CMS Proposes Merit-Based Incentive Payment and Alternative Payment Model Physician Incentive Systems

The Centers for Medicare & Medicaid Services has issued a proposed rule that would establish a Merit-Based Incentive Payment System. MIPS would consolidate components of three existing programs, the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program for eligible professionals. The proposed rule also would establish incentives for participation in certain alternative payment models, further supporting the Administration’s goals of moving more fee-for-service payments into APMs.

The proposal is scheduled for publication in the Federal Register on May 9. A 60-day comment period ending June 27 is provided. A copy of the 962-page document is currently available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf. This link will change upon publication.

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 amended title XVIII to repeal the Medicare physician sustainable growth rate. CMS says this rule is needed to propose policies to improve physician payments by changing the way Medicare incorporates quality measurement into payments and does not contain succinct summaries of actions being proposed. The rule’s appendix (tables A-H) contain nearly 200 pages of tables reflecting required quality measures for 2017.

CMS devotes some 30 pages to explain the cost and time burdens associated the new quality systems. The total gross burden estimate includes 12,493,654 hours and a total annual cost of $1,327,177,683. Some of these amounts are not new, but carry forward from existing programs. Nonetheless, this is an expensive program. This is an important rule going forward and requires a deep understanding of its requirements. The following discussions are solely aimed at trying to explain the proposals and does not address the quality measures themselves. Much may change in the final rule inasmuch as CMS is asking more than 300 times for comments to its proposed actions.

COMMENT

This is a long, complex and difficult rule to follow, especially if one is not involved in the reporting of quality data. CMS’ proposed changes are not clearly identified and one must search for these actions. The proposal

continued
by developing new policies to address and incentivize participation in alternative payment models.

Generally, the MACRA did not change hospital participation in the Medicare EHR Incentive Program or participation for EPs in the Medicaid EHR Incentive Program.

MIPS applies to Medicare Part B clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialist, and certified registered nurse anesthetists. All Medicare Part B clinicians will report through MIPS during the first performance year, which begins January 2017. Medicare Part B clinicians may be exempted from the payment adjustment under MIPS if they: are newly enrolled in Medicare; have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients; or are significantly participating in an Advanced Alternative Payment Model.

**MEDICAID**

CMS does not propose any changes to the objectives and measures previously established in rulemaking for the Medicaid EHR Incentive Program, and thus EPs participating in that program must continue to report on the objectives and measures under the guidelines and regulations of that program.

**PROVISIONS OF THE PROPOSED REGULATIONS**

Section 101(b) of the MACRA calls for the sun-setting of payment adjustments under three existing programs for Medicare enrolled physicians and other practitioners:

- The PQRS that incentivizes EPs to report on quality measures;
- The VM that provides for budget neutral, differential payment adjustment for EPs in physician groups and solo practices based on quality of care compared to cost; and
- The Medicare EHR Incentive Program for EPs that entails meeting certain requirements for the use of certified EHR technology.

CMS proposes to revise certain regulations associated with these programs. CMS is not proposing to delete these regulations entirely, as the final payment adjustments under these programs will not occur until the end of calendar year 2018.

**Meaningful Use Prevention of Information Blocking and Surveillance Demonstrations for MIPS Eligible Clinicians, EPs, Eligible Hospitals and CAHs**

CMS is proposing to require EPs, eligible hospitals, and CAHs to attest (as part of their demonstration of meaningful use under the Medicare and Medicaid EHR Incentive Programs) that they have cooperated with the surveillance of certified EHR technology under the Office of the National Coordinator for Health Information Technology Health IT Certification Program.

CMS is proposing to revise the definition of a meaningful EHR user at §495.4 and the attestation requirements at §495.40(a)(2)(i)(I) and §495.40(b)(2)(i)(I) to provide that, for attestations submitted on or after April 16, 2016, an EP, eligible hospital, or CAH under the Medicare and Medicaid EHR Incentive Programs must attest to a three-part attestation.

