2018 Proposals for MACRA's Quality Payment Program (QPP)

The Centers for Medicare & Medicaid Services (CMS) in June released a proposed rule with detailed proposals affecting the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP). The QPP includes two main components, Advanced Alternative Payment Models (Advanced APMs) and, for those not in Advanced APMs, the Merit-Based Incentive Payment System (MIPS). 2017 is the first QPP performance year and corresponds to Medicare Physician Fee Schedule payment adjustments in 2019. NAACOS developed The *ACO Guide to MACRA* which provides a detailed analysis of the 2017 QPP requirements. This proposed rule focuses on changes for 2018 performance, which following a comment period and final rule, will be effective for the 2018 performance year and correspond to the 2020 payment adjustment year. Depending on the particular ACO model or track, ACOs are evaluated either as Advanced APMs or participate in MIPS under a special scoring standard and set of criteria for APMs. NAACOS has developed the following summary of the 2018 Proposed QPP rule, outlining the key components for ACOs to be aware of. NAACOS will submit comments on the proposed rule, which will be followed by a final rule likely to be released in the fall of 2017.

Advanced APM Proposals

Advanced APM Participation Growth

CMS estimates the number of providers qualifying for Advanced Alternative Payment Model (Advanced APM) bonuses will roughly double in the second year of the program, which includes the 2018 performance year and 2020 payment adjustments. The agency estimates that around 70,000 to 120,000 providers will earn Advanced APM bonuses in the first performance year of the program and in the second year that number will grow to between 180,000 and 245,000. This expected growth is due in part to reopening of the Next Generation ACO Model and the Comprehensive Primary Care Plus (CPC+) for 2018, and the introduction of the Medicare Shared Savings Program (MSSP) Track 1+, which is projected to have a large number of participants. Overall, CMS estimates the agency will pay aggregate 2020 Advanced APM bonuses between $590 million and $800 million.

Advanced APM Risk Thresholds

A key criterion for an APM to be designated as Advanced is that the model requires a sufficient amount of risk. In the rule, CMS proposes to maintain the current revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the 2019 and 2020 performance periods, rather than raising the threshold as the agency previously discussed. CMS notes it may consider changing this revenue-based threshold after 2020. There are no proposed changes for the 3 percent benchmark-based standard.

CMS requests comments on whether the agency should create a different, potentially lower, revenue-based nominal risk standard for the 2019 and 2020 performance years for small or rural practices as well as small and/or rural practices that join larger APM Entities in order to participate in APMs. CMS would define rural areas as ZIP codes designated as rural in the Health Resources and Services Administration (HRSA)

Area Health Resource File data set, and a small practice would be one that consists of 15 or fewer clinicians and solo practitioners.

The amount of required risk for APMs considered under the Medical Home Model standard is different and CMS proposes changes to these requirements for future years. Specifically, CMS proposes to lower the Medical Home Model nominal risk standard from 2.5 percent in 2017 to 2 percent in 2018. The table below details the proposed minimum risk levels that an APM Entity would potentially owe CMS or forego under the Medical Home Model risk standards.

Proposed Nominal Risk Thresholds for Medical Home Models

Medicare QP Performance Period	% of Ave. Estimated Total Medicare Part A and B Revenue for All Providers/Suppliers in Participating APM Entity in a Medical Home Model
2018	2%
2019	3%
2020	4%
2021	5%

APMs Introduced During the Performance Year

CMS proposes flexibility to allow new Advanced APMs that start during a performance year to have an opportunity to qualify for Advanced APM bonuses. Those that start during the performance period can qualify for Advanced APM bonuses as long as they participate for at least 60 continuous days during the performance period. CMS proposes to modify its policies regarding the timeframe for which payment amount and patient count data are included in the Qualifying APM Participant (QP) calculations for Advanced APMs that start after January 1 or end before August 31. In these situations, CMS would calculate QP Threshold Scores using only data in the numerator and denominator for the dates that APM Entities participated, as long as it was at least 60 continuous days during the Medicare QP Performance Period, which is January 1 to August 31.

Eligible Clinician Participation in Multiple Advanced APMs

CMS proposes to amend its regulations to make clear that if an eligible clinician (EC) is a determined to be a QP based on participation in multiple Advanced APMs, but any of the APM Entities in which he or she participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the EC is not a QP. As a reminder, ECs are only evaluated using participation in multiple Advanced APMs if none of their corresponding Advanced APM Entities meet the QP thresholds as a collective entity.

