

Medicare Releases Final Rule for the CY2019 Quality Payment Program

Overview

On November 1, 2018, CMS issued the Calendar Year 2019 Quality Payment Program (QPP) final rule for the third transition year for physicians to begin participation in either the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). The third transition year increases the potential MIPS payment adjustments to +/- 7% for payment year 2020. These policies become effective on January 1, 2019.

CMS has added a third criterion for determining MIPS eligibility with respect to the low-volume threshold. To be excluded from MIPS in 2019, clinicians or groups will need to meet one of the following three criteria: have \leq \$90K in Part B allowed charges for covered professional services, provide care to \leq 200 beneficiaries, or provide \leq 200 covered professional services under the Physician Fee Schedule. If a radiologist or practice falls below one or more of these thresholds, they will be exempt from participating in the Quality Payment Program. Starting in 2019, CMS will also allow for exempt physicians to opt-in to MIPS if they choose, as long as they exceed at least one of these three thresholds.

CMS has finalized an increase in the cost category to 15% of the overall performance score, while the quality category will be reduced to 45%. The promoting interoperability (formerly called advancing care information) and improvement activities categories will remain at 25% and 15% respectively. CMS has increased the MIPS performance threshold for neutral adjustments from 15 to 30 points in 2019. This performance threshold defines the total points required to earn a neutral payment adjustment and avoid a negative payment adjustment. MIPS eligible clinicians who score higher than the 30-point threshold may earn a positive payment adjustment for 2021. CMS has also increased the exceptional performance bonus threshold from 70 to 75 points.

The small practice bonus score, which in previous years had been an addition of 5 points to a group or individual's final MIPS score, has been changed to a bonus of 6 points added to the quality performance category score. CMS defines small practices as 15 or fewer clinicians.

MIPS Eligible Clinicians

CMS has modified the definition of a MIPS eligible clinician to include the following types of clinicians as eligible to participate in MIPS for the 2019 performance year: physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists and registered dietitian or nutrition professionals. These new MIPS eligible clinicians are exempt from the promoting interoperability performance category.

MIPS Determination Period

During the first two years of MIPS, there were various determination periods in place to identify MIPS eligible clinicians for different applicable policies, such as non-patient-facing and low-volume threshold. CMS has finalized a single MIPS determination period that includes low-volume threshold, non-patient-facing, small practice, hospital-based and ambulatory surgical center (ASC)-based statuses.

CMS has finalized that for 2019, the MIPS determination period for the aforementioned statuses will be a 24-month assessment period consisting of two 12-month analyses of claims data; the first 12-month segment begins on October 1, 2017 and ends on September 30, 2018 and the second period begins on October 1, 2018 and ends on September 30, 2019. The first determination period includes a 30-day claims run out and the second segment includes quarterly snapshots for informational purposes. CMS believes that these quarterly snapshots allow new TIN/NPIs and TINs to be aware of their eligibility status sooner. These 12-month segments now align with the fiscal year that begins on October 1.

Non-patient facing Clinicians

There are no changes to the eligibility of non-patient facing clinicians. For the 2019 MIPS performance year, non-patient-facing status will still be extended to individual MIPS eligible clinicians who bill 100 or fewer patient facing encounters (including Medicare telehealth services) during the non-patient facing determination period. The same will be true of groups or virtual groups for which more than 75% of the NPIs billing under the group's TIN (or virtual group's TINs) meet the definition of non-patient facing individuals. Non-patient facing clinicians will remain exempt from the promoting interoperability performance category; the 25% weight of that category will be reweighted to the quality performance category. For the improvement activities performance category, non-patient facing clinicians may submit either one high-weighted improvement activity or two medium-weighted improvement activities for full credit in the category.

Low-Volume Threshold

For the 2020 MIPS payment year and future years, the low-volume threshold has already been defined as an individual eligible clinician or group that has Medicare Part B allowed charges less than or equal to \$90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries. Eligible clinicians or groups who meet this definition are automatically excluded from MIPS. CMS has amended the current definition of low-volume threshold to be: an individual eligible clinician or group that bills Medicare Part B-allowed charges for covered professional services less than or equal to \$90,000; provides care for 200 or fewer Part B-enrolled Medicare beneficiaries; or provides 200 or fewer covered professional services to Part B-enrolled individuals. If an exempt clinician exceeds at least one of the three determinations, then the clinician is not required to participate but now has the choice to opt-in to MIPS by making an affirmative election.