- First, the eligible clinician, EP, eligible hospital or CAH would be required to attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
• Second, the eligible clinician, EP, eligible hospital or CAH would be required to attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times.

• Third, the eligible clinician, EP, eligible hospital or CAH would be required to attest that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 USC 300jj(3)), and other persons, regardless of the requestor’s affiliation or technology vendor.

MIPS Program Details

For the first and second year for which MIPS applies to payments, a MIPS eligible clinician is defined as a physician (as defined in section 1861(r) of the Act), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act), a certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act), and a group that includes such professionals.

CMS proposes to define a non-patient-facing MIPS eligible clinicians for MIPS at §414.1305 as an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period. This proposal includes telehealth services in the definition of patient-facing encounters.

MIPS Eligible Clinicians Who Practice In Critical Access Hospitals Billing Under Method II (Method II CAHs)

CMS proposes the MIPS adjustment does apply to Method II CAH payments under section 1834(g)(2)(B) of the Act when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights to the CAH.

MIPS Eligible Clinician Identifier

CMS is proposing to use multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or collectively through a group’s performance. CMS also proposes that the same identifier be used for all four performance categories; for example, if a group is submitting information collectively, then it must be measured collectively for all four MIPS performance categories: quality, resource use, Clinical Practice Improvement Activity, and advancing care information.

MIPS Performance Period

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

Performance Category Measures and Reporting

Section 1848(q)(2)(A) of the Act requires the Secretary to use four performance categories in determining each MIPS eligible clinician’s Composite Performance Scoring under the MIPS: quality; resource use; CPIA; and advancing care information. Payment adjustments would be scaled for budget neutrality, as required by statute.
Within each performance category, CMS proposes some specific standards, including:

- **Quality**: For most MIPS eligible clinicians, CMS proposes to include a minimum of six measures with at least one cross-cutting measure (for patient-facing MIPS eligible clinicians) and an outcome measure if available; if an outcome measure is not available, then the eligible clinician would report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an outcome measure. MIPS eligible clinicians can meet this criterion by selecting measures either individually or from a specialty-specific measure set.

- **Resource Use**: Continuation of two measures from the VM: total per costs capita for all attributed beneficiaries and Medicare Spending per Beneficiaries (MSPB) with minor technical adjustments. In addition, episode-based measures, as applicable to the MIPS eligible clinician.

- **CPIA**: Generally encouraging but are not requiring a minimum number of CPIAs.

- **Advancing Care Information**: Assessment based on advancing care information measures and objectives.

### Low-Volume Threshold

CMS proposes at §414.1305 to define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

### Performance Categories

#### Quality

Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS. MIPS allows Medicare clinicians to be paid for providing high value care through success in four performance categories:

- **Quality** (50 percent of total score in year 1) — replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program: Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. CMS says this category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.

- **Advancing Care Information** (25 percent of total score in year 1) — replaces the Medicare EHR Incentive Program for physicians, also known as “Meaningful Use”: Clinicians would choose to report customizable measures that reflect how they use electronic health record (EHR) technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement or quarterly reporting.

- **Clinical Practice Improvement Activities** (15 percent of total score in year 1) — Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices’ goals from a list
of more than 90 options. In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes.

- Resource Use (10 percent of total score in year 1) — The score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.

### Quality Data Submission Criteria
MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS measures in Table A or a set of specialty-specific measure set in Table E. [These tables are in the appendix of the rulemaking]

CMS proposes at §414.1325(e) the data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms would be March 31 following the close of the performance period.

