to the current design of the listed APMs. CMS will modify this list based on changes in the designs of APMs or the announcement of new APMs.

Advanced APMs & Proposed APMs for Performance Year 2018

Advanced APMs in Performance Year (PY) 2017	Advanced APMs in PY 2018 & Future Years*
Comprehensive ESRD Care (CEC) – Two-Sided Risk (LDO & non-LDO two-sided risk arrangements)	Medicare ACO Model – Track 1+
Comprehensive Primary Care Plus (CPC+)	Acute Myocardial Infarction (AMI) Model (Track 1 – CEHRT)[1]
Next Generation ACO Model	Coronary Artery Bypass Graft (CABG) Model (Track 1 – CEHRT)[1]
Medicare Shared Savings Program ACOs – Track 2	Surgical Hip/Femur Fracture Treatment (SHFFT) Model (Track 1 – CEHRT)[1]
Medicare Shared Savings Program ACOs – Track 3	*Medicare-Medicaid Financial Alignment Initiative*[2]
Oncology Care Model (OCM) – Two-Sided Risk	*State Innovation Models — Round 2 (SIM 2)*[3]
Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT)	Potential Announcement of New Advanced APMs
Medicare-Medicaid ACO Model (MMACO) (for participants in Shared Savings Program Track 2)	
Medicare-Medicaid ACO Model (MMACO) (for participants in Shared Savings Program Track 3)	
Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)[4]	

Physician-Focused Payment Models (PFPMs)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is an 11-member federal advisory committee tasked with reviewing stakeholders' proposed PFPMs. PTAC also provides recommendations to the Secretary regarding whether the proposals meet the established PFPM criteria. "PTAC comments and recommendations will be reviewed by the CMS Innovation Center and the Secretary, and the agency will post a detailed response to them on the CMS website."

CMS is seeking comment on a more broad definition of PFPM that would include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer – even if Medicare is not included as a payer. This definition "might be more inclusive of potential PFPMs that could focus on areas not generally applicable to the Medicare population, and could engage more stakeholders in designing PFPMs". As CMS continues to garner additional experience with the process of public submission of PFPM proposals to the

[1] Beginning in performance year 2018 for participants in the Model that choose to voluntarily implement downside risk, and performance year 2019 for all other participants in Track 1.
[2] The Medicare-Medicaid Financial Alignment Initiative agreements are between CMS and state and health plan participants. CMS will assess agreements between states or health plans and health care providers as other payer arrangements under the All-Payer Combination Option.
[3] SIM 2 provides financial and technical support to 11 states to test and evaluate multi-payer health system transformation models. CMS will assess agreements between states and health care providers as other payer arrangements under the All-Payer Combination Option.
[4] The Vermont All-Payer ACO Model is a new APM. Note that this Advanced APM determination applies only to this APM's payments under Medicare; determinations with respect to whether the other payer arrangements in the Vermont All-Payer ACO Model are Other Payer Advanced APMs will be made separately.

PTAC, **the agency is seeking comment on criteria established by the Secretary and stakeholders' requirements in developing proposals that meet the current criteria.**

What's Next?

Comments are due on August 21, 2017. Additionally, CMS notes that they will continue open communication with stakeholders on an ongoing basis as the agency develops the Quality Payment Program in future years.

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. "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 [their] message and education delivery."

As always, it is possible that we'll see substantial shifts between the proposed and final rule based on public comments and further analysis by CMS. Look for another detailed summary from our office when the final rule is released.

Additional Resources

Chelsea Arnone, Regulatory Affairs and Government Relations Director in Vizient's Washington, D.C. Office, can be reached at (202) 354-2608, and is monitoring this rule and other regulatory developments. Please reach out to her if you have any questions or if Vizient can provide any assistance as you consider these issues. The Centers for Medicare & Medicaid Services provides additional resources on the official Quality Payment Program website.