Small and Rural Practice

CMS offers further flexibility in helping small and rural practices to transition into participating in APMs and MIPS. CMS is going to retain the small practice bonus, but it will now apply to the quality performance category rather than the MIPS final score. Small practices will now receive a bonus of 6 points to the numerator of their quality score rather than the previous year's bonus of 5 points added to the overall MIPS score. Also, only individuals and groups in small practices will be allowed to continue using Medicare Part B claims for submission of data for the quality performance category. Practices not defined as small and rural will need to use another

submission type as described in the “Data Submission” section below. Small practices will also continue to receive 3 points for submitting quality measures that do not meet data completeness criteria, whereas individuals and groups not in small practices will receive 1 measure achievement point in performance year 2019 and zero points beginning in 2020 for measures not meeting completeness criteria.

Facility-Based Measurement Option

In the CY 2018 QPP final rule, CMS established the potential for a facility-based measurement scoring option for clinicians that meet certain criteria beginning with the 2019 MIPS performance period/2021 MIPS payment year. CMS has finalized that the 2019 MIPS performance year will be the first year physicians can choose to use a facility-based scoring option for the MIPS quality and cost performance categories. The measure set for the fiscal year’s Hospital Value-Based Purchasing (VBP) program will be used to determine performance for facility-based clinicians.

The Hospital Value-Based Purchasing (VBP) is an existing program under Medicare that provides adjustments to bundled payments based on facility-wide quality measures. There are currently 13 quality and efficiency measures defined under VBP. In the 2018 Final Rule, CMS finalized allowing MIPS eligible clinicians who are facility-based to use their institution’s performance in VBP for the Quality and Cost category scores in MIPS. CMS also finalized adding on-campus outpatient hospital services (POS 22) to the criteria for facility-based determination.

To qualify for facility-based scoring, physicians must perform 75% of their services in inpatient, on-campus outpatient hospital or emergency room settings, and must have at least one service billed with the place of service (POS) code used for inpatient (21), on-campus outpatient hospital (22) or emergency room (23). For groups, 75% or more of the National Provider Identifiers (NPIs) billing under the group’s Tax Identification Number (TIN) must be eligible for facility-based measurement as individuals.

Facility-based scoring will automatically be applied to MIPS eligible clinicians and groups without a separate election process, and the higher of the facility based and MIPS scores will be used for the Quality and Cost Categories. CMS will score facility-based clinicians as a group if data is submitted for the Improvement Activity (IA) and Promoting Interoperability (PI) categories as a group.

MIPS Performance Period

CMS finalized the performance periods for 2019 as follows:

- Quality: full calendar year
- Cost: full calendar year
- Improvement Activities: minimum of a continuous 90-day period within the calendar year
- Promoting Interoperability: minimum of a continuous 90-day period within the calendar year

These remain unchanged from the 2018 performance periods.

Performance Categories and Reporting

Quality Performance Category

CMS will maintain the 60% data completeness threshold for QCDRs, qualified registries, EHRs and claims-based data submissions with the expectation that this threshold will increase over time. The quality performance category weight is finalized at 45% of a clinician's final score for the 2019 MIPS performance year, unless points are redistributed from reweighting of other performance categories.

CMS finalized the use of the following measures as applicable to assess performance: CMS' final list of MIPS quality measures, QCDR measures, facility-based measures, and MIPS APM measures. Measure requirements remain the same: MIPS eligible clinicians must submit 6 quality measures, one being a high priority or outcome measure.

Topped-out Measures

CMS defines a topped-out measure as one whose median performance score is 95% or higher and whose performance is "so high and unvarying that meaningful distinctions and improvement in performance can no longer be made." CMS has established a 4-year timeline for identifying and removing topped-out measures. If a measure is classified as topped-out for 3 consecutive years, it may be removed the 4th year subject to rule-making and public comment period. In the final rule, CMS has added a new criterion for removing measures identified as "extremely topped-out," that is, measures with an average performance within the 98th to 100th percentile. For these measures, regardless of where they are in the topped out measure lifecycle, CMS may propose to remove them in the following year's rulemaking cycle. These measures may not follow the 4-year lifecycle that is applicable to other measures.

CMS also finalized another policy for topped-out QCDR measures. QCDR measures are excluded from the topped-out measure timeline. If a QCDR measure is identified as topped-out during the QCDR self-nomination process, CMS may not approve this measure for use in the next performance period.