The table below reflects CMS’ proposed Quality Data Submission Criteria for MIPS:

<table>
<thead>
<tr>
<th>Performance</th>
<th>Measure Type</th>
<th>Submission Mechanism</th>
<th>Data Completeness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 1 – Dec. 31</td>
<td>Individual MIPS eligible clinicians</td>
<td>Part B Claims</td>
<td>Report at least six measures including one cross-cutting measure and at least one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty specific measures in Table E. 80 percent of MIPS eligible clinician’s patients</td>
</tr>
<tr>
<td>Jan. 1 – Dec. 31</td>
<td>Individual MIPS eligible clinicians or Groups</td>
<td>QCDR Qualified Registry EHR</td>
<td>Report at least six measures including one cross-cutting measure and at least one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty specific measures in Table E. 90 percent of MIPS eligible clinician’s or groups patients</td>
</tr>
<tr>
<td>Jan. 1 – Dec. 31</td>
<td>Groups</td>
<td>CMS Web Interface</td>
<td>Report on all measures included in the CMS Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group’s sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries. Sampling requirements for their Medicare Part B patients</td>
</tr>
<tr>
<td>Jan. 1 – Dec. 31</td>
<td>Groups</td>
<td>CAHPS for MIPS Survey</td>
<td>CMS-approved survey vendor would have to be paired with another reporting mechanism to ensure the minimum number of measures are reported. CAHPS for MIPS Survey would fulfill the requirement for one crosscutting and/or a patient experience measure towards the MIPS quality data submission criteria. CAHPS for MIPS Survey will only count for one measure. Sampling requirements for their Medicare Part B patients</td>
</tr>
</tbody>
</table>

continued
Selection of Quality Measures for Individual MIPS Eligible Clinicians and Groups

In the first year of MIPS, CMS proposes to maintain a majority of previously implemented measures in PQRS for inclusion in the annual list of quality measures. These measures can be found in the appendix at Table A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017. Also included in the appendix in Table B is a list of quality measures that do not require data submission, some of which were previously implemented in the VM that CMS proposes to include in the annual list of MIPS quality measures. These measures can be calculated from administrative claims data and do not require data submission. CMS is also proposing measures that were not previously finalized for implementation in the PQRS program. These measures and their draft specifications are listed in Table D. The proposed specialty-specific measure sets are listed in Table E.

Section 1848(s)(1)(B) of the Act defines “quality domains” as at least the following: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention.

Under MIPS, CMS is proposing fewer cross-cutting measures than those available under PQRS for 2016 reporting; however, CMS believes the list contains measures for which all patient-facing MIPS eligible clinicians should be able to report, as the measures proposed include commonplace health improvement activities such as checking blood pressure and medication management. The proposed MIPS cross-cutting measure set can be found in Table C of the appendix.

Resource Use Performance Category

Section 1848(q)(2)(A)(ii) of the Act establishes “resource use” as a performance category. As required by section 1848(q)(5)(E)(i)(II)(bb) of the Act, the resource use performance category shall make up no more than 10 percent of the CPS for the first MIPS payment year (CY 2019) and not more than 15 percent of the CPS the second MIPS payment year (CY 2020). Starting with the third MIPS payment year and for each MIPS payment year thereafter, the resource use performance category would make up 30 percent of the CPS.

For the CY 2017 MIPS performance period, CMS proposes to utilize the total per capita cost measure, the MSPB measure, and several episode-based measures. CMS proposes at §414.1380(b)(2)(ii) to use a minimum of 20 cases for the MSPB measure.

The rule’s Tables 4 and 5 list 41 clinical condition and treatment episode-based measures proposed for the CY 2017 MIPS performance period, as well as whether the episodes have previously been reported in a Supplemental Quality and Resource Use Reports (sQRURs).

CMS notes that while it is proposing the measures listed in Tables 4 and 5, CMS is uncertain as to how many of these measures it will ultimately include in the final rule. As these measures have never been used for payment purposes, CMS may choose to specify a subset of these measures in the final rule.

Clinical Practice Improvement Activity Category

CMS proposes at §414.1355, that the CPIA performance category will account for 15 percent of the CPS.
CMS proposes in to allow for submission of data for the CPIA performance category using the qualified registry, EHR, QCDR, CMS Web Interface and attestation data submission mechanisms.

