American Hospital Association

Regulatory Advisory

November 30, 2017

MACRA Physician Quality Payment Program Final Rule for CY 2018

At a Glance

At Issue:

The Centers for Medicare & Medicaid Services (CMS) Nov. 2 issued a final rule with comment period updating the requirements of the quality payment program (QPP) for physicians and other eligible clinicians mandated by the Medicare Access and CHIP Reauthorization Act (MACRA). The QPP includes two tracks – the default Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). Data reporting for the QPP began on Jan. 1, 2017. Most of the final rule's policies specify what eligible clinicians must report for the QPP's 2018 performance period, which will affect eligible clinicians' payment under the Medicare physician fee schedule (PFS) in calendar year (CY) 2020. In addition, CMS included an interim final rule to provide MIPS relief to clinicians impacted by the recent hurricane season.

The rule makes several significant changes to QPP policies starting in CY 2018, including the following:

- **Significant increase in the MIPS low-volume threshold.** To provide small and rural practices more time to transition into the MIPS, CMS finalizes an increase to the low-volume threshold that will result in the exclusion of more than 540,000 clinicians from the MIPS in 2018. Specifically, clinicians billing $90,000 or less of Medicare Part B charges, or seeing 200 or fewer Medicare Part B patients, will **not** be expected to participate in the MIPS, or be subject to the payment adjustments.

- **MIPS-facility-based clinician measurement option.** CMS will allow clinicians and groups providing at least 75 percent of their covered professional services in a hospital or emergency department to have their MIPS quality and cost scores tied to their hospital's CMS value-based purchasing (VBP) program performance. That is, CMS will convert a hospital's total performance score in the hospital VBP program into scores for the MIPS quality and cost categories. Due to concerns about operational readiness and a desire to further educate the field about this option, CMS will make the option available for the **CY 2019** performance period (affecting CY 2021 MIPS payment adjustments), rather than CY 2018 as it had proposed.

- **Continued MIPS advancing care information (ACI) category flexibility.** CMS finalizes the option to report the ACI transition objectives and measures, based on modified Stage 2 meaningful use requirements. The rule also provides a 90-day reporting period in 2018 and 2019.

- **Virtual group reporting option.** The MACRA permits individual clinicians and group practices of 10 or fewer clinicians to form "virtual groups" to participate jointly in the MIPS. CMS finalizes its proposal to implement a virtual group participation option beginning with the 2018 reporting period. To participate in a virtual group, CMS will require a formal written agreement among all members of the virtual group. Virtual groups that wish to use the option in the CY 2018 reporting period must elect it by Dec. 31, 2017.

- **Weighting the MIPS cost category for CY 2020.** CMS will assign a weight of 10 percent to the cost category for CY 2020, rather than the zero percent weight it had proposed. The agency believes this approach will smooth the transition to the higher cost category weight of 30 percent that the MACRA statute requires starting in CY 2021.

- **Advanced APMs.** CMS will continue most CY 2017 policies for the advanced APM track into CY 2018. The agency also will implement an "Other Payer Advanced APM Determination Process" allowing clinicians, APM entities and payers to obtain approval for Medicaid, Medicare Advantage and multi-payer models to qualify as advanced APMs.

- **Interim Final Rule for Extreme and Uncontrollable Circumstances.** To provide relief to clinicians in areas affected by Hurricanes Harvey, Irma and Maria, CMS issued an interim final rule that will grant an automatic exemption from the MIPS for the CY 2017 reporting period. Specifically, for clinicians in the areas affected by the hurricanes, CMS will automatically assign a weight of zero percent to the quality, improvement activities and advancing care information performance categories of the MIPS, thereby holding clinicians harmless from MIPS payment adjustments in CY 2019. However, clinicians have the option of overriding the zero percent payment adjustment and participating in the MIPS by reporting data by the Mar. 31, 2018 deadline. Additional details are provided in this CMS fact sheet.

Our Take:

This final rule continues a flexible approach to the QPP. While we believe the facility-based clinician measurement option could be adopted in 2018, we understand CMS's decision to push its adoption to 2019. This option will allow many hospitals and clinicians to spend less time collecting data, and more time collaborating to improve care. In addition, we applaud CMS for providing much-needed relief from unrealistic and unfunded mandates for electronic health records capabilities for clinicians. But we are disappointed the agency has yet to provide similar relief for hospitals. Finally, we urge CMS to provide additional avenues for clinicians to earn incentives for partnering with hospitals to provide better quality, more efficient care through advanced APMs.

What You Can Do:

- ✓ Share this advisory with your senior management team – including your chief medical officer, chief nursing officer, chief quality officer, chief financial officer and leaders involved in APMs – and ask them to examine the impact of the rule on your organization.

- ✓ While the rule is final, CMS requests comment on the policies it has adopted, along with several specific areas of future policy development. **Submit comments to CMS with your specific concerns by Jan. 1, 2018 at 5:00 p.m. ET at www.regulations.gov.**

- ✓ Learn more about MACRA and its implications for hospitals by visiting www.aha.org/MACRA for resources targeting hospital leaders, physicians, trustees and others. **You will find an on-demand webinar on the final rule**. The site also offers a range of tools and resources, including an AHA MACRA Decision Guide, PowerPoint slides, an issue brief, and other resources to help you understand MACRA and meet requirements for this year and strategize for future years.

Further Questions:

Please contact Akin Demehin, director of policy, at (202) 626-2365 or ademehin@aha.org.

November 30, 2017

MACRA PHYSICIAN QUALITY PAYMENT PROGRAM FINAL RULE FOR CY 2018

TABLE OF CONTENTS

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) Nov. 2 issued a final rule with comment period updating the requirements of the quality payment program (QPP) for physicians and other eligible clinicians mandated by the Medicare Access and CHIP Reauthorization Act (MACRA). The QPP includes two tracks – the default Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). Data reporting for the QPP began on Jan. 1, 2017. Most of the final rule's policies specify what eligible clinicians must report for the QPP's 2018 performance period, which will affect eligible clinicians' payment under the Medicare physician fee schedule (PFS) in calendar year (CY) 2020. In addition, CMS included an interim final rule to provide MIPS relief to clinicians impacted by the recent hurricane season.

A summary of the key provisions of the final rule follows.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview of the MIPS

The MACRA sunsets three existing physician quality performance programs – the physician quality reporting system (PQRS), Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals and the value-based payment modifier (VM) – and consolidates aspects of those programs into the MIPS. Starting with CY 2019 payment, the MIPS will be the default QPP track for eligible clinicians. Clinicians may participate as individuals or as group practices.

The MIPS must assess eligible clinicians on four performance categories – quality measures, cost/resource use measures, improvement activities and advancing care information (ACI), a modified version of the historical "meaningful use" program. Each MIPS performance category has a weight, as outlined below in Figure 1. CMS will combine the scores across the categories to create a MIPS "final score." Based on their MIPS final score, eligible clinicians will receive positive, neutral or negative payment adjustments under the Medicare PFS of 4 percent in CY 2019, 5 percent in CY 2020, 7 percent in CY 2021, and a maximum of 9 percent in CY 2022 and beyond.

For the first year of the MIPS, CMS will not score MIPS participants on the cost / resource use category, and has reallocated the weight to the quality category. However, CMS will assign a weight of 10 percent to the cost category for CY 2020, rather than the zero percent weight it had proposed. The agency believes this approach will smooth the transition to the higher cost category weight of 30 percent that the MACRA statute requires starting in CY 2021.

Figure 1: Final MIPS Performance Category Weights

MIPS Performance Category	CY 2019	CY 2020	CY 2021 and beyond
Quality	60%	50%	30%
Cost / Resource Use	0%	10%	30%
Improvement Activities	15 %	15%	15%
Advancing Care Information (ACI)	25%	25%	25%

This section of the advisory describes CMS's finalized policies for the quality, cost / resource use and improvement activity categories of the MIPS. The next section describes the policies CMS will adopt for the ACI category of the MIPS.

