AMERICAN ACADEMY OF FAMILY PHYSICIANS
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Executive Summary of the CMS Proposed Rule—2018 Updates to the Quality Payment Program

On June 20, 2017, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule (link expires 6/30) regarding the 2018 Quality Payment Program (QPP). As part of this release, the agency issued a press release and a detailed fact sheet. After CMS released the proposed rule, the American Academy of Family Physicians (AAFP) expressed pleasure in a statement stating, "The proposed regulation will improve the ability of family physicians to participate successfully in payment reforms envisioned by the bipartisan *Medicare Access and CHIP Reauthorization Act (MACRA)*." Comments on the proposed rule are due to CMS by August 21, 2017, and the AAFP is reviewing the proposed changes and will formally comment on this major regulation.

The QPP offers two tracks for Medicare participating physicians:

- The Merit-based Incentive Payment System (MIPS) - CMS proposals will exclude approximately 134,000 additional clinicians from MIPS out of the approximately 700,000 clinicians that would have been eligible based on the low-volume threshold finalized in the 2017 QPP final rule. CMS estimates that nearly half of the additionally excluded clinicians are from small practices.
- Advanced Alternative Payment Models (AAPMs) - CMS had estimated that 70,000 to 120,000 eligible clinicians (ECs) will earn incentive payments for their AAPM participation for the 2019 payment year, based on AAPM participation in the 2017 performance year. In this proposed rule, CMS now estimates that approximately 180,000 to 245,000 ECs may become Qualifying APM Participants (QPs) for the 2020 payment year, based on AAPM participation in the 2018 performance year.

Related to the MIPS pathway, and of significance to family physicians, CMS proposes to:

- Offer the virtual groups participation option. In previous comments and in meetings with CMS, the AAFP identified virtual group participation as critical to the ability of practices to participate successfully in MIPS. Virtual groups that choose this participation option will need to make an election prior to the 2018 performance period.
- Significantly increase the low-volume threshold that excludes individual MIPS-eligible clinicians or groups. The current threshold is ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries. For the 2018 performance period, CMS proposes to exclude individual MIPS-eligible clinicians or groups with ≤$90,000 in Part B allowed charges OR ≤200 Part B beneficiaries.
- Modify the agency's definition of certified patient-centered medical homes (PCMH) by:
    - Expanding the definition of certified PCMH to include the CPC+ APM model;
    - Proposing to make it clear that the term "recognized" is the same as the term "certified" as a PCMH or comparable specialty practice.
    - Suggesting a threshold of 50% for the 2018 performance period for the number of practices within a tax identification number (TIN) that need to be recognized as PCMH for the TIN to get the full credit for the MIPS improvement activities category.
- Continue allowing the use of 2014 Edition CEHRT, while encouraging the use of 2015 edition CEHRT, via adding bonus points.
- Include accredited continuing medical education (CME) as an improvement activity.

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- Add bonus points for the care of complex patients in the scoring methodology by applying an adjustment of up to three bonus points by adding the average Hierarchical Condition Category risk score to the final score.
- Add a new, optional improvement activity if a clinician attests to using appropriate use criteria (AUC) through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. In repeated recommendations, the AAFP expressed significant concerns about the disproportionate burden primary care physicians will face when trying to comply with AUC requirements, and strongly urged CMS to align AUC with the MIPS program.
- Incorporate MIPS performance improvement in scoring quality performance.
- Add hardship exceptions for small practices (15 or fewer clinicians) for the advancing care information (ACI) performance category. For such practices, reweight ACI performance category to zero and reallocate the ACI performance category weight of 25% to the quality performance category.
- Add bonus points to the final score of clinicians in small practices. To do this, CMS proposes to adjust the final score of any EC or group who's in a small practice (15 or fewer clinicians) by adding five points to the final score if the EC or group submits data on at least one performance category in an applicable performance period.
- Continue to award small practices three points for measures in the quality performance category that don't meet data completeness requirements (all others get one point).
- Continue to weigh the cost category at 0%, quality category at 60%, improvement activity category at 15%, and ACI category at 25%; and require a full year performance period for quality and cost and a 90-day minimum performance period for the ACI and improvement activity categories.

Regarding Advanced APMs, CMS proposes to:

- Extend the revenue-based nominal amount standard. CMS previously finalized through the 2018 performance period for two additional years (through the 2020 performance period). The standard allows an APM to meet the financial risk criterion to qualify as an AAPM if participants are required to bear total risk of at least 8% of their Medicare Parts A and B revenue.
- Change the nominal amount standard for Medical Home Models, so the minimum required amount of total risk increases more slowly.
    - CMS would exempt the round one participants in the Comprehensive Primary Care Plus Model (CPC+) from the requirement that the medical home standard applies only to APM entities with fewer than 50 clinicians in their parent organization. This prevents the round one participants from falling back to the MIPS APM track.
    - Regarding the Medical Home Model nominal amount standard, CMS would adjust the minimum total potential risk for an APM entity to:
        - 2% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities for performance year 2018.
        - 3% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities for performance period 2019.
        - 4% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities for performance year 2020.
        - 5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities for performance years 2021 and after.

Among many additional changes, this proposed rule also further establishes policy regarding the all-payer combination option and further discusses the role of the Physician-Focused Payment Model Technical Advisory Committee (PTAC).