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Implementing the Medicare Access & CHIP Reauthorization Act of 2015—the Merit-Based Incentive Program and Alternative Payment Models

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The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)[1] was enacted to reform Medicare payment methods with the primary goal of promoting value over volume in the provision of medical care. MACRA repeals the Medicare Sustainable Growth Rate formula previously used to update the Medicare physician fee schedule and replaces it with a Quality Payment Program (QPP) that combines the current quality reporting programs into a single cohesive system. On October 14, 2016, the Department of Health and Human Services (HHS) issued its Final Rule[2] implementing the QPP to advance the goal of encouraging physicians to provide high-quality efficient medical care as further described below.

Physicians may choose to participate in one of two tracks under the QPP: (1) the Merit-Based Incentive Payment System (MIPS) track; or (2) the Advanced Alternative Payment Model (APM) track. Both options will be implemented over a timeline spanning from 2015 to 2022, and beyond.

The MIPS allows clinicians participating in traditional Medicare Part B to earn a performance-based payment adjustment to their Medicare reimbursement based on their performance in four main categories:

1. Quality (2017) (replacing the Physician Quality Reporting System (PQRS));
2. Advancing Care Information (2017) (replacing the Medicare Electronic Health Record (EHR) Incentive Program also known as Meaningful Use);
3. Clinical Practice Improvement (2017) (new category); and
4. Cost (2018) (replacing the Physician Value-Based Modifier Program (PM)).

The APM track allows physicians to participate in the QPP through APMs. For this purpose, APMs include certain payment approaches that offer added incentive payments in exchange for the provision of high-quality and cost-efficient care. Some examples of APMs are certain shared savings programs, patient-centered medical homes, and bundled payment models.

[1] Pub. L. No. 114 10 (Apr. 16, 2015).
[2] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77008-01 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).

MACRA Objectives and Context Within Payment Reform

In January 2015, the Centers for Medicare & Medicaid Services (CMS) announced new goals for transforming Medicare, including its intent to move Medicare fee-for-service (FFS) payments toward APMs and FFS models linked to quality.[3] As part of this initiative, CMS set an aggressive goal to have 90% of all traditional Medicare payments tied to quality or value by 2018.[4] MACRA, including the QPP, are integral parts of this strategy, driving Medicare's compensation system from one that rewards volume toward one that rewards value. In CMS' view, MACRA and the QPP build on the coverage expansions and improved access of the Affordable Care Act (ACA) to further increase focus on the quality and value of care delivered, and work with the ACA's provisions, such as the Medicare Shared Savings Program and creation of the Medicare and Medicaid Innovation Center, to introduce new payment models to the American health care system.

According to CMS, MACRA "marks a milestone" in efforts to improve and reform the American health care system, in that, by promoting participation in APMs (like the Medicare Shared Savings Programs) and by paying physicians for quality and value under MIPS, the program will support the nation's progress toward achieving "a patient-centered health care system that delivers better care, smarter spending, and healthier people and communities."[5]

CMS acknowledges the diversity among physician practices, and the fact that changes in technology, infrastructure, and physician support systems will likely change physician practices in the future. The QPP has been designed to offer physician practices differing levels of participation, and is intended to provide a flexible approach toward participation rather than imposing a "one-size-fits-all" system. Additionally, given anticipated changes

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[3] U.S. Centers for Medicare and Medicaid Services, *Better Care, Smarter Spending, Healthier People: Paying Providers for Value, Not Volume* (Jan. 26, 2015), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html.

[4] U.S. Department of Health and Human Services, Digital Communications Division (last updated Mar. 14, 2012), *available at* http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html.