Eligibility for the MIPS

As required by the MACRA, the CY 2018 MIPS program will continue to apply to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified registered nurse anesthetists (CRNAs) that bill under the Medicare PFS. MIPS-eligible clinicians may participate in the MIPS either as individuals or as groups. CMS considers each unique combination of taxpayer identification number (TIN) and national provider identifier (NPI) to be a different individual eligible clinician. Group practices will continued to be identified as a single TIN with two or more clinicians (as identified by NPI) who have reassigned their billing rights to the TIN.

For CY 2018, CMS adopts no changes to three of its four MACRA-mandated exemptions from the MIPS, including:

- *Qualifying APM participants* – These eligible clinicians meet the proposed requirements for receiving bonuses for participating in advanced APMs (detailed in the APM section of this advisory), and are not required to participate in the MIPS.

- *Partial qualifying APM participants* – These eligible clinicians participate in advanced APMs that meet CMS's criteria, but fall just short of receiving a high enough percentage of their payments from advanced APMs to receive the bonus payment. Additional details on this category of participation are provided in the APM section of this advisory. Partial qualifying APM participants may elect not to report MIPS data.

- *New Medicare-enrolled eligible clinicians* – These are eligible clinicians who enroll in Medicare for the first time during a MIPS performance period and have not previously submitted Medicare claims.

However, the agency adopts a significant change to the low-volume threshold exemption, as described below.

Low-volume Threshold MIPS Exemption

The MACRA requires CMS to define a volume threshold below which participation in the MIPS is not required. For CY 2017 reporting, CMS defined this threshold as eligible clinicians and groups that, during a MIPS performance period, have Medicare Part B billing charges of $30,000 or less, ***OR*** provide care to 100 or fewer Medicare Part B patients. CMS also established a process for identifying and notifying clinicians whether they are below the low-volume threshold in advance of the performance period. Clinicians and groups can verify their status on CMS's QPP website.

However, the agency has continued to receive feedback that this threshold may still be too high for many rural and small providers, who have expressed significant concern about their readiness to participate in the first year of the MIPS. **In response to these concerns, CMS will raise the low-volume threshold for CY 2018. Clinicians and group practices billing $90,000 or less of Medicare charges, or that see 200 or fewer Medicare patients, will not be required to participate in the MIPS.** CMS estimates that this policy would result in the exemption of approximately 540,000 clinicians from CY 2018 MIPS requirements. **Note, CMS will not apply this modified low-volume threshold to CY 2017 MIPS reporting.**

In addition, CMS will modify its process for identifying and notifying clinicians and groups whether they are below the low-volume threshold. CMS will continue to assess claims during two 12-month timeframes to identify clinicians and groups who are below the low-volume threshold, but will use a 30-day claims run out period rather than a 60-day period. As a result, the two low-volume threshold determination timeframes will be as follows:

- The last four months of a CY **two years before the performance period** followed by the first eight months of the following calendar year, including a 30-day claims run out period. This determination period would allow CMS to identify clinicians that are below the low-volume threshold **prior to the start** of the performance period.

- The last four months of a CY **one year before the period** followed by the first eight months of the following calendar year, including a 30-day claims run out period. This would allow CMS to identify additional clinicians below the low-volume threshold **during** the performance period.

Thus, to determine low-volume exemption status for CY 2018 reporting (and 2020 MIPS payment determination), CMS will examine data from Sept. 1, 2016 through Aug. 31, 2017, and Sept. 1, 2017 through Aug. 31, 2018. **CMS will not change the status of any group identified as below the low-volume threshold during the first determination period based on the results of the second determination period.** In

other words, the second determination period would only be used to exclude additional clinicians.

MIPS Facility-based Measurement Option

MACRA gives CMS the option to allow facility-based clinicians to receive MIPS quality and cost scores based on their facility's results from CMS's quality reporting and pay-for-performance programs. In this rule, CMS finalizes a facility-based measurement option in which clinicians will have their MIPS quality and cost scores tied to their hospital's CMS value-based purchasing (VBP) program total performance score (TPS). This approach will relieve data submission burden because clinicians and groups will not submit separate quality and cost data to CMS. However, due to concerns about operational readiness and a desire to further educate the field about the option, CMS will make the option available for the **CY 2019** performance period (affecting CY 2021 payments), rather than CY 2018 as it had proposed. **While we do not believe the delay is necessary, the AHA applauds CMS for responding to our longstanding request to develop a facility-based measurement option for the MIPS.**

Eligibility. The facility-based measurement option is available only to facility-based clinicians (of any specialty) that have at least 75 percent of their covered professional services provided in the inpatient hospital or emergency department settings. For group practices, CMS will require that at least 75 percent of clinicians in the group (as defined by TIN) meet the "facility-based" threshold for individual clinicians. CMS will determine whether clinicians and groups have met these threshold by reviewing claims to determine what percentage of covered professional service claims are identified by place of service (POS) codes 21 (for inpatient hospitals) and 23 (for emergency departments).

Similar to its process for identifying clinicians below the low-volume threshold, CMS will review claims data to inform clinicians and groups of whether they would be considered "facility-based" near the beginning of each performance period. Specifically CMS will review data from the last four months two years before the performance period followed by the first eight months of the following calendar year, including a 30-day claims run out period. For the CY 2019 performance period, CMS will review claims data from Sept. 1, 2017 to Aug. 31, 2018. CMS indicates it will provide providers

Facility Attribution. Because facility-based clinicians often practice at more than one facility, CMS finalizes an approach to identify which hospital's scores should be attributed to those clinicians and groups using the facility-based measurement option. Specifically, clinicians and groups will receive the VBP scores of the hospital where they provide services to the most Medicare beneficiaries. CMS will make this determination using the data from the same time period used to meet the definition of "facility-based" (i.e., Sept. 1 of two years prior to a performance period through August of the year prior to the performance period). In the event a clinician or group treats an equal number of patients at more than one facility, the clinician or group's performance will be tied to the highest-scoring facility.

Election of Option. In the CY 2018 QPP proposed rule, CMS proposed that clinicians and groups wishing to use facility-based measurement would need to "opt-in" by attesting to it by the measure submission deadline for a performance year. However, CMS chose not to finalize this approach, and will address how clinicians may elect to use facility-based measurement in future rulemaking. The agency seeks comment on the use of an "opt-out" approach in which all clinicians that meet the definition of facility-based automatically would be scored using facility-based measurement unless they opted out of it. CMS believes this approach may reduce administrative burden.

Translating VBP TPS Scores into MIPS Quality and Cost Scores. Rather than scoring clinicians on individual measures from the hospital VBP program, CMS will convert hospitals' VBP TPS into MIPS quality and cost category scores. Clinicians and groups would receive the same percentile of performance on the MIPS quality and cost categories as their hospital receives on the TPS in the hospital VBP program. For example, if hospital A receives the median (i.e., 50th percentile) TPS on the hospital VBP, the clinicians and groups attributed to that hospital would then receive MIPS quality and cost scores corresponding to the 50th percentiles of those categories.

In future rulemaking, CMS will specify which fiscal years (FYs) of hospital VBP TPSs will be used for MIPS facility-based measurement.

MIPS Virtual Group Reporting Option

The MACRA permits individual clinicians and group practices of 10 or fewer clinicians to form "virtual groups" to participate jointly in the MIPS. CMS finalizes its proposal to implement a virtual group participation option beginning with the 2018 reporting period. For this first year, CMS will not limit the size, composition (e.g., types of specialties) or geographic regions comprising virtual groups. As long as all of the virtual group members are individual clinicians or group practices of 10 or fewer clinicians, the virtual group will be permitted.

CMS's website offers a toolkit with additional information on how to use the virtual group reporting option.

Administrative Requirements. CMS adopts several administrative requirements that virtual groups must meet, including the following:

- *Formal Written Agreement.* CMS will require a formal written agreement that identifies all clinicians that are participating in the virtual group. The agreement must have several elements, including explicit statements that the agreements only cover participation in the virtual group and the MIPS performance period(s) covered by the agreement. CMS has included a model written agreement in its virtual group toolkit. The agreement does not have to be submitted to CMS. **CMS notes that electing the virtual group option does not exempt clinicians and groups from complying with the requirements of the physician self-referral law.**

- *Election.* CMS will require virtual groups to inform the agency of their intention to participate as a group by Dec. 1 of the year prior to the performance period. However, for virtual groups that want to use the option for the CY 2018 performance year, CMS finalizes a one-time deadline of Dec. 31, 2017. CMS will expect that a single representative of the virtual group would serve as point of contact. The representative also must submit a list of clinicians participating in the virtual group.