Beginning with the 2018 performance year and continuing through 2019 and beyond, measures identified as topped-out for two or more consecutive years will be eligible for no more than 7 points. It is important to note that a measure could be deemed topped-out in one collection type, but not reach topped-out status in another. In this scenario, the measure would only undergo topped-out methodology within the collection type for which it has been deemed topped-out. The topped out measure list for 2019 will not be available until late 2018.

Measures Finalized for Removal

Two measures reportable by diagnostic radiologists have been finalized for removal:

- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging (#359)
- Optimizing Patient Exposure to Ionizing Radiation: Search for Prior CT Studies through a Secure, Authorized, Media-Free Shared Archive (#363)

CMS provided rationale for removing Measure #359 asserting that it is duplicative of measure #361: Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry. Measure #363 was removed with the rationale that the quality action does not completely attribute to the radiologist reporting the measure.

Three measures pertinent to radiation oncologists have been finalized for removal in 2019 due to being evaluated as “extremely topped-out”:

- Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade (Measure #99)
- Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade (Measure #100)
- Oncology: Radiation Dose Limits to Normal Tissues (Measure #156)

Quality Scoring

CMS will maintain the 3-point floor for measures that can be reliably scored against a benchmark, with 10 points being the highest score for a measure. Measures submitted that do not have a benchmark or do not meet the case minimum will receive 3 points, as long as they meet the 60% data completeness threshold. Measures that do not meet data completeness will receive 1 point in the 2019 MIPS performance period; however, for the 2020 MIPS performance year, measures submitted will receive 0 points (excluding small practices, who will continue to receive 3 points). Measures that are identified as topped-out for two consecutive years will receive a maximum of 7 points. Bonus points will continue to be available for reporting high priority and outcome measures as well as end-to-end reporting and will each be capped at 10% of the quality performance weight.

Promoting Interoperability (PI) Category

Reweighting/Exempting PI

CMS did not significantly modify the options available to ACR members for reweighting the Promoting Interoperability (PI) MIPS performance category in performance year 2019/payment year 2021. MIPS eligible clinicians and groups determined to be non-patient-facing or hospital-based will continue to be automatically reweighted for the PI category unless they report PI participation data. For simplification purposes, CMS has decided to align the various determination periods used for certain special statuses such as non-patient-facing, hospital-based, small practice, etc., into a unified “MIPS determination period.”

As before, eligible clinicians who reweight PI would continue reallocating its 25 percent of the total MIPS score to the Quality category.

Participating in PI

For those radiologists who plan to participate in PI, CMS requires implementation of 2015 Edition certified EHR technology (CEHRT). CMS has decided to change the scoring methodology for the PI performance category by eliminating the paradigm of separate “base” and “performance” scores. Instead, CMS will score PI participants based on individual measure performance, with each measure having different weights/maximum points:

| Objective | Measures | Max Points: 2019 | Max Points: 2020 |
|--|---|---------------------|-----------------------|
| eRx | eRx | 10 | 10 |
| | Query of Rx drug monitoring program (PDMP) | 5 bonus | N/A (to be addressed) |
| | Verify opioid treatment agreement | 5 bonus | 5 bonus |
| HIE | Support electronic referral loops by sending health information | 20 | 20 |
| | Support electronic referral loops by receiving and incorporating health information | 20 | 20 |
| Provider-to-Patient Exchange | Provide patients with electronic access to their health information | 40 | 40 |
| Public Health and Clinical Data Exchange | Choose 2 of the following options, or report to 2 different agencies/registries: <ul style="list-style-type: none"> - Immunization registry reporting - Electronic case reporting - Public health registry reporting - Clinical data registry reporting - Syndromic surveillance reporting | 10 | 10 |

The numerator and denominator for a given measure will be used to calculate a performance rate which will then be calculated against the maximum available points for that measure to determine the actual awarded points (performance rate * total possible measure points = awarded points for the measure). The participant’s awarded points for all individual measures are then tallied and that sum is divided by the 100 total possible PI points to determine the PI performance score for the year (i.e., up to 25 percent of the MIPS score in performance year 2019).

Meeting the exclusion criteria of certain measures will result in the reallocation of those measures’ maximum available points to other measures. For example, if excluded from the eRx measure in 2019 (< 100 permissible prescriptions during the performance period), the maximum 10 points from eRx would be reallocated to increase the maximum points for the two health information exchange (HIE) measures, increasing both to 25 maximum points each. As another example, the HIE measure for “support electronic referral loops by receiving and incorporating health information” has an exclusion that will result in its 20 maximum points being reallocated to the other HIE measure (“support electronic referral loops by sending health information”), making it worth 40 maximum points.

