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Final Rule to Implement the Quality Payment Program

OVERVIEW

On October 14th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will implement provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA repeals the Medicare sustainable growth rate (SGR) physician fee schedule methodology and other payment models, and replaces them with a two-tracked Quality Payment Program (QPP).

The final rule establishes incentives for participation in Alternative Payment Models (APMs) and includes criteria for use by the Physician-Focused Payment Model Technology Advisory Committee (PTAC).

The provisions of the final rule are effective on January 1, 2017. This document summarizes several major provisions of the final rule. The final rule is available here.

QPP

Medicare providers currently participate in a variety of payment models, such as: accountable care organizations (ACOs); the Comprehensive Primary Care Initiative; the Physician Quality Reporting System; the Value Modifier Program; and the Electronic Health Record (EHR) Incentive Program, commonly referred to as "Meaningful Use."

In an effort to consolidate these programs and support the transition to value-based payments, the final rule establishes the QPP. The QPP includes two pathways for provider participation for certain Medicare-enrolled practitioners: the Merit-based Incentive Payment System (MIPS) and the Advanced APMs.

Participating Providers

CMS modified the proposed low-volume threshold for exclusion from QPP. Under the final rule, providers will be part of the QPP if they have $30,000 or more in Medicare-allowable charges a year and provide care for more than 100 Medicare patients a year. The proposed rule would have set the low-volume threshold at less than or equal to $10,000 in Medicare-allowable charges a year. As a result of this change, the number of low-volume providers that are excluded from QPP has increased.

Eligible providers will include: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that that include clinicians who bill under Medicare Part B.

MIPS

The final rule establishes the MIPS program. CMS finalized its proposal that providers will have their payments adjusted according to their composite score in the following performance categories:

1. *Quality* (60%) – Providers will choose to report a minimum of six measures that are relevant to their specialty. Quality measures will be selected annually from a list of measures that will be published by November 1st of each year. Providers will be required to choose at least one cross-cutting measure and one outcome measure. If a specialty-specific outcome measure is not available, the provider may choose to report on a high priority measure, such as: patient safety, appropriate use, or care coordination.
2. *Advancing Care Information* (25%) – CMS will require providers to report five measures that reflect how they use technology and exchange information, a decrease from 11 measures in the proposed rule. The remaining measures will be optional. Reporting on optional measures would allow a clinician to earn a higher score. Compared to Meaningful Use, this would: decrease the number of measures that are reported on, remove "all-or-nothing" EHR measurements and quality reporting requirements, and allow providers to report as a group.
3. *Clinical Practice Improvement Activities (CPIAs)* (15%) – CPIAs include efforts to improve care coordination, beneficiary engagement, and patient safety. Under the final rule, CMS is reducing the number of activities required to receive full credit from six medium-weighted or three high-weighted activities, as originally proposed, to four medium-weighted or two high-weighted activities in CY 2017. For small practices, rural practices, or practices located in geographic health professional shortage areas, this requirement will be reduced to only one high-weighted or two medium-weighted activities.
4. *Cost* (0%) – There will be no reporting requirements for this category. Providers will be scored according to 40 episode-specific measures based on their Medicare claims.

The cost category will be calculated in 2017, but it will not be used to determine the payment adjustment. In 2018, the cost category will start contributing to the final score. The cost category will gradually increase from 0 to 30 percent by 2021. The weight of the quality performance category will gradually decrease from 60 percent to 30 percent for year 2021 and beyond.

Timeline and Levels of Participation

CMS finalized its proposal to set the first performance period to begin on January 1, 2017. To allow time to understand the requirements of the QPP and become prepared to participate in the program, CMS has categorized CY 2017, the first performance period, as a "transition year" in order to encourage the participation, planning, and education of clinicians. CY 2019 will be the first payment year.

The final rule allows for more flexibility to begin participating in MIPS than the proposed rule. Providers participating in MIPS will be able to set their pace of participation depending on their level of readiness. CMS establishes three options for participation in the transition period and a penalty for nonparticipation:

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- **Test the QPP:** participants may submit data to the QPP from a period after January 1, 2017 as part of a readiness test. This option is intended to allow participants to ensure that their system is functioning properly, but does not require broader participation until 2018;
- **Participate for part of the CY:** participants may submit QPP information for a reduced number of days. Participants that submit 2017 data for 90 consecutive days may earn a neutral or small positive payment adjustment. The performance period may begin after January 1, 2017;
- **Participate for the full CY:** participants may choose to submit QPP information for a full CY. The first performance year will begin on January 1, 2017. Participants at this level could qualify for a moderate positive payment adjustment; and
- **Not participating in the QPP:** participants that do not send in any 2017 data will receive a negative four percent payment adjustment.

ADVANCED APMS

CMS finalized its proposal that participants may partake in QPP by joining an Advanced APM. Participants that receive sufficient Medicare payments or see enough Medicare patients through an Advanced APM will be excluded from MIPS requirements and qualify to receive a five percent incentive payment for 2017, to be paid in 2019.

For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and will receive a five percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and will receive a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

To be eligible for APM incentive payments, clinicians must meet either the following payment or patient requirements:

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

For 2017 and 2018, only services delivered to Medicare patients qualify clinicians for APM incentive payments. Starting in 2019, services delivered to non-Medicare patients may also qualify. Many clinicians who participate to some extent in APMs do not meet the law's requirements for sufficient participation in the most advanced models, but CMS expects the number of providers participating in Advanced APMs will increase over time. CMS estimates that approximately 70,000 to 120,000

clinicians will participate in Advanced APMs for the 2017 performance year and 125,000 to 250,000 clinicians will participate in Advanced APMs for the 2018 performance year. They are estimated to receive between $333 million and $571 million in APM Incentive Payments for calendar year 2019.

Eligibility Criteria

Advanced APMs must:

- Require participants to use certified EHR technology;
- Provide payment based on quality performance measures that are similar to those in MIPS; and
- Require that all participating APM entities bear risk for monetary losses of more than nominal amount under the APM, or be a Medical Home Model.

Included APMs

For 2017, CMS anticipates that Advanced APMs will include:

- The Comprehensive Primary Care Plus model;
- The Next Generation ACO model;
- Comprehensive ESRD Care Model;
- Medicare Shared Savings Program Track 2 and 3 participants; and
- Oncology Care Model (2-sided Track participants available in 2018).

For 2018, CMS anticipates that the following will qualify as Advanced APMs:

- ACO Track 1 Plus (a new model that CMS is considering testing);
- New Voluntary Bundled Payment Model; and
- Advancing Cardiac Care through Episode Payment Models (Cardiac and Joint Care).

For 2019 and 2020, clinicians may become eligible for incentives only through participation in Advanced APMs. For 2021 and later, clinicians may become eligible through participation in a combination of Advanced APMs and with other payer advanced APMs. The final rule reiterates that Medicare Advantage is not included in the advanced APM threshold calculations.

This list of Advanced APMs is subject to change. CMS will release a final list of 2017 APMs no later than January 1, 2017.

PTAC

The PTAC is an 11-member independent federal advisory committee to the HHS Secretary. The committee was established by MACRA to promote the development of physician-focused payment models (PFPMs). The PTAC will review stakeholder's proposals of PFPMs and make comments to the HHS Secretary on whether proposals meet criteria. The final rule outlines the criteria for use by the PTAC when reviewing stakeholder's proposals. PFPMs will be evaluated on whether they meet criteria including, but not limited to:

- Provide incentives to practitioners to deliver high-quality health care;
- Promote better care coordination, protect patient safety, and encourage patient engagement; and
- Encourage use of health information technology to inform care.