[5] 81 Fed. Reg. 77008–77009.

in the health care landscape, CMS expects the QPP to evolve over multiple years to achieve national goals. In early years, CMS intends to use the program to lay the groundwork for expansion toward an "innovative, outcome-focused, patient-centered, resource effective health system."[6] Through a staged approach, CMS intends to further develop policies that "are operationally feasible and made in consideration of system capabilities and our core strategies to drive progress and reform efforts."[7]

CMS has articulated six strategic objectives for the QPP, which it claims have guided development of its final policies and will guide future rulemaking with the goals of improving health outcomes, promoting smarter spending, minimizing the burdens of participation, and to provide fairness and transparency in operation.[8] Specifically, these strategic goals are:

- To improve beneficiary outcomes and engage patients through patient-centered advanced APM and MIPS policies;
- To enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools;
- To increase the availability and adoption of robust advanced APMs;
- To promote program understanding and maximize participation through customized communication, education, outreach, and support that meet the demands of the diversity of physician practices and patients, especially the unique needs of small practices;
- To improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders; and
- To ensure operational excellence in program implementation and ongoing development.[9]

[6] *Id.*
[7] U.S. Department of Health and Human Services, *QPP Executive Summary* (Oct. 14, 2016), *available at* https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf.
[8] 81 Fed. Reg. 77008, 77010.
[9] *Id*.

In CMS' view, by incorporating these objectives, the QPP provides "new opportunities to improve care coordination and population health management,"[10] and by setting ambitious yet achievable goals, CMS argues that clinicians will be able to move with "greater certainty" toward implementing these new approaches. To ensure the success of the QPP and the meeting of its strategic goals, CMS acknowledges that it must provide ongoing support, education, and technical assistance to clinicians for them to understand program requirements and successfully use the available tools to meet the program's goals. Finally, CMS also recognizes the need for excellence in program management to focus on customer needs, promote problem-solving and teamwork, and to provide the leadership necessary to continuously improve the program.

General Timeline of MACRA Implementation

- *October 14, 2016:* CMS announced the final regulations for the Quality Payment Programs (QPP) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), offering physicians the option to "pick their pace" for participating in QPP.
- *January 1, 2017:* The first performance period under MACRA begins for providers who are ready to collect record quality data and demonstrate how new technologies were implemented to support their practice.
- *October 2, 2017:* The first performance period for 2017 ends. Providers who are not ready to collect record quality data on January 1, 2017, may pick their pace and begin collecting data any time between January 1, 2017, and October 2, 2017.
- *December 31, 2017:* The first performance year under MACRA closes for all providers.
- *March 31, 2018:* Performance data, including record quality data and the use of new technology to support the practice of medicine, must be submitted. Medicare will provide feedback regarding each provider's performance following data submission in 2018.

[10] *Id*.

- *2019:* The first performance-based payment adjustments begin on January 1, 2019. Providers who participated under MIPS in the first performance year and submitted data by March 31, 2018, may receive positive, negative, or neutral payment adjustments based on performance. APM members who participated in the first performance year may earn a 5% incentive payment.[11]

Payment Timeline for APMs

- *2019 to 2024:* Providers receiving 25% of Medicare payments or seeing 20% of Medicare patients through an APM will receive a lump-sum payment of 5% annually in addition to any incentives paid through the existing APM.

Payment Timeline Under MIPS

- *2017 and 2018:* Physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists, and certified registered nurse anesthetists will be affected by MIPS. [Note, however, that performance in 2017 will not have an effect on payment until 2019.]
- *2019 and beyond:* Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dieticians/nutritional professionals will be affected by MIPS.
- *Pick your pace performance levels for 2017:*
    - *Not participating in the QPP:* A provider who does not submit any data for the first performance period will receive a negative 4% payment adjustment.
    - *Submitting some data:* A provider who submits a small amount of data, such as a single quality measure, will receive a neutral payment

[11] U.S. Centers for Medicare & Medicaid Services, *Timeline*, *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.pdf.

adjustment, meaning it will neither be penalized by a negative payment adjustment nor rewarded with a positive payment adjustment.