CMS proposes at §414.1380 to set the CPIA submission criteria under MIPS, in order to achieve the highest potential score of 100 percent, at three high-weighted CPIAs (20 points each) or six medium-weighted CPIAs (10 points each), or some combination of high and medium weighted CPIAs to achieve a total of 60 points for MIPS eligible clinicians participating as individuals or as groups (refer to Table H of the Appendix for CPIAs and weights).

**Advancing Care Information Performance Category**

CMS proposes at §414.1375 that performance in the advancing care information performance category will comprise 25 percent of a MIPS eligible clinician’s CPS for payment year 2019 and each year thereafter.

CMS is proposing that the score for the advancing care information performance category would be comprised of a score for participation and reporting, hereinafter referred to as the “base score,” and a score for performance at varying levels above the base score requirements, hereinafter referred to as the “performance score”.

<table>
<thead>
<tr>
<th>Base Score Primary Proposal Advancing Care Information Objective and Measure Reporting*</th>
<th>Objective</th>
<th>Measure</th>
<th>Total Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>2 Electronic Prescribing</td>
<td>ePrescribing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Patient Electronic Access</td>
<td>Patient Access Patient-Specific Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Coordination of Care Through Patient Engagement</td>
<td>View, Download or Transmit (VDT) Secure Messaging Patient-Generated Health Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Health Information Exchange</td>
<td>Patient Care Record Exchange Request/Accept Patient Care Record Clinical Information Reconciliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting (Optional) Syndromic Surveillance Reporting (Optional) Electronic Case Reporting (Optional) Public Health Registry Reporting (Optional) Clinical Data Registry Reporting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS has an alternate proposal for the base score of the advancing care information performance category, a MIPS eligible clinician would be required to submit the numerator (of at least one) and denominator, or yes/no statement as appropriate, for each measure, for all objectives and measures for Stage 3 in the 2015 EHR Incentives Program Final Rule (as outlined in the rule’s Table 7).

In addition to the base score, which includes submitting each of the objectives and measures in order to achieve 50 percent of the possible points within the advancing care information performance category, CMS proposes to allow multiple paths to achieve a score greater than the 50 percentage base score.
SCORING

**Scoring the Quality Performance Category**

CMS proposes to assign 1-10 points to each measure based on how a MIPS eligible clinician’s performance compares to benchmarks. The quality performance category score would be the sum of all the points assigned for the scored measures required for the quality performance category plus the bonus points (subject to the cap) divided by the sum of total possible points.

Since MIPS eligible clinicians would be generally required to submit six measures or six measures from a specialty measure set and CMS would also score MIPS eligible clinicians on up to three population-based measures calculated from administrative claims, the total possible points for the quality performance category would be 90 points (6 submitted measures x 10 points + 3 population-based measures x 10 points = 90).

For eligible groups reporting via CMS Web Interface, the total possible points for the quality performance category would be 210 [per CMS, but should this total be 200?] points (17 measures x 10 points + 3 population-based measures x 10 points = 200), subject to CMS Web Interface reporting criteria. Further, the total possible points for small groups of less than 10 would be 80 points (6 submitted measures x 10 points + 2 population-based measures x 10 points = 80). Therefore, small groups of less than 10 and MIPS eligible clinicians reporting as individuals would only be scored on two population-based measures.

**Quality Measure Benchmarks**

CMS proposes to establish benchmarks using a percentile distribution, separated by decile categories, “because it translates measure-specific score distributions into a uniform distribution of MIPS eligible clinicians based on actual performance values.”

The table below illustrates an example of using decile points along with partial points to assign achievement points for a sample quality measure.