Medical Home Model Size Restrictions

CMS proposes to remove size limit requirements for practices in CPC+ Round 1 qualifying for the Advanced APM bonus. Specifically, CMS proposes to modify its previously finalized requirement that beginning with the 2018 performance period the Medical Home Model risk standard would only apply to APM Entities with fewer than 50 ECs. Under this policy, in order to qualify for Advanced APM bonuses CMS required that these APM Entities either are themselves comprised of fewer than 50 ECs or are owned/operated by an organization with fewer than 50 ECs. However, in this rule CMS proposes to allow primary care practices participating in Round 1 of CPC+ to remain eligible for the Advanced APM bonus in 2020 regardless of their practice size or relationship to a parent organization. Unfortunately, and despite repeated requests from NAACOS to do so, CMS does not propose to modify its policy that MSSP Track 1 ACO primary care practices are not eligible for Advanced APM bonuses based on their Track 1 or CPC+ participation.

All-Payer Combination Option

Overview and Risk Standard

While Advanced APMs are only evaluated based on traditional Medicare in the early years of the Quality Payment Program (QPP), beginning with the 2021 payment adjustment year, which corresponds to 2019 performance, CMS will give ACOs and other APM Entities credit for qualifying APM participation with payers outside of Medicare, including Medicare Advantage (MA), Medicaid and commercial plans. The agency proposes a number of details on how this process would work. Developing a robust All-Payer Combination Option to allow clinicians to qualify for Advanced APM bonuses will be especially important as the QP thresholds become increasingly challenging in future program years. CMS proposes that the All-Payer QP Performance Period begin on January 1 and end on June 30 of the calendar year that is two years prior to the payment year.

In addition to the criteria already in place for Other Payer APMs to count towards the All-Payer Combination Option, which are detailed in NAACOS's resource *The ACO Guide to MACRA*, CMS proposes to add a revenue-based nominal risk standard of 8 percent, which matches the revenue-based standard for Medicare Advanced APMs. This standard would allow Other Payer APMs with risk levels based on revenue to qualify as Advanced and would be in addition to the 3 percent benchmark-based risk standard CMS previously finalized.

CMS Determination of Whether Other Payer APMs Qualify as Advanced

In order for CMS to evaluate and subsequently give credit for ACO/clinician participation with Other Payer Advanced APMs, the agency must first determine whether a specific Other Payer APM meets the required criteria for it to be considered an Advanced APM. CMS would approve Other Payer APMs based on those submitted for review by the agency. The reviews could be requested in a number of ways. For example, under a payer-initiated process the payer would submit information to CMS and under an Eligible Clinician Initiated Process, ECs or APM Entities such as ACOs could request an Other Payer Advanced APM determination by CMS. The agency will develop forms detailing what information would be required as part of these requests, and the process would be voluntary for those requesting review. There are different evaluation standards for Medicaid APMs to qualify as Other Payer APMs, and there would be a different review process as well. CMS also proposes that a state could request determinations for its Medicaid Fee for Service (FFS) and Medicaid managed care plan payment arrangements.

CMS proposes to phase in its All-Payer approach in the 2019 and 2020 performance periods, with the first submissions for 2019 performance occurring as early 2018. While certain plans including MA plans could submit information in 2018, it's important to note that information would be for the purposes of determining whether that plan meets 2019 performance year Other Payer APM criteria. Therefore, despite calls from NAACOS to do so, CMS does not propose changing the overall timeframe to count Other Payer APMs toward meeting the QP thresholds and the 2019 performance period still relates to the 2021 Advanced APM bonus. However, CMS does acknowledge receiving feedback from stakeholders requesting that the agency modify its previously established timeframe and give credit for MA APM participation sooner. The agency requests comments on this, and therefore CMS could potentially revise its timeframes in the final 2018 MACRA QPP rule.

Following CMS review of the information submitted, the agency would determine whether a payment arrangement meets the Other Payer Advanced APM criteria. CMS intends to post on its website a list of all Other Payer arrangements that the agency determines qualify as Other Payer Advanced APMs. CMS proposes that an EC or APM Entity submitting information to CMS about an All-Payer APM must maintain for 10 years after submission any contracts, records, documents, and other evidence as necessary to enable a potential audit of an Other Payer Advanced APM or QP determination and related Advanced APM bonus.