  - *Submitting part of a year's data:* A provider who submits at least 90 days' worth of data may also earn a neutral payment adjustment or a small positive payment adjustment.
  - *Submitting a full year's worth of data:* Providers submitting all data for the 2017 performance period may earn up to a 4% positive payment adjustment.
- *2020:* Providers submitting data under MIPS may receive up to a 5% positive or negative payment adjustment.
- *2021:* Providers submitting data under MIPS may receive up to a 7% positive or negative payment adjustment.
- *2022 and beyond:* Providers submitting data under MIPS may receive up to a 9% positive or negative payment adjustment.[12]

Track 1: Merit-Based Incentive Payment System (MIPS)

The MIPS track is available to certain Medicare-participating eligible clinicians and is intended to make payment adjustments based on performance on quality, cost, and other measures. The MIPS program is focused not only on improving health care quality, efficiency, and patient safety but also advancing the strategic goal of providing a meaningful and flexible program to encourage participation by MIPS-eligible clinicians.

After publishing the MACRA Proposed Rule in April 2016, CMS received many comments voicing frustration over its provisions. Many believed the MIPS requirements were too burdensome. In response to the comments received, CMS made a concerted effort to reduce the required measures and reporting requirements. The MACRA Final Rule included provisions designed to minimize some of the administrative burdens of MIPS-eligible clinicians. MIPS streamlines three existing programs—the PQRS, the VM,

[12] *Id.*

and the Medicare EHR Incentive Program—and consolidates them into a single payment system.

MIPS will be based on a composite score from four categories: (1) quality; (2) improvement activities; (3) advancing care information; and (4) cost. The total composite score will be used to determine the reimbursement the clinician is eligible to receive. The principal way MIPS measures quality of care is through evidence-based clinical quality measures that MIPS eligible clinicians can select. Over time the portfolio of quality measures will grow and develop.

2017—Pick Your Pace

Recognizing that it will be difficult for providers to participate and meet all the requirements in the QPP for 2017, the Final Rule provides that 2017 will be a transition year for eligible clinicians. During the 2017 transition year, eligible clinicians are allowed to pick their pace of participation for this first performance period (as further described above).

Eligible Clinicians & Exemptions

Most clinicians will be subject to MIPS in 2017. MIPS applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. There are exceptions for the following providers: newly enrolled Medicare clinicians, clinicians below the low-volume threshold, and clinicians significantly participating in Advanced APMs. Newly enrolled Medicare clinicians are those who enroll in Medicare for the first time during a performance period. Such clinicians are exempt from reporting measures and activities for MIPS until the following performance year. The low-volume threshold exception applies to clinicians who bill Medicare for $30,000 or less or provide care for 100 or fewer Medicare Part B beneficiaries during the performance period.

Small Practices

CMS notes that many small practices will be excluded from the new requirements due to the low Medicare volume threshold. According to CMS, protecting small and independent physician practices is an important objective of MACRA. The Final Rule allows solo and small practices to join “virtual groups” to combine their MIPS reporting. The Final Rule caps the eligible clinicians participating in virtual groups at ten individuals or less. Even though virtual groups will not be implemented during the 2017 transition year, solo clinicians and small practices should consider promptly exploring with whom they would like to partner in their virtual groups as this determination must be made prior to the start of the performance period. MACRA mandated $100 million in technical assistance to be given to eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas (HPSAs) in an effort to educate and maximize participation.

Performance Categories

Quality Performance

The current PQRS will be replaced by the quality category, which will make up 60% of the total composite MIPS score in the initial payment year in 2019. The quality category percentage of the total MIPS score will decrease to 50% in the 2020 payment year and will decrease further in 2021 to 30%. After the 2021 payment year, the quality category percentage will level out and remain at 30% of the total MIPS composite score as demonstrated by the following table:

MIPS Performance Year	Payment Year	Quality Percentage of MIPS Score
2017	2019	60%
2018	2020	50%
2019	2021	30%
2020	2022	30%

While the quality category contains similar reporting measures as the PQRS, the Final Rule reduces the number of measures to be reported from nine to six, including at least one outcome measure. If an outcome measure is not applicable, then the clinician should report one other high-priority measure (i.e., a measure related to appropriate use, patient safety, efficiency, patient experience, and care coordination) in lieu of an outcome measure. CMS clarified that if a clinician is unable to identify six measures that are applicable to the clinician or her organization, then the clinician should report only those measures that apply. Alternatively, an eligible clinician or group can report one specialty-specific measure set or the measure set defined at the subspecialty level, if applicable.