CMS finalized its proposal to eliminate several measures requiring action by patients as well as other measures the agency believes do not focus on the priority of interoperability: patient-specific education, view/download/transmit, patient-generated health data, and secure messaging. The HIPAA/security risk analysis measure has been eliminated as a separate measure, but remains as a mandatory prerequisite for PI reporting, so its elimination is entirely nominal. CMS also combined requirements from the 2018 “request/accept summary of care” measure with the 2018 “support electronic referral loops – receiving and incorporating health information” measure to create the proposed 2019 HIE measure of “support electronic referral loops by receiving and incorporating health information.”

CMS finalized its proposal to eliminate the previously available 10 percent bonus for completing one of several specified Improvement Activities using CEHRT.

Improvement Activities Performance Category

CMS defines improvement activities as those that support broad aims within healthcare delivery, including care coordination, beneficiary engagement, population management, and health equity. In the final rule, improvement activities remain weighted at 15% for the 2019 MIPS performance year final score. The submission process for activities is will remain the same; clinicians will still be able to attest to activities by indicating a “yes” response for each completed activity using their submission method of choice.

In the final rule, CMS will retain nearly all the 112 activities from the 2018 inventory while adding 6 new activities, modifying 5 existing activities and removing one activity. CMS has also finalized a new criterion for the consideration of new improvement activities related to items that have been declared a public health emergency by the HHS Secretary, such as the opioid epidemic. Of relevance to radiologists, several QCDR-based activities continue to be included as medium-weight activities as well as the 7 medium-weighted improvement activities that may be obtained by participation in the ACR’s Radiology Support Communication and Alignment Network program (R-SCAN).

Scoring for Improvement Activities

CMS did not make any changes to the number of activities (two high-weighted or four medium-weighted) that MIPS-eligible clinicians are required to report to reach the total of 40 points to receive full credit. CMS also maintains the policy that the weight for any activity selected is doubled for small, rural, health professional shortage area practices, and non-patient facing MIPS-eligible clinicians, so that these practices and ECs only need to select one high-weighted or two medium-weighted improvement activities to achieve the highest score of 40 points. Also, under the MIPS APM scoring standard, all clinicians identified on the Participation List of an APM will receive at least one-half of the highest score applicable to the MIPS APM with the opportunity to report additional improvement activities to add points to achieve the full 40 points. Lastly, CMS has removed the provision for receiving bonus points toward the Promoting Interoperability performance category if certain improvement activities are completed using CEHRT.

Cost Performance Category

CMS is finalizing its proposal to increase the cost performance category to 15 percent of a MIPS eligible clinician's final score for the 2021 MIPS payment year and continues to anticipate increasing the weight of the cost performance category by 5 percentage points each year until reaching the required 30 percent weight for the 2024 MIPS payment year. CMS will also continue to utilize the total per capita cost and Medicare spending per beneficiary (MSPB) measures, established for the 2017 MIPS performance period, for the 2019 MIPS performance period and future performance periods. CMS plans to reevaluate cost measures every 3 years to ensure that they continue to meet measure priorities and to analyze measure performance rates and reassess the reliability and validity of the measures.

CMS is finalizing its proposal to add 8 episode-based measures to the cost performance category. Episode-based measure specifications differ from total per capita cost and MSPB measures in that they include items and services related to the episode of care for a clinical condition or procedure, and not all services provided to a patient over a given timeframe. CMS will continue to develop additional episode-based measures for future rulemaking.

CMS reiterates in the final rule that episode-based measures are developed to inform attributed clinicians regarding the cost of the care clinically related to their treatment of a patient provided during the episode's timeframe. CMS defines cost as based on the allowed amounts on Medicare claims, which include both Medicare payments and beneficiary deductible and coinsurance amounts. Episode-based measures are calculated using Medicare Parts A and B fee-for-service claims data and are based on episode groups. Episode groups represent a clinically cohesive set of medical services rendered to treat a given medical condition, aggregate all items and services provided for a defined patient cohort to assess the total cost of care and are defined around treatment for a particular condition or the performance of a particular procedure.