CMS Table 52: Other Payer Advanced APM Determination Process for Medicare Health Plan Payment Arrangements for All-Payer QP Performance Period 2019

	Payer Initiated Process	Date	Eligible Clinician Initiated Process*	Date
Medicare Health Plans**	Guidance sent to Medicare Health Plans – submission period opens	April 2018	Guidance made available to ECs – Submission period opens	Aug. 2019
	Submission period closes	June 2018	Submission period closes	Dec. 2019
	CMS contacts Medicare Health Plans and Posts Other Payer Advanced APM List	Sept. 2018	CMS contacts ECs and Posts Other Payer Advanced APM List	Dec. 2019

*****Note that APM Entities or ECs may use the Eligible Clinician Initiated Process

** Medicare Health Plans include: Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All-Inclusive Care for the Elderly (PACE) plans

All-Payer QP Performance Period and Eligible Clinician Level Evaluation

CMS proposes to establish a separate All-Payer QP Performance Period, which would begin on January 1 and end on June 30 of the calendar year that is two years prior to the payment year. As another option, the agency is considering an even shorter timeframe, which would be from January 1 through March 31 and would also be two years prior to the payment year. The Medicare QP Performance Period will remain the same as previously finalized, which is January 1 through August 31 of the calendar year that is two years prior to the payment year. CMS proposes to reverse its previous decision to make QP determinations under the All-Payer Combination Option at the APM Entity level and proposes to instead make those determinations at the EC level only. Because of this, the agency also proposes to use the individual EC payment amounts and patient counts for the Medicare calculations that are included as part of the All-Payer Combination Option. However, when the EC's Medicare Threshold Score calculated at the individual level would be lower than what the APM Entity group level score would be, CMS proposes to use a modified approach reflective of the group's score but weighted to reflect the individual EC's Medicare volume. CMS would calculate the EC's threshold scores individually using the modified weighted methodology, and the final score would be the most advantageous one for the QP determination.

All-Payer QP Calculations

CMS proposes to calculate the payment approach for the QP determination by dividing the numerator by the denominator, with the numerator based on aggregating all payments for all payers, except those excluded, attributable to the EC only, under the terms of all qualifying Medicare Advanced APMs and Other Payer Advanced APMs from January 1 through March 31 or January 1 through June 30. CMS's proposed timeframes create two "snapshots," allowing two opportunities to meet the All-Payer QP thresholds. The denominator for the All-Payer QP determination would be the aggregate of all payments from all payers, except excluded payments, to the EC during the All-Payer QP Performance Period. CMS would use a similar approach with the All-Payer QP determination using the patient count approach. Specifically, the agency would divide the patient count numerator, the number of unique patients the EC furnishes services to under the terms of all his or her Advanced/Other Payer Advanced APMs during the All-Payer QP Performance Period, by the number of unique patient the EC furnishes services to under all payers during that period.

In order for CMS to conduct QP calculations and make QP determinations based on payers other than Medicare, detailed information would have to be provided to the agency about payments and patients for

qualifying Other Payer APM arrangements. This information would be submitted by an EC or their APM Entity using a CMS form and the information would need to be provided at the individual EC level, not aggregated at the APM Entity group level. This would allow CMS to make the All-Payer QP determination at the individual EC level, as proposed. CMS proposes this information would have to be submitted by December 1 of the All-Payer QP Performance Period. For ECs, who do not meet the QP thresholds under the Medicare or the All-Payer Combination Option but who do meet the lower Partial QP thresholds, CMS proposes to allow them to elect whether they want to report on MIPS and receive any resulting payment adjustments under that program. As a reminder, Partial QPs are not eligible for the Advanced APM bonuses.

Physician-Focused Payment Models

MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposed physician-focused payment models (PFPMs) submitted by individuals and stakeholders. PTAC is a federal advisory committee that reviews these models and provides advice to the Secretary of Health and Human Services (HHS) and recommendations about whether various models meet criteria set forth by CMS. The agency previously finalized that PFPMs be tested as APMs with Medicare as a payer, but in this rule CMS proposes to broaden the definition of PFPM to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer even if Medicare is not included.