CMS will compile an annual list of quality measures that will be published in the *Federal Register* by November 1 of the year prior to the first day of the next performance year. Any changes or removal of quality measures will be established through notice-and-comment rulemaking. Eligible clinicians or their group organizations are allowed to submit potential quality measures for selection on the annual list. However, only measures submitted before June 1 of each year for the performance period starting two years after the measure is submitted will be considered in the annual list.

Data Submission. Eligible clinicians can submit their quality measures in a variety of ways including: a qualified registry, EHR Submission, a Qualified Clinical Data Registry (QCDR), or via Medicare Part B claims. Practice groups composed of 25 or fewer

eligible clinicians may submit their MIPS quality measures through a CMS web interface.

Scoring. In calculating a quality performance score, each of the six quality measures is converted to a score between one and ten. All quality measures are added together and compared to a performance benchmark. Benchmarks are based on using historical Medicare claims data with a minimum of 20 individuals or groups reporting on the specific measure.

Gaming. CMS is aware that there is potential for "gaming" the system and will monitor whether MIPS-eligible clinicians appear to actively select submission mechanisms and measure sets with few applicable measures. If CMS believes that "gaming" deterrence policies are necessary, these additional policies will be proposed through future rulemaking.

Cost Performance

The cost performance category (referred to as "resource use" in the Proposed Rule) is modeled after the current VM Program. The VM is an adjustment to Medicare payments for items and services under the Medicare Physician Fee Schedule. It is applied at the Taxpayer Identification Number (TIN) level to physicians. The Value Modifier measures both quality and cost. The cost performance category under MIPS is essentially replacing the cost component of the VM. Under the cost performance category, CMS will be using two cost measures from the VM and several episode-based measures. For 2017, CMS will calculate two cost measures: total per capita costs and Medicare spending per beneficiary (MSPB).

For attribution of cost measures, eligible clinicians will only be assessed on cost for those Medicare patients attributed to the individual clinician. As stated in the Proposed Rule, eligible clinicians or groups that cannot attribute enough Medicare patients to exceed the case minimums will not be measured on cost performance. CMS will evaluate cost performance at the individual TIN/National Provider Identifier levels.

Similar to the VM, clinicians will not need to submit separate data for the cost performance category as CMS will determine performance through Medicare administrative claims.

Evaluation for the cost performance category will not be calculated for the first payment year in 2019. This means that for the 2017 transition year, the cost performance category will be weighted at 0%. CMS will be collecting and calculating cost performance data during the 2017 transition year, but such data will have no effect on eligible clinicians' reimbursement as it is only for information purposes to educate the clinicians. As more data becomes available, the cost performance score will increase as a greater percentage of the total MIPS score. For payment in 2020, cost performance will increase to 10% of the MIPS score. Following in 2021, cost performance will rise to 30% of the MIPS score and remain at this level for future years. The rising cost performance percentage balances the MIPS equation as the quality score is initially rated higher but decreases over time. As mentioned in commentary to the Final Rule, CMS recognized that clinicians do not personally provide or determine the prices of individual services, but they do believe that clinicians have the ability to impact cost through the volume and type of services that are provided to a patient through better coordination of care and improved outcomes. CMS will monitor existing cost measures and incorporate any new measures as necessary through future rulemaking.

Scoring. In calculating a cost performance score, each measure is converted to a score between one and ten and is based on performance relative to the established benchmark. The benchmark for each measure will be determined based on cost data from the performance period. CMS is still working to finalize a policy to create benchmarks for cost measures. CMS will award points for each measure based on how a provider scored in relation to overall performance. CMS will add up all the points from each measure and divide by the total possible points available.