Episode-based measures are classified as either acute inpatient episodes or procedural episodes. For the acute inpatient medical condition episode-based measures, an episode is attributed to each MIPS eligible clinician who bills inpatient E&M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization. For the procedural episode-based measures, an episode is attributed to each MIPS eligible clinician who renders a trigger service as identified by HCPCS/CPT procedure codes. For the procedural episode-based measures, the case minimum is 10. For the acute inpatient medical condition episode-based measures specified, the case minimum is 20. The Medicare Spending Per Beneficiary (MSBP) and Total Per capital Cost (TPCC) measures are unchanged for 2019, but the attribution methodology for both is currently undergoing revision.

The Bipartisan Budget Act of 2018 now requires information on cost measures in use under MIPS, cost measures under development and the time-frame for such development, potential future cost measure topics, a description of stakeholder engagement, and the percent of expenditures under Medicare Part A and Part B covered by cost measures, to be posted on the CMS website. The eight finalized episode-based cost measures as well as their measure type can be found below.

| Measure Topic | Measure Type |
|---------------|--------------|
|---------------|--------------|

| | |
|--|-----------------------------------|
| Elective Outpatient Percutaneous Coronary Intervention (PCI) | Procedural |
| Knee Arthroplasty | Procedural |
| Revascularization for Lower Extremity Chronic Critical Limb Ischemia | Procedural |
| Routine Cataract Removal with Intraocular Lens (IOL) Implantation | Procedural |
| Screening/Surveillance Colonoscopy | Procedural |
| Intracranial Hemorrhage or Cerebral Infarction | Acute inpatient medical condition |
| Simple Pneumonia with Hospitalization | Acute inpatient medical condition |
| ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) | Acute inpatient medical condition |

Data Submission

CMS has changed the terminology used for MIPS data submission to reflect the experience users have when submitting data more concisely. The new MIPS terms are as follows:

- “Collection type” is defined as a set of quality measures with comparable specifications and data completeness criteria.
- “MIPS CQMs” has now replaced the term formerly known as “registry measures” because other entities besides registries may submit data on these measures.
- “Submitter types” are MIPS eligible clinicians or third-party entities that submit data on behalf of MIPS eligible clinicians
- “Submission type” refers to the type of mechanism by which a submitter type submits data to CMS. The submission types are defined as follows: direct (transmitting data computer-to-computer, such as an API), log in and upload (using authenticated credentials to upload and submit data), and log in and attest (manually attesting measures and activities with a set of authenticated credentials). Claims submission would remain the same as there is no other way to define it.

The submission types are organized by performance category. For the quality performance category, individual MIPS clinicians may submit MIPS data through direct, log in and upload, and Medicare Part B claims (only if in a small practice). MIPS eligible clinicians reporting as groups may submit data through direct, log in and upload, or the CMS Web Interface (groups with more than 25 eligible clinicians).

Medicare Part B claims collection type will only be available to only small practices beginning with the 2021 MIPS payment year (2019 performance year).

In the 2018 Final Rule, CMS finalized two policies that would give clinicians flexibility to submit data through multiple submission mechanisms. However, both of these policies,

described below, were deferred until 2019 due to operational challenges and to give CMS more time to communicate this policy to clinicians. The following two policies will begin in 2019:

- Individual MIPS eligible clinicians and groups will be able to submit measures and activities via as many mechanisms as necessary to meet the requirements of the quality, IA or PI categories.
- If a MIPS eligible clinician or group submits the same measure via 2 different submission mechanisms, CMS will score each mechanism by which the measure is submitted for achievement and take the highest measure achievement points of the 2 mechanisms. CMS would not aggregate data from multiple submissions of the same measure towards the quality performance category score.

Virtual Groups

Definition of a Virtual Group

In the 2018 final rule, CMS defined three ways to participate in MIPS: as an individual, as a group, or as a new category called a “virtual group” in order to assist small, independent practices. In the virtual group option, two or more solo practitioners or groups made up of 10 or fewer eligible clinicians can voluntarily come together as a group to participate in MIPS. There are currently no proposed restrictions in terms of geography, specialty of the practices, or number of practices that can form a virtual group as long as the criterion for the size of each practice is met.