Merit-Based Incentive Payment System (MIPS) Proposals

CMS makes several proposed changes to MIPS for 2018, however the main components and structure of the program remain in place. Notably, CMS proposes a number of changes to benefit small practices, providing an exclusion from Advancing Care Information (ACI) reporting, a bonus opportunity for small groups and a new "virtual group" reporting option. CMS also proposes changes to the low volume exception criteria, which will exclude additional clinicians from the MIPS program if finalized. Additionally, the proposed changes to MIPS performance requirements are minimal. The total impact of these changes has the potential to reduce the opportunities for bonus payments in MIPS due to the budget neutrality requirements of the program. Therefore ACOs, which NAACOS anticipates will have high performance compared to their peers in this program, will have fairly limited opportunities to benefit from considerable bonus payments in MIPS. NAACOS will advocate for CMS to reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time and effort.

CMS makes a number of changes that will positively impact ACOs, including maintaining the 90-day reporting period in the ACI performance category and continuing to allow the use of 2014 Certified Electronic Health Record Technology (CEHRT). CMS also proposes a bonus opportunity for practices and clinicians seeing a high proportion of high-risk patients, which ACOs may benefit from. Unfortunately, CMS does not propose to reverse course on its policy decision to count MIPS bonuses as ACO expenditures. NAACOS will continue to advocate strongly for CMS to reverse this unfair policy.

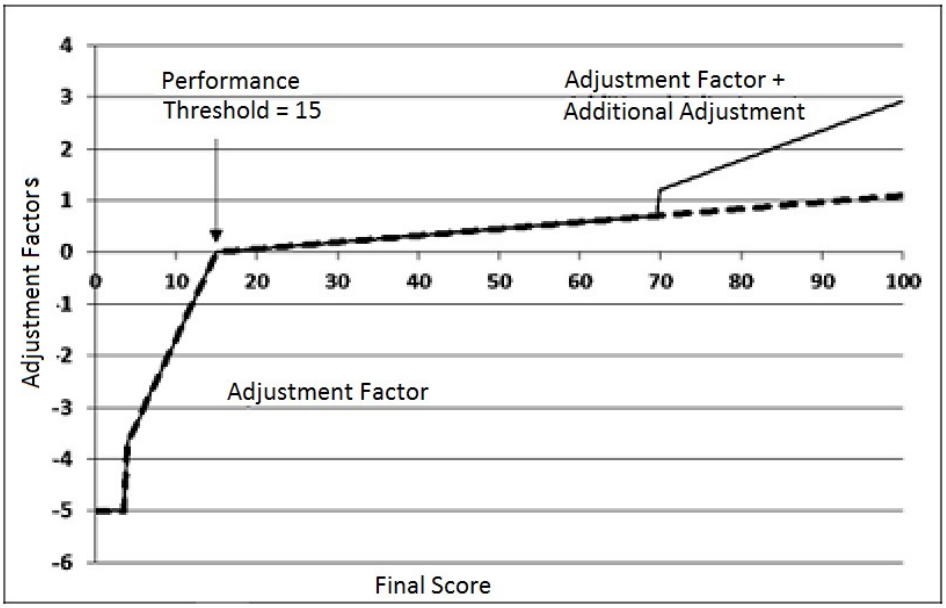
More details on the key changes to both the general MIPS requirements as well as the APM Scoring Standard are included on the next page.

General MIPS Requirements

Proposed Changes to MIPS Performance Thresholds

CMS proposes to increase the performance threshold from three points to 15 points, while maintaining the 70-point threshold for exceptional performance. CMS estimates approximately 96 percent of MIPS Eligible Clinicians (ECs) will receive a positive or neutral payment adjustment as a result of these changes to the performance criteria. Therefore, positive payment adjustments are expected to be minimal. In Figure A below (and found on page 30152 of the proposed rule), CMS provides an illustrative example of MIPS payment adjustment factors based on final scores and the proposed performance threshold for the 2020 payment year.