- *Verification of virtual group eligibility.* Once a group has notified CMS of its intention to participate as virtual group, CMS will verify that the group meets the requirement of having only individual clinicians and groups of fewer than 10 clinicians using claims data. CMS will use an "eligibility determination period" of five months beginning July 1 and ending Nov. 30 of the year before the performance period begins. As a result, the eligibility determination period for CY 2018 reporting will be July 1 – Nov. 30, 2017.

Those groups that meet the requirements will receive a confirmation from CMS, along with a "virtual group identifier" that would be used when submitting data.

Optional Technical Assistance. CMS acknowledges that forming virtual groups could entail some costs. As a result, the agency is offering an optional "technical assistance" stage that prospective virtual groups could use to help them determine whether they meet the requirements to be a virtual group before choosing to elect the option. The assistance is available through the QPP Service Center by calling 1-866-288-8292 or e-mailing QPP@cms.hhs.gov.

Application of MIPS Reporting Requirements. CMS finalizes its proposal that all MIPS program requirements that apply to group practices also would apply to virtual group. Members of the virtual group will aggregate their performance across multiple TINs and receive a score reflecting their performance at a group level. Payment adjustments will be applied at the TIN/NPI combination level.

MIPS Data Reporting

CY 2018 Performance Periods. CMS increases the performance period for the quality category from any continuous 90-day period to a **full year of data** from CY 2018. However, CMS will retain a reporting period of any continuous 90 days for the improvement activity and ACI categories. CMS also will retain a 90-day reporting period for the ACI category in CY 2019.

Reporting Mechanisms. For CY 2018 MIPS reporting, CMS will retain all of the options for submitting MIPS data it finalized last year. The mechanisms are outlined below in Figure 2. CMS will continue to require the selection of one submission mechanism for each MIPS performance category for CY 2018 reporting. However, starting in CY 2019, clinicians and groups may use more than one submission mechanism for each MIPS

performance category. For example, a group could choose to use a combination of EHRs and registries to report data.

Figure 2: MIPS Data Reporting Mechanisms for Individual Eligible Clinicians and Groups

MIPS Category	Individual Data Reporting Options	Group Data Reporting Options
Quality	- Part B claims-based reporting - Qualified Clinical Data Registry (QCDR) - Qualified Registry - EHR	- Qualified Clinical Data Registry (QCDR) - Qualified Registry - EHR - CAHPS Survey Vendor (for groups of 25 or more only) - CMS Web interface (for groups of 25 or more only)
Cost / Resource Use	- Part B claims-based reporting (no submission required)	- Part B claims-based reporting (no submission required)
Improvement Activities	- Attestation - QCDR - Qualified Registry - EHR	- Attestation - QCDR - Qualified Registry - EHR - CMS Web Interface (for groups of 25 or more only)
Advancing Care Information (ACI)	- Attestation - EHR - QCDR - Qualified Registry	- Attestation - EHR - QCDR - Qualified Registry - CMS Web Interface (for groups of 25 or more only)

Submission Deadlines. CMS will retain the data submission deadlines it finalized in the CY 2017 QPP final rule. That is, data submitted by qualified registry, qualified clinical data registry (QCDR) or EHRs, attestation be submitted by Mar. 31 of the year immediately following the performance period. Thus, for CY 2018 data, the deadline will be Mar. 31, 2019. For the web interface option, data will be due within eight weeks of reporting opening, and no later than Mar. 31, 2019.

MIPS Quality Category

For CY 2018 quality reporting, CMS will mostly carry over CY 2017 reporting requirements. Figure 3 below outlines the reporting requirements organized by reporting mechanism. Of note, CMS did not finalize a proposal to use a 50 percent data completeness requirement for the claims, qualified registry, QCDR and EHR reporting mechanisms for CY 2018 reporting. Instead, CMS will retain the threshold – 60 percent – that it finalized in last year's rule. That same threshold also will apply for CY 2019 reporting (which will affect MIPS payment adjustments in CY 2021).

Figure 3: MIPS Quality Data Submission Requirements for CY 2018 Performance Period

Reporting Mechanism	Submission Requirements	Data Completeness Requirements
QCDR, Qualified Registry and EHR	-Report at least six measures, including one outcome measure -If no outcome measure is available, then report another "high-priority" measure (i.e., appropriate use, patient safety, efficiency, patient experience, or care coordination) -If fewer than six measures apply, report on as many applicable measures as possible -If reporting a specialty measure set that contains fewer than six measures, report on all applicable measures. -Report on **both** Medicare and non-Medicare patients	Report on 60% of eligible clinician or group's patients from all payers that meet measures' denominator criteria
Part B claims-based reporting (individual eligible clinicians only)	Same as QCDR, Qualified Registry and EHR, except report on Medicare patients only	Report on 60% of eligible clinician's patients
CMS Web Interface (groups of 25 or more only)	Report on all measures included in CMS web interface	Web interface uses an attribution and sampling approach to assign patients to particular practices. Groups report on assigned beneficiaries: - Groups populate the data fields for first 248 assigned Medicare beneficiaries. - If fewer than 248 beneficiaries are assigned, report on 100% of assigned patients
CAHPS (groups of 25 or more only)	Use a CMS-approved vendor to collect and submit CAHPS for MIPS survey ***Note: The CAHPS survey counts as one measure*	CMS applies an attribution and sampling approach to assign beneficiaries to particular practices. CAHPS vendor would collect survey on assigned Medicare Part B patients.

MIPS Cost / Resource Use Category

Against the AHA's recommendation, CMS will assign a weight of 10 percent to the cost category for CY 2020, rather than the zero percent weight it had proposed. The agency believes this approach will smooth the transition to the higher cost category weight of 30 percent that the MACRA statute requires starting in CY 2021.

For CY 2020, CMS will score clinicians only on the two overall cost measures – Medicare spending per beneficiary and total cost per capita – that it finalized in the CY 2017 QPP final rule. Detailed descriptions of those measures are available in the AHA's Dec. 5, 2016 *Regulatory Advisory*. In future rulemaking, CMS intends to replace the condition and treatment-specific measures adopted in the rule last year. Additional details on those measures will be available in 2018.

MIPS Improvement Activity Category

The MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. CMS adopts a few changes to the requirements and scoring approach for the MIPS improvement activity category. CMS adds new activities to its inventory of improvement activities, and modifies several others, for a total of 112 activities for CY 2018. These changes are summarized in Table F of the final rule's appendix. Each activity is assigned a weight towards the overall score. There will be 40 possible points in the improvement activity category. Clinicians generally will need to participate in more than one activity to receive the highest score in the category.

As required by the MACRA, eligible clinicians participating in certified patient-centered medical homes (PCMHs) will automatically receive the highest score (40 out of 40 possible points) in the improvement activity category. For group practices, CMS finalizes its proposal to award this credit only when at least 50 percent of the practice sites in a TIN have PCMH recognition. In addition, CMS will add the Comprehensive Primary Care Plus (CPC+) initiative to its list of initiatives meeting the requirements for a certified PCMH.

MIPS Final Performance Score

Overview of MIPS Final Score. As required by the MACRA, CMS will calculate a final composite score of 0 to 100 points for each eligible clinician and group in the MIPS. The MIPS final score is used to determine whether the clinician or group receives positive, neutral or negative payment adjustments under the MIPS.

CMS carries over many aspects of the scoring approach finalized in the CY 2017 QPP final rule. However, as required by the MACRA, CMS adopts a methodology to award providers that have improved their quality and cost performance. CMS also finalizes an approach to identifying, scoring and phasing out "topped out" measures. Lastly, CMS will give providers two additional types of bonus points – small practice and complex

patient – that can be added to the overall MIPS final score. CMS's finalized MIPS scoring approach for CY 2020 payment adjustments is summarized in Figure 4, with some additional details immediately following the table.

