



**Medicare Access and CHIP Reauthorization Act (MACRA)
Quality Payment Program Final Rule
AMA Summary
October 19, 2016**

On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) [released the final rule](#) with comment period to implement MACRA's Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). Collectively, these programs are part of what CMS now calls the Quality Payment Program (QPP). CMS has also issued a [fact sheet](#), an [executive summary](#), and an [online toolkit](#) on the payment program. **It is evident from an initial review of the rule that CMS adopted numerous AMA recommendations and made significant improvements, including reducing reporting requirements for physicians to avoid penalties, creating a more realistic and flexible transition period, increasing the low-volume threshold that exempts more physicians, and eliminating the cost category in calculating the 2017 composite performance scores.** The AMA will continue to pursue every opportunity to work with CMS to further improve the QPP and develop practical tools to help physicians succeed under the program. Additional materials are listed below and are available on the AMA's [MACRA resource page](#), which will be updated as new details and information become available.

***** = *Notes changes that were strongly advocated for by the AMA.*

Quality Payment Program Overview

CMS finalized a transition year for the 2017 performance period, during which **the only physicians who will experience a -4 percent payment penalty in 2019 are those who choose not to report any performance data.** Physicians can avoid the payment penalty in 2019 by reporting for one patient on one quality measure, one improvement activity, or the 4 required Advancing Care Information (ACI) measures in 2017. Physicians who wish to possibly qualify for a positive payment adjustment must report more than the minimum one patient for one quality measure, improvement activity or the 4 required ACI measures.

Merit-Based Incentive Payment System (MIPS)

Overarching Issues

- **Shortens performance period:** Physicians who report for at least 90 continuous days in any of the three categories that will be included in the 2017 score will be eligible for positive payment adjustments.*
 - *The 2017 transition year with a 90-day reporting period is a significant reduction from the full calendar year reporting period that CMS required in the proposed rule.*
- **Increases low-volume threshold:** CMS raised the low-volume threshold in the proposed rule to exempt physicians from all performance reporting to \$30,000 in annual Medicare revenue or 100 or fewer Part B-enrolled Medicare beneficiaries. CMS estimates that this change will exempt 32.5 percent of eligible clinicians from the program.*
 - *The proposed rule called for a threshold of \$10,000 in annual Medicare revenue and less than 100 Medicare patients.*
- **Increases non-patient facing eligible clinicians encounter threshold:** CMS expanded the definition of a non-patient facing physician as an individual clinician that bills 100 or fewer patient-facing encounters during the non-patient facing determination period.

- *CMS had previously proposed to define a non-patient facing clinician as an individual clinician that bills 25 or fewer patient-facing encounters.*
- **Provides for individual or group reporting:** The final rule retains a provision allowing data submission and performance assessment to be done at either the individual or group level. Physicians must choose to report as an individual or group consistently across all MIPS categories. CMS also plans to allow physicians to participate in virtual groups beginning in 2018.

Quality

- **Reduces reporting burden:** Physicians are required to report on 6 measures or a specialty measure set, one of which must be an outcome measure or, if no outcome measures are available, a high priority measure.*
 - *This requirement is a decrease from the 9 quality measures physicians were previously required to report under the Physician Quality Reporting System (PQRS). CMS also eliminated the proposal to report on a cross-cutting measure as one of the six quality reporting measures.*
- **Reduces administrative claims measures:** An all-cause hospital readmissions measure was finalized for groups of 15 (up from 10 in the proposed rule) or more physicians and with 200 attributed cases. The measure will be calculated based off of administrative claims data.*
 - *CMS eliminated its proposal to score physicians on the acute and chronic composite measures using administrative claims data.*
- **Reduces data completeness criteria:** In 2017, any physician who reports on one quality measure for at least one patient will receive at least 3 points on the measure, thereby avoiding a payment adjustment in 2019.
- **Reduces reporting thresholds:** In 2017, physicians have to report on a measure successfully on 50 percent of patients, and in 2018, physicians have to report on a measure successfully on 60 percent of patients. CMS intends to increase the measure thresholds over time. If a physician is only avoiding a penalty and not attempting to earn an incentive, they are only required to report on one patient in 2017.*
 - *In the proposed rule, CMS required that physicians reporting via registry, Electronic Health Record (EHR), or Qualified Clinical Data Registry (QCDR) had to report on 90 percent of patients to report a measure successfully, and that physicians reporting via claims had to report on 80 percent of Medicare Part B patients to report a measure successfully.*
- **Increases quality percent of composite performance score:** 60 percent of the composite performance score will be based on the quality performance category in 2017, due to the reduction of the cost performance category weight to zero percent. 50 percent of the composite performance score will be based on the quality performance category in 2018. In 2019 and beyond, 30 percent of the composite performance score will be based on the quality performance category.*
 - *In the proposed rule, the quality category was weighted as 50 percent of the composite performance score in 2017.*
- **Encourages the use of QCDRs and electronic sources:** CMS provides preferential scoring for physicians who report quality measures through an EHR, qualified registry, QCDR, or web-interface.