Improvement Activities Performance

The improvement activities performance is a new category and does not replace an existing program. Under MACRA, an improvement activity is defined as an activity that eligible clinicians or groups identify as improving clinical practice or care delivery in patient outcomes. Activities considered improving outcomes include expanding access to care, care coordination, beneficiary engagement, and patient safety, and participating in APMs and medical home models. For 2017 and beyond, improvement activities will account for 15% of the total MIPS score.

To receive credit for performing an improvement activity, the eligible clinician or group must perform the activity for at least 90 days during the performance period. Additionally, if the eligible clinician or group started the activity prior to the performance period and continues performance, credit will be given provided that the activity was engaged in for at least 90 days during the performance year. CMS will actively monitor improvement activities and may consider extended time requirements in the future if it is necessary to achieve more effective outcomes.

Similar to the quality performance category data submission, eligible clinicians can submit their improvement activity performance data through a qualified registry, EHR Submission, a QCDR, CMS web interface or attestation.

The improvement activity performance score is based on participation in certain activities. The activities are scored differently based on whether the activity is a high-weighted activity or a medium-weighted activity. Performing a high-weighted activity will earn 20 points while performing medium-weighted activities contributes 10 points to the score. The highest score possible to achieve credit for improvement activities is 40 points. This means that eligible clinicians must attest to two high-weighted activities, four medium-weighted activities, or any other combination of high and medium-weighted activities. Clinicians who are unable to complete all of their requirements can still earn partial credit based on the weighting of the improvement activities they performed. If a clinician chooses not to complete any improvement activities, the clinician will receive a score of zero.

Clinicians are eligible to choose from potential various activities as CMS wants to give clinicians the flexibility to select activities that best fit their practices. The activities are broken down into the following subcategories:

- Expanded Practice Access
    - Use of same-day appointments for urgent needs and after-hours access to clinician advice
- Population Management
    - Monitoring health conditions of individuals to provide timely health care interventions or participation in a QCDR
- Care Coordination
    - Timely communication of test results; timely exchange of clinical information to patients and other clinicians; and use of telehealth
- Beneficiary Engagement
    - Establishment of care plans for individuals with complex care needs; beneficiary self-management assessment and training; and use of shared decision-making mechanisms
- Patient Safety and Practice Assessment
    - Use of clinical or surgical checklists and practice assessments related to maintaining certification
- Participation in an APM
- Achieving Health Equity
    - Performing high quality care for underserved populations
- Emergency Preparedness and Response
    - Measuring participation in disaster medical teams or participation in domestic or international humanitarian volunteer work
- Integrated Behavioral and Mental Health
    - Measuring and evaluating certain practices, including, for example, co-location of behavioral health and primary care services; shared/integrated behavioral health and primary care records; or cross-training of eligible clinicians or groups participating in integrated care

A listing of all the activities is contained in Table H of the Final Rule Appendix. CMS will add any new subcategory only under limited circumstances.

Exceptions for reporting requirements will be made for the following clinicians: small practices (group consisting of 15 or fewer clinicians), eligible clinicians in rural areas or HPSAs, and non-patient facing MIPS-eligible clinicians. These clinicians can achieve the highest score possible by completing only two improvement activities that can be either medium or high-weighted. Participation in patient-centered medical home models or APMs alone can qualify eligible clinicians or groups to earn 100% or 50% respectively of the potential improvement activities score. In an effort to ease reporting requirements during the 2017 transition year, credit earned for improvement activities performed using EHR technology can also count as a bonus point in the Advancing Care Information Category. According to the Final Rule commentary, CMS believes these requirements are not burdensome on clinicians due to the following reasons: (1) no minimum hour requirements for performing an activity; (2) broad list of activities (over 90) to pick from in the Final Rule; and (3) activities must be performed for only 90 days during the performance period to earn credit.