Figure 4: MIPS Final Performance Score Approach, CY 2020 MIPS Payment Adjustments

Category	Weight for CY 2020	How Scored
Quality	50%	• Receive 0 points for any measure on which data are not submitted when applicable data are available • Three "classes" of measures eligible for a varying number of points: o Class 1: Measures with at least 20 cases, an available benchmark, and that meet data completeness standard ▪ Receive 3-10 points based on performance compared to benchmark ▪ "Topped out" measures capped at 7 points o Class 2: Measures that meet data completeness standard, but do not have a benchmark or at least 20 cases ▪ Receive 3 points o Class 3: Measures submitted that do not meet completeness standard ▪ If a group of 15 or more clinicians, receive 1 point ▪ If an individual clinician or group under 15 clinicians, receive 3 points • Measures are averaged to calculate an overall "achievement" score expressed as a percentage (e.g., if reporting 6 measures, CMS would determine points on each measure and divide by 60 possible points. Assuming perfect performance, the score would be 100%) • Quality "bonus points" available: o "High-priority measure" bonus points of up to 10 percent of total possible quality category points available for: ▪ Reporting additional outcome or patient experience measures (2 points each) ▪ Reporting additional "high-priority" measures (1 point each) o Certified EHR measure reporting bonus of up to 10 percent of total possible quality category points for clinicians/groups reporting measures using Certified EHRs o Improvement points of up to 10 percent of the year-on-year increase in quality achievement score
Improvement Activities	15%	• Receive score out of a possible 40 possible points • Receive points on each improvement activity o "Medium" value activity worth 10 points o "High" value activity worth 20 points • Participation in certified PCMH: Receive maximum score (40 points) • Participation in APM: Receive at least half the highest score (20 points)

Category	Weight for CY 2020	How Scored
Advancing Care Information	25%	See "MIPS – Advancing Care Information Category" section of this advisory for more details
Cost / Resource Use	10%	• Receive 0-10 points for each measure based on decile of performance o Deciles based on performance period data o Measures are averaged to calculate overall score • Improvement points available based on proportion of measures with statistically significant improvement in performance

Scoring for Improvement – Quality Category. To be eligible for improvement points, groups and clinicians must report on the required number of measures and meet the data completeness threshold. CMS recognizes that clinicians may change their TINs and choice of whether to participate as individuals or groups over time. Table 23 of the final rule outlines the various scenarios that would qualify eligible clinicians and groups to receive an improvement score.

CMS will not calculate improvement points on each individual reported measure. Rather, it will base improvement points on the year-on-year increase in the quality category "achievement" score (which is expressed as a percentage), and add it to the achievement score. Specifically, CMS will use the following formula:

Improvement percent score = (Increase in the quality achievement percent score from prior performance period to current performance period / prior performance period quality achievement score) x 10 percent

For example, suppose group practice A improves its quality achievement score by 10 percent – from 50 percent in CY 2017 to 60 percent in CY 2018. The group would therefore be eligible to receive a 2 percentage point increase in their quality category score (i.e., 10 percent/50 percent x 10 percent = 2 percentage points).

Scoring for Improvement – Cost Category. CMS adopts a different methodology for scoring improvement on the cost category. CMS will determine which cost measures have had a statistically significant improvement in measure performance (as measured by a t-test), and divide by the number of measures scored in the category. The agency will then multiply by number of available points in the cost category to determine the number of improvement points.

Topped Out Quality Measure Scoring. In the CY 2017 QPP final rule, CMS noted there are a significant number of measures in the MIPS program that could be considered "topped out" in performance. But the agency did not finalize any policies for removing and altering the scoring of such measures. In this rule, CMS adopts a process for phasing out topped out measures. That is, measures that have topped out performance for at least two years are eligible for removal from the MIPS. In addition, any measures identified as topped out that are not yet eligible to be removed from the program would

have performance capped at seven points. CMS identifies six specific measures that it will score as topped out for the CY 2018 performance period:

- *Perioperative care*: Selection of prophylactic antibiotic – first or second generation cephalosporin (MIPS quality measure ID #21)
- *Melanoma*: Overutilization of imaging studies in melanoma (MIPS quality measure ID 224)
- *Perioperative care*: Venous thromboembolism (VTE) prophlaxis (MIPS quality measure ID 23)
- *Image confirmation of successful excision of image-localized breast lesio*n (MIPS quality measure ID 262)
- *Optimizing patient exposure to ionizing radiation*: Utilization of a standardized nomenclature for computerized tomography (CT imaging description (MIPS quality measure ID 359)
- *Chronic obstructive pulmonary disease (COPD*): Inhaled brochodialator therapy (MIPS quality measure ID 52)

Small Practice Bonus. In the proposed rule, CMS notes that it continues to receive concerns from small practices about their ability to meet the full requirements of the MIPS due to resource and technology constraints. As a short-term strategy to help practices transition into the MIPS, CMS finalizes its proposal to add five points to the MIPS final score of all practices of 15 or fewer clinicians that submit data in at least one performance category.

Complex Patient Bonus. The AHA and numerous other stakeholders have raised concerns that the measures in the MIPS – especially outcome measures – may not be adequately risk adjusted to account for the clinical and sociodemographic differences across patient populations. This makes it more likely that practices caring for sicker and poorer patients may be at an unfair performance disadvantage.

In response, CMS adopts a policy to add up to five bonus points to the MIPS final scores of clinicians and groups based on the calculation of two factors:

- *Average hierarchical condition category (HCC) risk score*. HCC scores (which generally range from 0 to 3) are derived from Medicare claims data and are a proxy for measuring the clinical risk factors of patients – the higher a clinician or group's HCC score, the more complex its patients are. CMS will calculate the HCC scores for each clinician and group.

- *Dual-eligible ratio.* CMS will calculate the proportion of each clinician's/group's patients that are dually eligible for Medicare and Medicaid. Dual-eligibility is a proxy for sociodemographic status and will be used to adjust hospital readmissions penalties starting in FY 2019.

To calculate the number of bonus points a clinician or group will receive, CMS will sum the HCC score and dual-eligible ratio and multiply by five. This final policy differs from the approach CMS proposed in that it uses both HCC scores and dual-eligible ratio to determine the complex patient bonus, rather than HCC scores alone.

MIPS APM Scoring Standard

CMS will continue applying a modified scoring standard for clinicians and groups that participate in certain Medicare APMs. Some of these APMs are the same as those that qualify for the advanced APM track (described later in this advisory), while others (e.g., Track 1 of the Medicare Shared Savings Program (MSSP)) are not. CMS will continue to publish a list of APMs to its QPP website before the start of each performance period. The list of models available in the CY 2017 performance year is available here.

For the CY 2018 reporting period, CMS will apply uniform performance score weightings across most MIPS APMs, including all of the APMs that are eligible for the MIPS scoring standard in 2017.

Figure 5: MIPS APM CY 2018 Scoring Standard

MIPS Category	Weight	Requirements
Quality	50%	Report measures required by the APM
Cost / Resource Use	0%	Waived due to differences in scoring methodology between resource use measures and the two programs
Improvement Activities	20%	Receive at least half of the maximum category score. CMS to review the APMs against list of improvement activities each year and determine whether reporting additional activities is needed to receive highest score)
ACI	30%	Give highest score attributable to the TIN/NPI combination of each MIPS-eligible clinician (from either group or individual reporting)

MIPS Payment Adjustment Approach

As required by the MACRA, CMS must implement MIPS payment adjustments in a budget-neutral manner. That is, the agency may not pay out more in incentive payments than it recoups in penalties. However, for CYs 2019 through 2024, CMS also must pay out $500 million in “exceptional performance bonuses” to groups that perform exceptionally well on the MIPS. This exceptional performance bonus is above and beyond the budget-neutral MIPS payment adjustment.