<table>
<thead>
<tr>
<th>Decile</th>
<th>Sample Quality Measure Benchmarks</th>
<th>Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmark Decile 1</td>
<td>0-6.9%</td>
<td>1.0-1.9</td>
</tr>
<tr>
<td>Benchmark Decile 2</td>
<td>7.0-15.9%</td>
<td>2.0-2.9</td>
</tr>
<tr>
<td>Benchmark Decile 3</td>
<td>16.0-22.9%</td>
<td>3.0-3.9</td>
</tr>
<tr>
<td>Benchmark Decile 4</td>
<td>23.0-35.9%</td>
<td>4.0-4.9</td>
</tr>
<tr>
<td>Benchmark Decile 5</td>
<td>36.0-40.9%</td>
<td>5.0-5.9</td>
</tr>
<tr>
<td>Benchmark Decile 6</td>
<td>41.0-61.9%</td>
<td>6.0-6.9</td>
</tr>
<tr>
<td>Benchmark Decile 7</td>
<td>62.0-68.9%</td>
<td>7.0-7.9</td>
</tr>
<tr>
<td>Benchmark Decile 8</td>
<td>69.0-78.9%</td>
<td>8.0-8.9</td>
</tr>
<tr>
<td>Benchmark Decile 9</td>
<td>79.0-84.9%</td>
<td>9.0-9.9</td>
</tr>
<tr>
<td>Benchmark Decile 10</td>
<td>85.0%-100%</td>
<td>10</td>
</tr>
</tbody>
</table>

In the example above, a MIPS eligible clinician with a measure performance rate of 41 percent would receive 6.0 points based on the benchmark. MIPS eligible clinicians with measure performance rates of 85 percent or above would receive 10 points because they were in the top benchmark decile.

continued
COMMENT
The above does not reflect numerous alternatives in scoring. The reader needs to review the proposal for additional information.

Scoring the Resource Use Performance Category
For the resource use performance category, CMS proposes to score the resource use measures similarly to the quality performance category. CMS proposes to create a single set of benchmarks for each measure specified for the resource use performance category.

CMS proposes that for resource use measures, lower costs represent better performance.

<table>
<thead>
<tr>
<th>Benchmark Decile 1</th>
<th>Average Resource Use</th>
<th>Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000 or more</td>
<td>1.0-1.9</td>
<td></td>
</tr>
<tr>
<td>Benchmark Decile 2</td>
<td>$75,893-$99,999</td>
<td>2.0-2.9</td>
</tr>
<tr>
<td>Benchmark Decile 3</td>
<td>$69,003-$75,892</td>
<td>3.0-3.9</td>
</tr>
<tr>
<td>Benchmark Decile 4</td>
<td>$56,009-$69,002</td>
<td>4.0-4.9</td>
</tr>
<tr>
<td>Benchmark Decile 5</td>
<td>$50,300-$56,008</td>
<td>5.0-5.9</td>
</tr>
<tr>
<td>Benchmark Decile 6</td>
<td>$34,544-$50,299</td>
<td>6.0-6.9</td>
</tr>
<tr>
<td>Benchmark Decile 7</td>
<td>$27,900-$34,543</td>
<td>7.0-7.9</td>
</tr>
<tr>
<td>Benchmark Decile 8</td>
<td>$21,656-$27,899</td>
<td>8.0-8.9</td>
</tr>
<tr>
<td>Benchmark Decile 9</td>
<td>$15,001-$21,655</td>
<td>9.0-9.9</td>
</tr>
<tr>
<td>Benchmark Decile 10</td>
<td>$1,000-$15,000</td>
<td>10</td>
</tr>
</tbody>
</table>

Unlike the quality performance category score, CMS is not proposing bonus points as part of the resource use performance category score.

Scoring the CPIA Performance Category
CMS proposes a scoring methodology that assigns points for the CPIA performance category (based on patient-centered medical home participation and the CPIAs reported by the MIPS eligible clinician).

CMS proposes to assign points for each reported activity within two categories: medium-weighted and high-weighted activities. Medium-weighted activities are worth 10 points. High-weighted activities are worth 20 points.