Advancing Care Information Performance Category

The EHR incentive program that was established under the Health Information Technology for Economic and Clinical Health Act, will sunset under MACRA. However, EHR meaningful use will continue as the “Advancing Care Information” performance category (ACI). Under ACI, CMS is adopting a more flexible scoring methodology that puts greater focus on patient access to protected health information and health information exchange to encourage interoperability. The ACI category will account for 25% of the MIPS overall score.

The ACI category will only apply to non-hospital-based physicians as physicians employed by hospitals likely have little control over the implementation or utilization of hospital EHRs. It is important for hospital-employed physicians to keep in mind that their ACI scores will be zero since they have no reporting obligations for this measure. This

does not mean the zero score will negatively affect their overall MIPS score. But hospital-employed physicians need to focus on hitting their goals for the quality and improvement activity performance categories in 2017 and both of these performance measures including cost performance once this category begins in 2018.

Scoring. The ACI category score is based on a score for participation ("ACI Base Score"), a score for performance determined by varying levels above the base requirements ("ACI Performance Score") and potential bonus points ("ACI Bonus Points"). An eligible clinician can receive up to 50 points for the ACI Base Score, 90 points for an ACI Performance Score, and 15 ACI Bonus Points for a possible overall MIPS ACI score of 155. However, once clinicians receive a score of 100, no additional points will be counted because the clinician will receive full credit the ACI category.

The ACI Base Score can be achieved by:

1. Utilizing the required Certified Electronic Health Record Technology (CEHRT) during the performance period.
2. Reporting a numerator (of at least 1) and a denominator, or yes/no statement as applicable for the following five measures:
    a. Electronic prescribing;
    b. Patient electronic access;
    c. Security risk analysis;
    d. Summary of care record; and
    e. Summary of care measure.
3. Affirmatively attesting to support information exchange and prevent information blocking.
4. Cooperating in good faith and, if requested, cooperating in good faith with the Office of the National Coordinator for Health Information Technology's direct review of the clinician's health information technology.

If a clinician doesn't receive an ACI Base Score, then the clinician will receive a zero for the ACI category. For the ACI Performance Score, a clinician may earn a possible ten points on each of the following measures: provide patient access; patient-specific

education; view, download or transmit; secure messaging; patient-generated health data; send a summary of care; request/accept summary of care record; clinical information reconciliation; and immunization registry reporting. It is important for clinicians to consider which measures fit best with his/her practice and focus on performing well on those measures. A clinician can earn ACI Bonus Points by reporting affirmatively for any measures under the Public Health and Clinical Data Registry Reporting measures. As mentioned previously, an eligible clinician can receive bonus points for reporting at least one improvement activity using CEHRT.

Performance Feedback and Review Process

CMS has not yet finalized a process for providing performance feedback to clinicians. CMS will initially provide performance feedback on an annual basis but aims to provide feedback more frequently during later years. Clinicians will be given the option of requesting a CMS targeted review process that will analyze the calculation of the MIPS payment adjustment.

Track 2: Advanced Alternative Payment Models

The second track in the QPP involves participation in an APM. APMs were embraced by the ACA, which established the CMS Innovation Center to develop and test payment and service delivery models to shift provider payment systems from volume-based to value-based care. APMs include, for example, the Medicare Shared Savings Program, Medicare Health Care Quality Demonstration Programs, and Medicare Acute Care Episode Demonstration Programs. Advanced APMs are a subset of APMs that fulfill certain additional requirements established in the MACRA Final Rule. APMs that meet the criteria to be Advanced APMs allow eligible clinicians to become qualifying APM participants, instead of participating in the MIPS track, and eligible to earn a 5% incentive payment each year from 2019 through 2024 for their involvement in an Advanced APM.

CMS created two categories of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. Other Payer Advanced APMs are payment arrangements with Medicaid or a commercial payer. Both categories of Advanced APMs must: (1) require participants to use certified EHR technology, (2) provide payment based on quality measures comparable to those in the quality performance category under MIPS, and (3) require participants to bear risk for monetary losses of more than a nominal amount, or be a Medical Home Model expanded under the CMS Innovation Center (for an Advanced APM), or be a Medicaid Medical Home Model (for Other Payer Advanced APMs).