As outlined in Figure 6, CMS is required by law to identify several final score thresholds to translate MIPS final scores into a payment adjustment:

- **A performance threshold** above which there are positive payment adjustments on a sliding scale, and below which there are negative payment adjustments on a

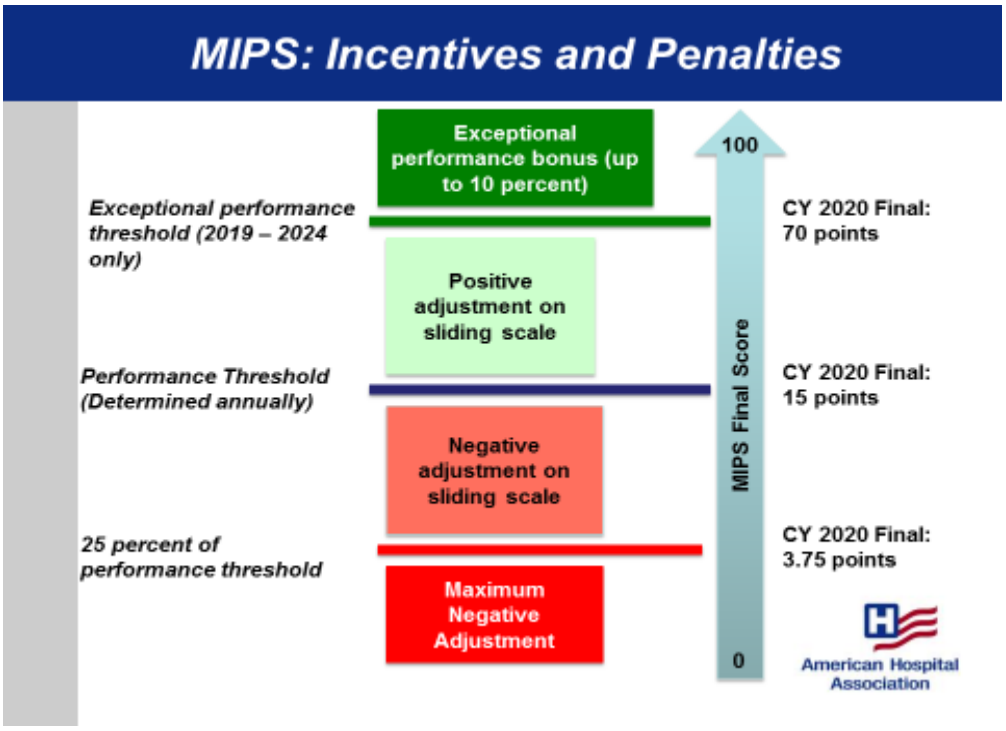
sliding scale. The MACRA requires that CMS publish this number prior to the start of the performance period so that MIPS participants know what level of performance is expected in order to receive positive or negative adjustments. For the CY 2020 MIPS payment adjustments, the performance period is CY 2018.

For CY 2020 payment, CMS will set the performance threshold at 15 points. CMS notes that this is an increase over the CY 2019 threshold of 3 points. CMS intends for the increase in the threshold to incentivize the reporting of more measures and more complete data into the MIPS.

- **25 percent of the performance threshold final score,** at or below which MIPS-eligible clinicians and groups receive the maximum negative payment adjustment (-5 percent in CY 2020). For CY 2020, the value will be 3.75 points.

- **An exceptional performance threshold final score** at or above which MIPS-eligible clinicians and groups are eligible for an additional bonus beyond their positive MIPS adjustment. For CY 2020, CMS will retain a value of 70 points. Therefore, all clinicians and groups receiving a score at or above 70 would be eligible for exceptional performance bonuses of up to 10 percent on a sliding scale.

Figure 6: Translating MIPS Final Score into Payment Adjustments for 2020 based on CY 2018 Performance



Scaling Factor for Positive Payment Adjustments. CMS will, as required by the MACRA, apply a scaling factor of up to 3.0 to positive payment adjustments to maintain the budget neutrality of the MIPS. The scaling factor likely will be applied in years where CMS is taking in a significant amount in MIPS performance penalties. In CY 2019, this means that clinicians and groups could receive positive payment adjustments as high as 15 percent. However, CMS believes it is unlikely the agency would need to apply the full scaling factor.

MIPS – ADVANCING CARE INFORMATION CATEGORY

ACI Category Reporting Requirements

The ACI category requires MIPS-eligible clinicians to report on objectives and measures in a methodology that includes reporting on participation (a base score), performance at varying levels (a performance score) and bonus reporting. The ACI objectives and measures are derived from Stage 3 of the EHR Incentive Program and the ACI transition objectives and measures are derived from modified Stage 2 of the EHR Incentive Program.

For the 2018 reporting period, CMS finalizes the option for MIPS-eligible clinicians to report the ACI transition objectives and measures derived from modified Stage 2 of the EHR Incentive Program. This is a change from the current requirement that MIPS-eligible clinicians must report the ACI objectives and measures derived from Stage 3 of the EHR Incentive Program in 2018. **The AHA appreciates the flexibility and strongly supports relief from Stage 3 requirements for the 2018 reporting period**.

ACI Category Objectives
- Protect patient health information
- Electronic prescribing (eRX)
- Patient electronic access
- Coordination of care through patient engagement
- Health information exchange
- Public health and clinical data registry reporting

CMS finalizes a revision in the ACI public health and clinical registry reporting measures to allow MIPS-eligible clinicians to report any of the available measures to obtain points in the ACI performance score. The prior rule limited MIPS-eligible clinicians to earning performance score points for Public Health reporting through the Immunization Registry reporting measure.

CMS finalizes an increase in the number of designated activities in the MIPS Improvement Activities category including the use of certified EHRs that also will qualify for the ACI bonus points. Ten percentage points is the maximum bonus a MIPS-eligible

clinician can receive. Table 6 in the proposed rule lists the new improvement activities in the improvement activities category that CMS proposes to be eligible for the ACI bonus.

CMS also finalizes that this flexibility is available for MIPS-eligible clinicians that report the ACI transition objectives and measures in 2018. **AHA applauds the proposal to offer flexibility to report the ACI measures derived from modified Stage 2 or Stage 3 for the 2018 reporting period**.

ACI Category Transition Objectives
- Protect patient health information
- Electronic prescribing (eRX)
- Patient electronic access
- Patient-specific education
- Secure Messaging
- Health information exchange
- Medication Reconciliation
- Public health and clinical data registry reporting

CMS finalized a list of 30 Improvement activities that will be eligible for the ACI performance category bonus score if the activity is completed using a certified EHR. In future rulemaking, CMS will consider whether MIPS-eligible clinicians and groups that attest to completing one or more of the improvement activities using a certified EHR should automatically earn the base score for the ACI performance category.

Detailed information about the ACI objectives and measures and the ACI transition objectives and measures for the base score, performance score, bonus points as well as the Improvement activities proposed for ACI bonus points are included in Appendices 1-3 of this advisory.

ACI Reporting Requirements and Certified EHRs

CMS finalizes a reporting period for 2019 is a minimum of any 90 consecutive days. CMS also retained the prior requirement that the reporting period for 2018 is a minimum of any 90 consecutive days. **The AHA appreciates the 90-day reporting period in 2018 and 2019**.

CMS finalizes that MIPS-eligible clinicians may use 2014 Edition, 2015 Edition certified EHR or a combination of 2014 and 2015 Edition certified EHR for the 2018 performance period if reporting the ACI transition objectives and measures. MIPS-eligible clinicians must use the 2015 Edition certified EHR if reporting the ACI objectives and measures. CMS also states that under its current policy, 2015 Edition certified EHRs will be required for the 2019 performance period.

CMS also finalizes to offer a bonus of 10 percentage points under the ACI category for MIPS-eligible clinicians who report the ACI Objectives and Measures for 2018 using only 2015 Edition certified EHR. CMS states the one-time bonus for 2018 is designed to

support and recognize new MIPS-eligible clinicians and groups that may be adopting health IT for the first time, do not have a 2014 Edition EHR available to use or have no prior experience with meaningful use objectives and measures. CMS adds that the bonus will not be available to MIPS-eligible clinicians who use a combination of the 2014 and 2015 Editions. Figure 7 indicates the edition of certified EHR that will be required for the reporting of objectives and measures for each ACI reporting option.