The rule’s Table H in the Appendix provides the CPIA Inventory of all activities, both medium-weighted and high-weighted.

Scoring the Advancing Care Information Performance Category
In the advancing care information performance category, CMS proposes to score for both participation and performance. CMS refers to these scoring methods as the “base score” and the “performance score.”

continued
Calculating the Composite Performance Score

The CPS is the sum of the products of each performance category score and each performance category’s assigned weight multiplied by 100.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>2019 MIPS Payment Year</th>
<th>2020 MIPS Payment Year</th>
<th>2021 MIPS Payment Year and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

MIPS PAYMENT ADJUSTMENTS

The law requires MIPS to be budget neutral. Therefore, clinicians’ MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments.

In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent. The positive adjustments will be scaled up or down to achieve budget neutrality, meaning that the maximum positive adjustment could be lower or higher than 4 percent.

Per the law, both positive and negative adjustments would increase over time. Additionally, in the first five payment years of the program, the law allows for $500 million in an additional performance bonus that is exempt from budget neutrality for exceptional performance. This exceptional performance bonus will provide high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent. As specified under the statute, negative adjustments would increase over time, and positive adjustments would correspond. The maximum negative adjustments for each year are: 2019 - 4%; 2020 - 5%; 2021 - 7%; 2022 and after 9%.

CMS is proposing to use a single identifier, TIN/NPI, for all MIPS eligible clinicians, regardless of whether the TIN/NPI was measured as an individual, group or APM Entity group. In other words, a TIN/NPI may receive a CPS based on individual, group, or APM Entity group performance, but the payment adjustment would be applied at the TIN/NPI level.

For the 2019 MIPS payment year, CMS proposes to set the performance threshold at a level where approximately half of the eligible clinicians would be below the performance threshold and half would be above the performance threshold, which CMS says it believes is consistent with the intent of section 1848(q)(6)(D)(i) of the Act which requires the performance threshold in year 3 and beyond to be equal to the mean or median of CPS from a prior period.
OVERVIEW OF INCENTIVES FOR PARTICIPATION IN ADVANCED ALTERNATIVE PAYMENT MODELS

Section 1833(z) of the Act, as added by section 101(e)(2) of the MACRA, requires that an incentive payment be made to Qualifying APM Participants (QPs) for participation in eligible alternative payment models (referred to as Advanced APMs).

QPs would receive the APM Incentive Payment as specified in section 1833(z) of the Act for each of the years they qualify from 2019 through 2024, and the differential update incentive in section 1848(d)(20) of the Act for each of the years they qualify beginning in 2026. Per section 1833(z)(1)(A) of the Act, the APM Incentive Payment that an eligible clinician receives as a QP for a year between 2019 and 2024 is a lump sum payment equal to 5 percent of the QP’s estimated aggregate payments for Medicare Part B covered professional services (services paid under or based on the Medicare PFS) for the prior year.

Eligible clinicians who are QPs for a year are also excluded from MIPS for that year. In addition, beginning in 2026, QPs receive a higher Medicare PFS update (the “qualifying APM conversion factor”) than non-QPs. This QP determination is made for one calendar year at a time.

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. The participation requirements are specified in statute and increase over time.

Advanced APMs are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily-required demonstrations where clinicians accept both risk and reward for providing coordinated, high quality, and efficient care. These models must also meet criteria for payment based on quality measurement and for the use of EHRs.

The proposed rule lays out specific criteria for determining what would qualify as an Advanced APM. These include criteria designed to ensure that primary care physicians have opportunities to participate in Advanced APMs through medical home models.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program — Track 2
- Medicare Shared Savings Program — Track 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

CMS will continue to modify models in coming years to help them qualify as Advanced APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based, in part, on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs. The proposed rule also establishes the Physician-Focused Payment Technical Advisory Committee to review and assess additional physician-focused payment models suggested by stakeholders.