Figure A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Proposed Performance Threshold and Additonal Performance Threshold for the 2020 MIPS Payment Year



For MIPS ECs with a final score of 100, the adjustment factor would be 5 percent times a scaling factor greater than zero and less than or equal to 3.0. The scaling factor is used to ensure budget neutrality and cannot exceed 3.0. The additional adjustment factor for exceptional performance will start at 0.5 percent and cannot exceed 10 percent. MIPS ECs at or above the additional performance threshold of 70 points will receive the amount of the positive adjustment factor plus the additional adjustment factor. NAACOS expects many ACOs will meet the exceptional performance threshold.

Making Changes to the Low-volume Exception

CMS proposes to make changes to the low volume threshold to allow more ECs the opportunity to meet the threshold and therefore be exempt from MIPS reporting. Specifically, CMS proposes to increase the threshold from $30,000 or 100 or fewer Medicare patients to $90,000 or 200 or fewer Medicare patients seen in the measurement period. CMS estimates this will exclude an additional 585,560 clinicians from the MIPS program.

Special Considerations for Small Practices

CMS makes a number of proposed changes to benefit small practices and solo practitioners including: providing exemptions for small practices in the ACI performance category; creating a new bonus opportunity available to small practices (to be added to the final MIPS performance score); and

implementing a new virtual group option for MIPS participation for groups of 10 or fewer providers who want to aggregate performance data for purposes of MIPS analysis. These exemptions generally are not applicable to ACOs, which will continue to report and be evaluated as an ACO entity in the MIPS program. However, it is critical to be knowledgeable about these proposed policy changes in order to discuss the alternative options small practices are being afforded in MIPS in this proposed rule. NAACOS has developed talking points for ACOs to clearly communicate the benefits of continued participation in the ACO program as it relates to MACRA and MIPS evaluation.

Continuing the Policy to Exclude a Cost Performance Category Analysis in 2020

CMS proposes to continue its policy to exclude cost performance category analysis for ECs in MIPS. This will undoubtedly assist low-performing clinicians from avoiding penalties in MIPS by artificially increasing their MIPS overall performance score. ACOs are excluded from a cost analysis as part of their overall MIPS score due to the fact that the MSSP and/or Next Generation Model programs already evaluate ACOs on cost. NAACOS will urge the agency to hold clinicians accountable for costs to more accurately evaluate clinicians in the program.

Facility-based Reporting

CMS proposes to allow ECs to take advantage of certain facility-based quality reporting in some cases, however, this does not apply to ACOs since ACOs will report quality through the MSSP or Next Generation Model for MIPS evaluation and will not be scored in the cost performance category.

Public Reporting of MIPS Performance Data

CMS proposes to continue its policy of adding MIPS performance information to the Physician Compare website. Currently, Physician Compare users can view information about Medicare clinicians, such as: name; Medicare primary and secondary specialties; practice locations; group affiliations; hospital affiliations, Medicare assignment status; education; residency; and board certification information. CMS also recently added ACO-specific data such as a notation when a clinician participates in an ACO as well as 19 quality measures for ACOs participating in the MSSP or Pioneer ACO programs.

As finalized in the 2015 and 2016 Physician Fee Schedule (PFS) rules, CMS also will include a benchmark and five-star rating in late 2017 based on 2016 data. Further, MACRA requires CMS to also publicly report performance information, as detailed in the 2017 Quality Payment Program (QPP) final rule, including:

- EC or group final MIPS score;
- Performance score for each MIPS performance category (quality, cost, improvement activities, and ACI);
- Names of clinicians in Advanced APMs, the name of the Advanced APM, and the Advanced APM performance scores;
- Aggregate information on MIPS including the range of final scores for all MIPS ECs and the range of performance of all MIPS ECs for each MIPS performance category

As finalized in the 2016 Physician Fee Scheduled (PFS), CMS will also release utilization data, integrated on the Physician Compare website starting with 2016 data. CMS expects this data to be released in late 2017. CMS will continue its policy to provide a 30-day review period for any clinician or group with QPP data before such data is published on Physician Compare. Lastly, CMS seeks comments on how the agency should account for social risk factors in publicly available data by stratifying public reporting by risk factors. CMS seeks feedback regarding which social risk factors or indicators should be used and from what sources. The agency seeks this input for possible inclusion in future rulemaking.