Figure 7: Edition of Certified EHR and ACI Reporting Requirements

Edition of Certified EHR	ACI Reporting Option
2014 Edition Certified EHR	MIPS-eligible clinicians report the ACI Transition objectives and measures that are derived from modified Stage 2 objectives and measures in CY 2018 and CY 2019
A combination of 2015 Edition and 2014 Edition Certified EHR	MIPS-eligible clinicians report: the ACI Transition objectives and measures derived from modified Stage 2, if they have the appropriate mix of technologies to support each measure selected.
015 Edition Certified EHR	MIPS-eligible clinician report the ACI objectives and measures derived from Stage 3 requirements.

ACI Objectives and Measures

CMS finalizes changes to the ACI objectives and measures, with some changes taking effect in the current 2017 reporting period and others beginning in the 2018 reporting period:

ePrescribing. This objective requires that at least one permissible prescription written by the MIPS-eligible clinician be queried for a drug formulary and transmitted electronically using certified EHR technology. CMS finalizes the addition of an exclusion for the ePrescribing measure for any MIPS-eligible clinician who writes fewer than 100 permissible prescriptions during the performance period. Beginning with the 2017 performance period, MIPS-eligible clinicians who wish to claim this exclusion would select “yes” to the exclusion and submit a null value for the measure, thereby fulfilling the requirement to report this measure as part of the base score. Currently, MIPS-eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value.

Patient Electronic Access. This objective, with two measures, provides patients (or a patient-authorized representative) with timely electronic access to their health information and patient-specific education. CMS finalizes the definition of “timely” as within four business days of the information being available to the MIPS-eligible clinician, beginning with the 2018 reporting period. CMS states they may consider aligning the Medicaid EHR Incentive Program definition of timely in the future, which currently is a 48-hour standard in Stage 3.

CMS finalizes the revision of the ACI transition patient electronic access objective, beginning with in the 2017 performance period, by removing the word “electronic” from the description of timely access for measure one.

Patient-specific Education. CMS finalizes this ACI transition objective to state the MIPS-eligible clinician uses clinically relevant information from a certified EHR to identify patient-specific education resources and provide those resources to the patient. This change will begin with the performance period in 2017.

Health Information Exchange. This objective, with three measures, requires providing a summary of care record when a patient transitions, is referred to or received by another care setting or when the MIPS-eligible clinician has the first patient encounter with a new patient and incorporates summary of care information into their EHR. CMS finalizes the replacement of the term “health care clinician” with the term “health care provider” in the objective and in measures and finalizes this change will begin with the 2017 performance period.

For measure one, patient care record exchange, CMS previously finalized that for at least one transition of care or referral, the MIPS-eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care record and (2) electronically exchanges the summary of care record. CMS proposes an exclusion for any MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

For measure two, the MIPS-eligible clinician receives or retrieves and incorporates into the patient’s record an electronic summary of care document for at least one transition of care or referral received or patient encounter in which the MIPS-eligible clinician has never before encountered the patient. CMS finalizes an exclusion for any MIPS-eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS-eligible clinician has never before encountered the patient fewer than 100 times during the performance period

The ACI transition health information exchange objective requires MIPS-eligible clinician to use a certified EHR to create a summary of care record and electronically transmit such summary to a receiving health care provider for at least one transition of care or referral. The denominator is the number of transitions or care and referrals during the performance period for which the eligible professional was the transferring or referring health care provider. CMS finalizes an exclusion for any MIPS-eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

Medication Reconciliation. CMS finalizes a revision of the description in this ACI transition objective to state that the MIPS-eligible clinician who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation. CMS also finalizes a revision to the measure’s numerator by

removing medication list, medication allergy list and current problem list. This change will begin with the 2017 performance period.

Public Health and Clinical Data Registry Reporting. Public health and clinical data registry reporting includes five measures in the ACI category and three measures in the ACI transition category. CMS finalizes that MIPS-eligible clinicians may report measures other than the Immunization Registry and earn points for the performance score. CMS acknowledges there are areas of the country where immunization registries are not available. In the current regulation, only reporting to the immunization registry earns performance score points.

- *Measure 1 – Immunization Registry Reporting*. The MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
- *Measure 2 – Syndromic Surveillance Reporting*. The MIPS-eligible clinician is in active engagement with a public health agency to submit surveillance data from an urgent care setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.
- *Measure 3 – Electronic Case Reporting*. The MIPS-eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.
- *Measure 4 – Public Health Registry Reporting*. The MIPS-eligible clinician is in active engagement with a public health agency to submit data to public health registries.
- *Measure 5 – Clinical Data Registry Reporting*. The MIPS-eligible clinician is in active engagement to submit data to a clinical data registry.

ACI Transition Public Health Reporting measures:

- *Measure 1 - Immunization Registry Reporting*. The MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data.
- *Measure 2 – Syndromic Surveillance Registry Reporting*. The MIPS-eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.
- *Measure 3 – Specialized Registry Reporting*. The MIPS-eligible clinician is in active engagement to submit data to a specialized registry.

CMS clarifies that in order to earn the bonus score for public health and clinical data registry reporting, the MIPS-eligible clinician must be in active engagement with a different public health agency or clinical data registry than the one reported to earn the 10 percentage points for the performance score. **The AHA supports the increased flexibility in the public health and registry reporting measures.**

Hardship Exceptions in the ACI Category for Select MIPS-eligible Clinicians

CMS finalizes revisions to the hardship exceptions available for the ACI category for select MIPs-eligible clinicians. Specifically, CMS uses the authority provided in the 21st Century Cures Act for significant hardship exceptions under the ACI performance category to assign a zero percent weight for MIPS-eligible clinicians who successfully demonstrate a significant hardship.

CMS finalizes a new hardship exception for MIPS-eligible clinicians that cannot report on the measures specified for the ACI category due to the decertification of their EHR under the Office of National Coordinator for Health Information Technology's Health IT Certification Program. CMS finalizes that this exception will be subject to annual renewal, and a MIPS-eligible clinician will not be granted an exception for more than five years. CMS also finalizes that MIPS-eligible clinicians may qualify for this exception if their certified EHR was decertified either during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year. CMS states that MIPS-eligible clinicians must demonstrate in their application and through supporting documentation, if available, that they made a good faith effort to adopt and implement another certified EHR in advance of the performance period. CMS adds that a MIPS-eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by Dec. 31 of the performance period, or a later date specified by CMS.

ALTERNATIVE PAYMENT MODEL INCENTIVES

The MACRA provides incentives for physicians who participate in advanced APMs. These include a lump-sum bonus payment of 5 percent of payments for professional services in 2019 through 2024; exemption from MIPS reporting requirements and payment adjustments; and higher base payment updates beginning in 2026. In 2016, CMS finalized the criteria by which clinicians will be determined to be qualified APM participants (QPs) to receive these incentives.

CMS will use the following general process to determine whether a clinician participating in an APM is a QP:

- Determine whether the APM meets the criteria to be deemed an advanced APM;
- Identify the APM entity, which is the entity that is primarily responsible for the cost and quality of care provided to beneficiaries under the terms of a direct agreement with CMS; and
- Determine whether the eligible clinicians in the APM entity collectively meet the specified threshold of APM participation.

CMS will assess clinicians' participation in APMs in 2018 for the 2020 incentive payment. **The AHA continues to believe CMS could foster greater participation in advanced APMs by reassessing its requirement for downside risk. Nevertheless,**

CMS makes several incremental changes that we support, including the grandfathering of first year CPC+ participants in groups of more than 50 clinicians.

Advanced APM Determinations

The MACRA defines broad categories of Medicare payment models that may qualify as advanced APMs. Those include a demonstration model under Center for Medicare and Medicaid Innovation (CMMI) authority; the MSSP; and certain other demonstrations under federal law. Further, the statute requires that, to qualify as an advanced APM, a model must:

- Require participants to use certified EHR technology;
- Condition some amount of payment for covered professional services on quality measures comparable to those in the MIPS quality performance category; and
- Require that APM entities bear risk for monetary losses of more than a nominal amount. Alternatively, the APM entity may be a medical home under a model expanded under CMMI authority.