Cost (Resource Use in proposed rule)

- **Reduces weight of composite performance 2:** In 2017, the cost performance category is reduced to zero percent of the composite performance score. In 2018, the cost performance category is reduced to 10 percent of the composite performance score. In 2019 and beyond, the cost performance category will make up 30 percent of the composite performance score as required by MACRA. Although this category will not count in the composite performance score, CMS will calculate scores on the cost measures and provide them as informational to physicians in 2017.*

- *This is a reduction from CMS' proposal to weight the resource use category as 10 percent of the composite performance score in 2017.*
- **Phases in episode-based measures:** CMS finalized 10 episode based measures in 2017, and plans to finalize additional episode-based measures in future years.*
 - *This is a decrease from the 41 episodes listed for possible use in the proposed rule.*
- **Retains two problematic cost measures currently used in the value modifier:** CMS finalized the total per capita cost and Medicare Spending Per Beneficiary (MSPB) administrative claims cost measures. The minimum number of cases required to count the total cost measure is 20. The minimum case threshold for the MSPB measure is 35.
- **Tools to improve cost measurement are under development:** CMS is developing patient condition groups and patient relationship codes to assist with attribution beginning in 2018, as well as working for future years to refine its risk-adjustment methodologies.

Improvement Activities (Clinical Practice Improvement Activities in proposed rule)

- **Reduces reporting burden:** Physicians must attest to two 20-point high weighted activities, four 10-point medium-weighted activities, or another combination of high and medium weighted activities equaling 40 points or more to achieve full credit in the CPIA category.*
 - *This is a reduction from CMS' proposal that physicians report three 20-point high weighted activities or six 10-point medium-weighted activities (or another combination of high and medium weighted activities equaling 60 or more points) to achieve full credit in the CPIA performance category.*
- **Provides accommodations for small, rural, health professional shortage areas (HPSAs) and non-patient facing physicians:** A lower reporting threshold of two medium-weighted or one high-weighted improvement activities are required for small, rural, HPSA and non-patient facing physicians to receive full credit.*
 - *This is a reduction from CMS' proposal that small, rural, HPSAs or non-patient facing physicians report two CPIAs regardless of weight to receive full credit.*
- **Finalizes 90-day reporting period:** CMS finalized its proposal to only require a 90-day performance period for Improvement Activities.*
- **Increases number of highly-weighted activities:** The final rule increases the number of highly-weighted activities available to physicians, including participation in rural health clinics.*
- **Expands definition of medical homes eligible for full Improvement Activity credit:** Participants that have received certification or accreditation as a Patient Centered Medical Homes (PCMH), or comparable specialty practices, including those certified by a national, regional or state program, private payer or other body that administers PCMH accreditation and certifies 500 or more practices for PCMH accreditation or comparable specialty practice certification will receive full credit in the CPIA performance category.
- **Provides full credit for MIPS APMs:** APM Entities participating in the 2017 MIPS APMs receive a full score for the Improvement Activities in 2017. The eligible MIPS APMs are subject to change in future years. Other APMs are eligible for at least half-credit.*
 - *This is an increase from CMS' proposal that APMs—regardless of the model—would only receive half credit in the CPIA category.*
- **Incentivizes use of certified electronic health record technology (CEHRT):** Physicians may receive preferential scoring in the ACI category by using CEHRT to perform one or more of 18 designated improvement activities.*

Advancing Care Information (Replaces Meaningful Use)

- **Reduces reporting burden:** Physicians must report on all required ACI measures in the Base Score (4 in 2017 and 5 thereafter), with up to an additional 9 optional measures in the Performance Score, for which physicians may receive additional percentage points. The Base Score measures are met via

one unique patient or attestation to a “yes” option. The Performance Score measures are eligible for partial credit.*

- *This is a reduction from CMS’ proposal to require reporting on 11 measures in the Base Score.*
- **Temporarily shortens reporting period:** In 2017 and 2018, physicians must report the ACI measures for a minimum of 90-days.*
 - *This is a reduction from CMS’ proposal that physicians must report ACI measures for a full year beginning in 2017.*
- **Promotes coordination between performance categories:** Physicians can earn preferential scoring in the ACI performance category by reporting to public health and clinical data registries, and by using CEHRT to complete certain activities in the improvement activities performance category.*
- **Eliminates measures:** CMS finalized its proposal to eliminate the Clinical Decision Support (CDS) and Computerized Physician Order Entry (CPOE) measures from the Advancing Care Information measures.*
- **Retains a pass-fail element:** CMS finalized a pass-fail element in the base performance score, as physicians must report on all measures in the base score in order to earn a score in the ACI performance category.