As mentioned above, an Advanced APM requires participants to bear risk for monetary losses of more than a nominal amount, or be a Medical Home Model or Medicaid Medical Home Model. These models are APMs with a patient-centered health care delivery system in which a physician or other practitioner establishes an ongoing relationship with patients and provides comprehensive care. CMS established two core requirements for this type of model. To be an APM, the medical home model must include primary care practices or multispecialty practices that include primary care physicians and practitioners who offer primary care services, and each patient must be assigned to a primary practitioner. In addition, a medical home model must have at least four of the following elements: planned coordination of chronic and preventive care, patient access and continuity of care, risk-stratified care management, coordination of care across the medical neighborhood, patient and caregiver engagement, shared decision making, and payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).[13]

Eligible clinicians can become qualifying APM participants (QPs) based on their level of participation in an Advanced APM each year. CMS will score eligible clinicians based on the clinician's payments or patient count. Under the payment method, the clinician must receive at least 25% of their Medicare Part B payments through an Advanced APM. Under the patient count method, a clinician must see at least 20% of their patients through an Advanced APM.

[13] 81 Fed. Reg. 77008, 77403 (Nov. 4, 2016).

The steps to follow the Advanced APM track in the QPP are as follows: (1) the design of an APM meets the specified criteria for it to be deemed an Advanced APM; (2) an entity with a group of individual eligible clinicians participates in the Advanced APM; (3) CMS determines whether, during a performance period, the eligible clinicians in the Advanced APM entity collectively have at least 25% of their aggregate Medicare Part B payments for covered professional services, or at least 20% of patients received covered professional services through the Advanced APM; (4) all of the eligible clinicians in the Advanced APM entity are designated QPs for the payment year associated with that performance period.[14]

Since APMs already have performance assessments, CMS will solely assess the design of an APM to determine whether it is an Advanced APM. This is an important distinction from the MIPS track. CMS is not adding further performance assessments on top of existing Advanced APM standards. The QP determination process assesses the relative degree of participation of eligible clinicians and entities in Advanced APMs, not their performance as assessed under the APM.[15] Each APM will continue to utilize its own measurements and rewards for success within its design without alteration. The purpose of the Advanced APM track under the Quality Payment Program is to recognize and reward a substantial degree of participation in an APM.[16]

CMS has announced that the following programs are considered Advanced APMs for 2017:

- Medicare Shared Savings Program (two-sided models; Tracks 2 and 3);
- Next Generation ACO Model;
- Comprehensive ESRD Care;
- Comprehensive Primary Care Plus; and
- Oncology Care Model.

[14] *Id.* at 77400.
[15] *Id.* at 77408.
[16] *Id*.

In 2018, CMS anticipates that these programs also will qualify as Advanced APMs:

- ACO Track 1+;
- New voluntary bundled payment model;
- Comprehensive Care for Joint Replacement Payment Model (CEHRT track); and
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track).

With regard to APMs that offer multiple options or tracks with variations in the level of financial risk, or multiple tracks designed for different types of organizations, CMS will independently assess the eligibility of each such track or option within the APM to determine whether it is an Advanced APM.

The incentive to take the Advanced APM track and become a QP is significant: for years 2019 through 2024, QPs receive a lump sum incentive payment equal to 5% of their prior year's payments for Part B covered professional services. It is important to note that this incentive payment expires after six years. Beginning in 2026, QPs will then receive a higher update under the Physician Fee Schedule than non-QPs.[17]

Practical Resources

For additional information about MACRA and each of the tracks described above, please see the following links:

CMS

MACRA: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

[17] *Id.* at 77400.

QPP: https://qpp.cms.gov/

MIPS Track: https://qpp.cms.gov/learn/qpp

APM Track: https://qpp.cms.gov/learn/apms

AMA

MACRA: www.ama-assn.org/MACRA