In this year's rule, CMS adopts a few changes to the standards it will use to determine whether an APM qualifies as an advanced APM for purposes of the APM incentive payment.

Generally Applicable Financial Risk Standard. In 2016, CMS finalized a standard that sets the total potential risk (i.e., the maximum potential payment for which an entity could be liable under the model) that most models must require to be considered an advanced APM. Specifically, under the standard finalized by CMS, the standard is met if the terms of the APM require that an APM entity potentially owes or forgoes the following amount:

- 3 percent of the expected expenditures for which an APM entity is responsible under the APM, such as through a benchmark or target price (the "benchmark standard"), or
- 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM entities (the "revenue-based standard").

CMS finalized the revenue-based standard only for the 2017 and 2018 performance periods, stating that it intended to increase the standard in subsequent years. However, CMS will now extend the 8-percent revenue-based standard to the 2019 and 2020 performance periods. The agency plans to evaluate the impact of the revenue-based standard and address any changes after 2020 through rulemaking.

Financial Risk Standard for Medical Homes. In 2016, CMS finalized a relaxed financial risk standard to allow qualified medical home models to qualify as advanced APMs without requiring significant downside risk. However, CMS limited the relaxed standard, beginning in 2018, to only those APM entities owned and operated by organizations

with 50 or fewer clinicians. The only existing model to qualify for the relaxed standard is the CPC+ model, which began Round 1 Jan. 1, 2017. CMS's limitation meant that CPC+ practices owned and operated by hospitals or health systems would be very unlikely to receive credit toward advanced APM incentives after 2017.

However, CMS will now exempt from the 50-clinician limitation all CPC+ practices enrolled in Round 1. Organizations that enroll in later rounds would be subject to the limitation. CMS states it is adopting this change because the limitation was enacted after Round 1 enrollees had signed agreements to participate in the CPC+ program. In contrast, future CPC+ participants will be aware of the requirement when they enroll. **The AHA is pleased that CMS will allow clinicians who partnered with hospitals as early adopters of the CPC+ models to receive advanced APM credit for those efforts.**

CMS also previously adopted policies for the amount of revenue that must be at risk under a medical home model in order to qualify as an advanced APM. Specifically, CMS finalized for 2017 that 2.5 percent of the medical home entity's total Medicare Parts A and B revenue must be at risk; the amount gradually increases to 5 percent in 2020 and beyond.

However, in this rule, CMS adopts a revised policy that increases the amount of risk more gradually. The total amount of revenue that an APM entity enrolled in a medical home model potentially forgoes or owes must be at least the following percentage of the entity's total:

- 2018 – 2.5 percent (reduced from 3 percent)
- 2019 – 3 percent (reduced from 4 percent)
- 2020 – 4 percent (reduced from 5 percent)
- 2021 and beyond – 5 percent

Partial Year APM Performance Period and QP Determination

In last year's rule, CMS finalized a QP performance period of Jan. 1 through Aug. 31 two years prior to the payment year (e.g., Jan.1 – Aug. 31, 2017 for payment year 2019). CMS will calculate QP status by comparing an APM entity's patient counts or payment amounts through the applicable advanced APM with all fee-for-service Medicare patient counts or payment amounts for the APM entity.

However, some APMs may start after Jan. 1 or end before Aug. 31, placing APM entities at a disadvantage if CMS calculates patient counts or payment amounts under the APM with all fee-for-service Medicare payment amounts or patient counts for the full performance year. Therefore, in this year's rule, CMS finalizes a two-pronged approach to account for "partial year APMs." First, CMS will consider only those advanced APMs that were actively tested for at least 60 continuous days during the applicable QP performance period. For example, for a partial year APM to count during the CY 2018

performance period, it would have to be active for at least 60 continuous days between Jan. 1 through Aug. 31, 2018.

Second, for "partial year APMs" that are active for at least 60 continuous days during the performance period, CMS will calculate Medicare fee-for-service payment amounts and patient counts only from the time period when the APM was "actively tested". For example, if a partial year APM is active from Mar. 1 through Aug. 31, 2018, CMS will calculate payment amounts and patient counts only from that time period.

All-payer Advanced APMs

In 2016, CMS finalized criteria that must be met by APM arrangements through Medicare Advantage, private payers and state Medicaid programs in order to qualify as advanced APMs in the all-payer option beginning in 2021. The MACRA imposes requirements for all-payer advanced APMs similar to those for Medicare APMs. Specifically, the arrangement must meet three criteria: certified EHR technology must be used; quality measures comparable to those in the MIPS quality category must apply; and the APM entity must bear more than nominal financial risk, or be a Medicaid medical home.

Generally Applicable Revenue-based Financial Risk Standard. In 2016, CMS finalized standards for the amount of risk that a payment arrangement with a non-Medicare payer must meet in order to qualify as an Other Payer Advanced APM. In contrast to Medicare advanced APMs, CMS did not create a revenue-based standard, only a benchmark-based standard.

CMS now adopts a revenue-based standard for Other Payer Advanced APMs, parallel to that for Medicare advanced APMs. Specifically, an Other Payer APM will qualify as an advanced APM if it meets the benchmark-based standard, or if it requires that the APM entity potentially owe or forgo at least 8 percent of the total combined revenues made by the payer to providers and suppliers in the APM entity.

Medicaid Medical Home Financial Risk Standard. CMS also finalizes changes to the standards for financial risk applicable to Medicaid medical homes, similar to those proposed for Medicare medical homes. For Medicaid medical homes, CMS will require that the minimum amount that an APM entity must potentially owe or forgo must be at least the following percentage of the entity's total revenue under the medical home arrangement:

- 2019 – 3 percent
- 2020 – 4 percent
- 2021 and beyond – 5 percent

Other Payer Advanced APM Determination Process. CMS finalizes its proposal to implement a "Payer Initiated Other Payer Advanced APM Determination Process," beginning in 2018. CMS will use this process to evaluate whether payment arrangements under Medicaid, Medicare Advantage and CMS multi-payer models (such

as CPC+) qualify as advanced APMs. Payers (including state Medicaid agencies) will be able to submit details of their payment arrangements to CMS in advance of the 2019 performance year to obtain pre-approval for their advanced APMs that participate in the financial arrangements. CMS intends to list these "pre-approved" arrangements on its website. CMS will extend this process to private payers starting in performance year 2020. The agency states that this would allow it to gain experience with the determination process before including private payers.

CMS also adopts processes for clinicians and APM entities to submit information and seek a determination that a financial arrangement qualifies as an Other Payer Advanced APM (the "APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process"). CMS will make available a standard submission form that will allow clinicians and APM entities to provide information and submit documentation on their arrangements with non-CMS payers.

However, CMS chose not to finalize its proposal to shorten the timeframe for the QP performance period under the all-payer option to Jan. 1 through Jun. 30. Rather, the performance period for the all-payer option will align with that of the rest of the program (i.e., Jan.1 through Aug. 31).

NEXT STEPS

While the rule is final, CMS requests comment on the policies it has adopted, along with several specific areas of future policy development. For example, the agency is interested in additional feedback on how to inform clinicians of their eligibility for the facility-based measurement option, and the process for opting in or out of the option. The agency also is accepting comments on the interim final rule providing relief to clinicians in hurricane-affected areas. Comments may be submitted electronically at www.regulations.gov through Jan. 1, 2018. Follow the instructions for "Comment or Submission" and enter the file code CMS-5522-FC (or CMS-5522-IFC for the interim final rule) to submit comments.

The AHA offers a full suite of MACRA products and resources for hospital leaders, physicians, trustees and others. At www.aha.org/MACRA you will find an on-demand webinar on the CY 2018 final rule, our MACRA Decision Guide, PowerPoint slides, an issue brief and other resources to help you understand MACRA and its implications to your organization.

FURTHER QUESTIONS

Please contact Akin Demehin, director of policy, at (202) 626-2365 or ademehin@aha.org.