Alternative Payment Models (APM)

Advanced APMs

- **Reduces the amount of losses defined as “more than nominal” in Advanced APMs:** An APM will qualify as an Advanced APM in 2019 and 2020 if the APM Entity is either (1) at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or (2) at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower. CMS states that it plans to increase the risk standard to 10 or 15 percent of revenues in future years.*
 - *This is a significant reduction from CMS’ proposed financial risk requirements in which physicians were expected to pay up to 4 percent of total Medicare spending (as opposed to revenue) in order to qualify as an Advanced APM.*
- **Simplifies the definition of “more than nominal financial risk”:** To qualify as a Medicare Advanced APM, the APM must only meet the requirement for total risk.*
 - *The final rule eliminated the requirements for “marginal risk” and “minimum loss rate” and retained only the requirement for total risk for Medicare APMs.*
- **Adopts flexible CEHRT and quality requirements:** In 2017, 50 percent of participants in Advanced APMs would need to use CEHRT. To satisfy quality measure requirements, Advanced APM participants would be required to report quality measures similar to those used in the MIPS quality performance category.*
 - *CMS dropped its proposal to increase the number of physicians that must use CEHRT from 50 percent to 75 percent in the second year.*
- **Indicates future APM expansion:** CMS acknowledged the need to expand the number of APMs quickly in the final rule. CMS indicates that it plans to modify existing programs, such as the Bundled Payments for Care Improvement initiative, so they meet the Advanced APM requirements. It also plans to develop a new MSSP ACO Track 1+ that requires less downside risk than current Track 2 and Track 3 ACOs, but sufficient risk to meet the Advanced APM standards.*

MIPS APMs

- **MIPS APM requirements:** MIPS APM participants can improve their MIPS scores in APMs that do not meet criteria to be Advanced APMs or if the physicians are participating in Advanced APMs but do not meet the revenue or patient thresholds to be exempt from MIPS.

- Medicare Shared Savings Program and Next Generation ACOs would report quality for participants and the CPIA and ACI performance categories will be reweighted to 20 percent and 80 percent respectively.
- Non-ACO MIPS APM participants will have their quality score reweighted to zero for the 2017 performance period and the CPIA and ACI performance categories will be reweighted to 25 percent and 75 percent respectively.
- Each year, CMS will compare the requirements of the APM with the list of Improvement Activities and score those measures in the same manner they are otherwise scored for MIPS eligible clinicians. Prior to the start of each performance period, CMS will publish a list of the pre-assigned Improvement Activities score for each MIPS APM. In the event that the assigned score does not represent the maximum Improvement Activities score, APM Entities will have the opportunity to report additional Improvement Activities.
- **Patient-Centered Medical Homes definition:** Medical homes that have received certification or accreditation as a patient-centered medical home (PCMH) or comparable specialty practices, including those certified by a national program, regional or state program, private payer, or other body that administers PCMH accreditation and certifies 500 or more practices, will receive full credit in the CPIA performance category.*
 - *CMS expanded the recognized certification entities to include state, regional, and private programs.*

Physician-Focused Payment Models (PFPMs)

- **PFPMs:** The final rule expanded the definition of PFPM to include practitioners other than physicians. Payment models can target the quality and costs of services that other practitioners provide, order, or significantly influence, rather than just physician services.

Physician Attestation Requirements

- **The Office of the National Coordinator for Health Information Technology (ONC) Direct Review:** Physicians must attest that they engaged in good faith in “Supporting Providers with the Performance of Certified Electronic Health Record (EHR) technology” (SPPC) activities related to ONC’s direct in-the-field review of EHRs.
 - Physicians must attest to their acknowledgment of the requirement to cooperate in good faith with ONC’s direct review of EHRs if a request to assist in ONC direct review is received.
 - A physician who receives a request must also attest that they cooperated in good faith with ONC’s direct review of EHRs.*
- **Prevention of Information Blocking:** To be a meaningful EHR user, a physician must demonstrate that they have not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the interoperability of their EHR. Including attestation that they:
 - did not knowingly and willfully take to limit or restrict the interoperability of their EHR;
 - implemented technologies, standards, policies, practices, and agreements to ensure—and did not limit or restrict—the exchange of electronic patient data in their EHR; and
 - responded in good faith and in a timely manner to requests to retrieve or exchange electronic patient information—including from patients, health care providers and other persons regardless of the requestor’s affiliation or EHR vendor.

Current AMA and CMS Resources

[AMA Medicare Physician Payment Resources](#)

(Includes the New AMA Payment Model Evaluator)

[CMS’ Quality Payment Program Website](#)

[CMS’ Small Practice Fact Sheet](#)

[CMS’ Comprehensive List of APMs](#)