Reviews and Appeals Process

In the 2017 QPP final rule, CMS finalized that MIPS ECs or groups may request a targeted review of the calculation of the MIPS payment adjustment factor, including clinicians scored under the MIPS APM scoring standard such as ACOs. CMS does not propose any changes to the targeted review process and includes information on the process the agency will use for targeted reviews. CMS will provide MIPS ECs and groups with a 60-day period to submit a request for targeted review, which will begin on the day CMS makes the MIPS payment adjustment factor available to the public for the MIPS payment year. CMS will provide further information on this process in the future.

MIPS Scoring		
Total Points Scored in MIPS	**Resulting Payment Adjustment**	**Notes Regarding ACO Performance**
0 points	Negative payment adjustment of -5%	ACOs reporting quality data through MSSP and/or the Next Generation Model will automatically avoid this penalty
15 points	Neutral payment adjustment	ACOs receive an automatic full credit for the Clinical Practice Improvement Activities (CPIA) performance category, which will earn them the minimum 15 points required for a neutral payment adjustment
16-69 points	Positive payment adjustment	Payment adjustment amount to be determined following the performance year. ACOs scoring between 16 and 69 points will not be eligible for an exceptional performance bonus
≥70 points	Positive payment adjustment for exceptional performers	ACOs scoring at or above 70 points will earn the additional, exceptional performance bonus of .5% or greater

MIPS APM Scoring Standard

CMS proposes the continued evaluation of ACOs under the MIPS APM Scoring Standard. The general weights for each MIPS performance category remain unchanged, however, CMS does propose several changes to the MIPS APM Scoring Standard affecting ACOs, which are further detailed below. For more information on the finalized MIPS APM Scoring Standard policies for 2017 performance, please access NAACOS's resource *The ACO Guide to MACRA*.

MIPS APM Scoring Standard Performance Category Weights		
	MIPS APM Weight for ACOs	**Generally Applicable MIPS Weight**
Quality	50%	60%
Cost	0%	0%
Advancing Care Information	30%	25%
Improvement Activities	20%	15%

Including a Fourth Snapshot Date

CMS proposes to include a fourth snapshot date to determine which ECs are participating in the ACO for purposes of MIPS APM Scoring Standard evaluation. This additional snapshot date will occur on 12/31/2018 to ensure that an EC who joins an ACO TIN late in the performance year would be scored under the APM Scoring Standard along with the rest of the ACO. The remaining snapshot dates will also continue to be in place (March 31, June 30 and August 31). As a reminder, to identify ECs who are part of a MIPS APM, CMS uses the same approach as identifying ECs who are part of an Advanced APM Entity. This includes the use of these snapshot dates which establish and then add ECs to the MIPS APM during the performance year. For MSSP ACOs in MIPS, this means that CMS will identify ECs who reassign their Medicare billing rights to an ACO Participant TIN on the snapshot dates; the reassignment data is exported from the Provider Enrollment, Chain and Ownership System (PECOS). Note that the additional, fourth snapshot date would only apply to MIPS APM evaluations (not Advanced APM Entity evaluations).

Quality Performance Category

CMS proposes to add the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey in the MIPS quality performance score analysis for performance year (PY) 2018. Most questions in the CAHPS for ACOs survey can also be found in the CAHPS for MIPS survey except for one question ("Between Visit Communication") that CMS feels is inappropriate for use by ACOs and will therefore not be included in the ACO's MIPS quality score.

Improvement Points

CMS also presents a new opportunity for additional points to be earned for quality improvement year over year in MIPS. This will compare quality scores from the prior performance period and will be measured at the performance category level (rather than at the measure level). Up to 10 percentage points will be available in this performance category. Specifically, CMS proposes to award an improvement score based on the following formula: (increase in quality performance category achievement percent score from prior performance period to current performance period / prior year quality performance category achievement percent score) * 10 percent. For an example, please see Table 28 in the proposed rule (p. 30118).

Complex Patient Bonus

CMS also proposes to add a bonus opportunity for those seeing a large proportion of high-risk patients. CMS proposes using average hierarchical condition category (HCC) risk scores or, alternatively, dual eligible status to determine the proportion of high-risk patients being seen by the practice. Under the HCC calculation CMS proposes for MIPS APMs, including ACOs, CMS would use the beneficiary weighted average HCC risk score for all MIPS ECs, and if technically feasible, TINs for models that rely on complete TIN participation such as the MSSP. CMS would calculate the weighted average by taking the sum of the individual clinician's (or TIN's as appropriate) average HCC risk score multiplied by the number of unique beneficiaries cared for by the clinician and then divide by the sum of the beneficiaries cared for by each individual clinician (or TIN) in the APM Entity.