APPENDIX 1: ADVANCING CARE INFORMATION OBJECTIVES AND MEASURES AND SCORING METHODOLOGY

Advancing Care Information Transition Objective	Advancing Care Information Measure	Base Score (50 percent of the ACI Score)	Performance Score (Up to 90 percent)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	Not included	Yes/No Statement
Electronic Prescribing	E-Prescribing	Required	Not included	Numerator / Denominator
	Provide Patient Access	Required	Up to 10 percent	Numerator / Denominator
	Patient-Specific Education	Not Required	Up to 10 percent	Numerator / Denominator
	View, Download or Transmit (VDT)	Not Required	Up to 10 percent	Numerator / Denominator
	Secure Messaging	Not Required	Up to 10 percent	Numerator / Denominator
	Patient-Generated Health Data	Not Required	Up to 10 percent	Numerator / Denominator
	Send a Summary of Care	Required	Up to 10 percent	Numerator / Denominator
	Request/Accept Summary of Care	Required	Up to 10 percent	Numerator / Denominator
	Clinical Information Reconciliation	Not Required	Up to 10 percent	Numerator / Denominator
Public Health Reporting	Immunization Registry Reporting	Not Required	Zero or 10 percent	Yes /No statement
	Syndromic Surveillance Reporting	Not Required	Zero or 10 percent. Bonus Points available	Yes / No Statement
	Electronic Case Reporting	Not Required	Zero or 10 percent.	Yes / No Statement

			Bonus Points available	
	Public Health Registry Reporting	Not Required	Zero or 10 percent. Bonus Points available	Yes / No Statement
	Clinical Data Registry Reporting	Not Required	Zero or 10 percent. Bonus Points available	Yes / No Statement

Advancing Care Information Category Objectives and Measures Bonus Points
Up to 25 Percent

Advancing Care Information Category Objective	Measure	Bonus Points	Reporting Requirement
	Syndromic Surveillance Reporting	Five Percent	Yes / No Statement
	Electronic Case Reporting	Five Percent	Yes / No Statement
	Public Health Registry Reporting	Five Percent	Yes / No Statement
	Clinical Data Registry Reporting	Five Percent	Yes / No Statement
Improvement Activity Category	Report one of 30 Improvement Activities	10 Percent	Yes / No Statement
Use of 2015 Edition certified EHR		10 Percent	Based upon the measures submitted

APPENDIX 2: ADVANCING CARE INFORMATION CATEGORY TRANSITION OBJECTIVES, MEASURES AND SCORING METHODOLOGY (AVAILABLE IN 2018)

Advancing Care Information Transition Objective	**Advancing Care Information Measure**	**Base Score**	**Performance Score**	**Reporting Requirement**
Protect Patient Health Information	Security Risk Analysis	Required	Not included	Yes/No Statement
Electronic Prescribing	E-Prescribing	Required	Not included	Numerator/Denominator
	Provide Patient Access	Required	Up to 20 percent	Numerator/Denominator
	View, Download, or Transmit (VDT)	Not Required	Up to 10 percent	Numerator / Denominator
Patient-Specific Education	Patient-Specific Education	Not Required	Up to 10 percent	Numerator/Denominator
Secure Messaging	Secure Messaging	Not Required	Up to 10 percent	Numerator/Denominator
Health Information Exchange	Health Information Exchange	Required	Up to 20 percent	Numerator/Denominator
Medication Reconciliation	Medication Reconciliation	Not Required	Up to 10 percent	Numerator / Denominator
Public Health Reporting	Immunization Registry Reporting	Not Required	Zero or 10 percent	Yes/No statement
	Syndromic Surveillance Reporting	Not Required	Zero or 10 percent. Bonus Points available	Yes/No Statement
	Specialized Registry Reporting	Not Required	Zero or 10 percent. Bonus Points available	Yes/No Statement

Advancing Care Information Category Transition Bonus Points
Up to 15 percent

Advancing Care Information Category Objective	Measure	Bonus Points	Reporting Requirement
	Syndromic Surveillance Reporting	Five Percent	Yes/No Statement
	Specialized Registry Reporting	Five Percent	Yes/No Statement
Improvement Activities Category	Report one of 30 Improvement Activities	Ten Percent	Yes /No Statement

APPENDIX 3: IMPROVEMENT ACTIVITIES ELIGIBLE FOR BONUS POINTS IN ADVANCING CARE INFORMATION CATEGORY)

Improvement Activity Performance Category Subcategory	Activity Name	Related Advancing Care Information Measure(s)
Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	Provide Patient Access Secure Messaging Send A Summary of Care Request/Accept Summary of Care
Patient Safety and Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	Secure Messaging Send a Summary of Care Request / Accept Summary of Care
	Consulting AUC using clinical decision support when ordering advanced diagnostic imaging	Clinical Decision Support (certified EHR function only)
	Cost Display for Laboratory and Radiographic Orders	Clinical Decision Support (certified EHR function only)
Population Management	Glycemic Screening Services	Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings
	Glycemic Management Services	Patient Generated Health Data Clinical Information Reconciliation Clinical Decision Support, CCDS, Family Health History (certified EHR functions only)
	Glycemic Referring Services	Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings
	Anticoagulant management improvements	Provide Patient Access Patient-Specific Education

Improvement Activity Performance Category Subcategory	Activity Name	Related Advancing Care Information Measure(s)
		View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting Send a Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation Exchange Clinical Decision Support (certified EHR function only)
	Provide Clinical Community Linkages	Provide Patient Access Patient-Specific Education Patient-Generated Health Data
	Chronic care and preventative care management for empaneled patients	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation Clinical Decision Support, Family Health History

Improvement Activity Performance Category Subcategory	Activity Name	Related Advancing Care Information Measure(s)
		(certified EHR functions only)
	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide Patient Access Patient-Specific Education Patient Generated Health Data or Data from Non-clinical Settings Send A Summary of Care Request/Accept Summary of Care Clinical information reconciliation Clinical Decision Support, CCDS, Family Health History, Patient List (certified EHR functions only)
	Implementation of episodic care management practice	Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation
	Implementation of medication management practice improvements across transitions and referrals	Clinical Information Reconciliation Clinical Decision Support, Computerized Physician Order Entry Electronic Prescribing (certified EHR functions only)
	Advance Care Planning	Patient-Specific Education Patient-Generated Health Data
Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	Send a Summary of Care Request/ Accept Summary of Care
	PSH Care Coordination	Send a Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Related Advancing Care Information Measure(s)
		Request/ Accept Summary of Care Clinical Information Reconciliation Health Information Exchange
	Implementation of use of specialists reports back to referring clinician or group	Send a Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation
	Implementation of documentation improvements for developing regular individual care plans	Secure Messaging Send a Summary of Care Request/ Accept Summary of Care
	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s)	Provide Patient Access View, Download, Transmit Secure Messaging Patient-Generated Health Data or Data from Non-clinical Setting
	Practice improvements for bilateral exchange of patient information	Send a Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation
Beneficiary Engagement	Engage Patients and Families to Guide Improvement in the System of Care	Patient-Generated Health Data Provide Patient Access View, Download, Transmit
	Use certified EHR to capture patient reported outcomes	Provide Patient Access Patient-Specific Education

Improvement Activity Performance Category Subcategory	Activity Name	Related Advancing Care Information Measure(s)
		Care Coordination through Patient Engagement
	Engagement of patients through implementation / access to enhanced patient portal	Provide Patient Access Patient-Specific Education
	Engagement of patients, family and caregivers in developing a plan of care	Provide Patient Access Patient-specific Education View, download, transmit (patient action) Secure Messaging
Patient Safety and Practice	Use of decision support and standardized treatment protocols to manage workflow in the team to meet patient needs	Clinical Decision Support (certified EHR function only)
Achieving Health Equity	Promote use of patient-reported outcome tools	Public Health Registry Reporting Clinical Data Registry Reporting Patient-Generated Health Data
Behavioral and Mental Health	Implementation of integrated Patient-centered Behavioral Health (PCBH) model	Provide Patient Access Patient-Specific Education View, download, transmit Secure Messaging Patient Generated Health Data or Data from Non-clinical Setting
	Electronic Health Record Enhancements for BH data capture	Patient Generated Health Data or Data from Non-clinical Setting Send a Summary of Care Request/ Accept Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Related Advancing Care Information Measure(s)
		Clinical Information Reconciliation