Under the dual eligible calculation, CMS would use the average dual eligible patient ratio for all MIPS ECs, and if technically feasible, TINs for models that rely on complete TIN participation. CMS would use data on dual-eligibility status sourced from the state Medicare Modernization Act (MMA) files, submitted by each state to CMS with monthly Medicaid eligibility information analyzing claims from September 1, 2017 to August 31, 2018. CMS would multiply the dual eligible ratio by five points to calculate a complex patient bonus for each MIPS EC.

Under these proposals, the complex patient bonus could not exceed three points, and the bonus would be added to the EC's final MIPS score. For examples of HCC and dual eligible status calculations, see Tables 34-36 in the proposed rule (p. 30136-30137).

Assigning Points Based on Benchmarks
CMS does not propose to change the way points are assigned in the quality performance category. As in PY 2017, CMS proposes to score quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories. For each benchmark, CMS will calculate the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls. CMS proposes to continue to use a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile. For example, a raw score of 55 percent would fall within the sixth decile of 41.0 percent to 61.9 percent and would receive between 6.0 and 6.9 points. See Table 11 which outlines the benchmark decile distribution (p. 255).

Advancing Care Information (ACI) Performance Category
Under CMS proposals, the ACI performance category will require a minimum 90-day reporting period for PY 2018 and will not require the use of 2015 CEHRT, although bonus points will be provided to those who choose to use 2015 CEHRT. The ACI performance category also included new exemptions for certain measures but otherwise maintains the same scoring methodology. Also, per the 21st Century Cures Act, ECs in Ambulatory Surgical Centers (ASCs) will be exempt from ACI requirements and will have their ACI performance category reweighted to 0 percent of their total overall MIPS score. CMS will provide more details on this exemption status later in 2017. CMS proposes to maintain the same scoring structure for 2018, including Base Score and Performance Score components to the overall ACI performance category score.

Exemptions
CMS proposes to add exclusions for the e-prescribing and Health Information Exchange measures in the ACI performance category. CMS also proposes to expand options beyond the one immunization registry reporting measure for 10 percent toward the performance score and allow reporting on a combination of other public health registry measures that may be more readily available for 5 percent each toward the performance score (capped at 10 percent). For the five percent bonus, the EC must report to a different public health agency or registry than those used to earn the performance score.

As directed by Section 4002(b)(1)(A) of the 21st Century Cures Act, CMS is also adding an exception for MIPS ECs using decertified EHR technology. The EC would demonstrate through an application process that reporting on the measures specified for the ACI performance category is not possible because the CEHRT used by the MIPS eligible clinician has been decertified under Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. CMS proposes that if the MIPS eligible clinician's exception is granted, CMS would assign a 0 percent weighting to the ACI performance category in the MIPS final score for the MIPS payment year.

Clarifications Applicable to ACOs
CMS makes a clarification that the agency will aggregate ACI performance for those using the group reporting option, regardless of ECs meeting certain exemptions like non-patient facing, NPPs, or hospital-based or ASC exceptions. This will also be the case for 2017 ACI reporting. See Table 7 in the proposed rule for an outline of the ACI scoring methodology (p. 30067).

Clinical Practice Improvement Activities Performance Category

CMS does not propose any changes to the way ACOs are evaluated in the Clinical Practice Improvement Activities (CPIA) performance category. ACOs will not have to report any CPIA information in 2018 and will receive full credit for this performance category. ACOs and/or their MIPS ECs (or TINs) participating in the MIPS APM will not need to submit data for the improvement activities performance category in order to receive that maximum improvement activities score. Therefore, ACOs earn 40 points, receiving full credit in this performance category. More information is available in this CMS fact sheet.

Cost Performance Category

CMS proposes to continue its policy of not evaluating ACOs on cost in MIPS due to the fact that the MSSP and Next Generation Model already evaluate ACOs on cost.

Performance Feedback

CMS proposes to provide quality and cost feedback on the performance categories "as technically feasible" for MIPS APMs. NAACOS will continue to advocate for CMS to provide relevant, timely and transparent performance information to ACOs on their MIPS analysis.