Requirements for Virtual Group Reporting

There are two types of practices that can form virtual groups: (1) MIPS-eligible solo practitioners who bill under a single Tax Identification Number (TIN) with a single NPI; and (2) a group with 10 or fewer eligible clinicians. MIPS performance measures for the virtual group will be assessed on the basis of the combined performance of the entire group, payment adjustments will be made on an individual TIN/NPI level. Eligible practices may only be a part of one virtual group. The virtual group election process will not change from 2018; physicians or groups who wish to report as part of a virtual group for 2019 must apply through CMS by December 31, 2019.

CMS finalized one change to virtual group eligibility in 2019 regarding the determination of group size. In the 2018 reporting year, the size of a TIN was determined by analyzing claims over a 5-month period from July 1 to November 30 of the year preceding the performance period. CMS has now changed this to a 12-month period beginning on October 1 of the previous year through September 30 of the calendar year preceding the performance period. This analysis will be used to determine a group’s eligibility to participate as a virtual group.

Participation in a virtual group will not change the financial relationship between a clinician and/or group and an entity furnishing health services for the purposes of self-referral.

Advanced Alternative Payment Models (APMs)

Medicare Advanced APMs

CMS finalized changes to the three criteria to qualify as an Advanced APM;

- 1) **Use of CEHRT:** CMS finalized that Advanced APMs require 75% of eligible clinicians in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals. This is being increased from 50% currently required in 2018.
- 2) **MIPS-Comparable Quality Measures:** CMS clarified that effective January 1, 2020, that at least one of the quality measures upon which an Advanced APM bases their payment must either be on the MIPS final list of measures, endorsed by a consensus-based entity; or otherwise determined by CMS to be evidenced-based, reliable, and valid. CMS in this rule also clarifies that at least one outcome measure should be reported, if applicable, and that it must meet these same quality measure criteria. This requirement does not apply if CMS determines that there are no available or applicable outcome measures included in the MIPS quality measures list for the Advanced APM's first QP Performance Period.
- 1) **Bearing Financial Risk for Monetary Losses:** CMS maintains the generally applicable 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 QP Performance Periods 2021 through 2024.

Other Payer Advanced APM Criteria

CMS is moving forward with allowing eligible clinicians to become Qualifying APM Participants (QP) by utilizing the All-Payer Combination of participating in Medicare's Advanced APMs and with Other Payers. To be consistent and reduce burden, CMS will require that other payers meet the same criteria as Medicare APMs by January 1, 2020. Also, CMS will phase in the CEHRT requirement by requiring at least 50 percent in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals for 2019 and then 75% for 2020 and beyond.

CMS will allow QP determinations to be requested at the tax ID number (TIN) level in addition to the APM Entity and individual eligible clinician levels. QP determinations made at the TIN level requires all clinicians to reassign their billing rights to the APM Entity. CMS clarifies that, in making QP determinations using the All-Payer Combination Option, eligible clinicians may meet the minimum Medicare threshold using one method, and the All-Payer threshold using the same or a different method.

Qualifying APM Participant (QP) and Partial QP Determinations

CMS finalized that for each of the three QP determinations (March 31, June 30, and August 31), they will allow for claims run-out for 60 days (approximately 2 months), before calculating the Threshold Score so that the three QP determinations will be completed approximately 3 months after the end of that determination time period. CMS is shortening the claims run-out period by 30 days so that eligible clinicians are notified of their QP status more quickly after each of the

three QP determination snapshot dates, and prior to the beginning of the MIPS data submission period after the last determination. This offers clinicians the option of electing to report under MIPS for the reporting year if they do not receive a QP status.

CMS also decided that when an eligible clinician is determined to be a Partial QP for a year at the individual eligible clinician level, the individual eligible clinician can make an election whether to report to MIPS. If the eligible clinician elects to report to MIPS, they will be subject to the MIPS reporting requirements and payment adjustment. In the absence of an explicit election to report to MIPS, the eligible clinician will be excluded from the MIPS reporting requirements and payment adjustment. CMS states that this is meant to ensure that no actions other than the eligible clinician's affirmative election to participate in MIPS would result in that eligible clinician becoming subject to the MIPS reporting requirements and payment adjustment.

All-Payer Combination

The All-Payer Combination Option allows eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess a combination of both Medicare Part B covered professional services furnished through their Advanced APMs and services furnished through Other Payer Advanced APMs. CMS will use the Threshold Score, of either the payment amount or patient count, that is most advantageous to the eligible clinician toward achieving QP status, or if QP status is not achieved, Partial QP status, for the year.

Other APM Entities or eligible clinicians working with them must submit all of the payment amount and patient count information to CMS in order for them to make QP determinations by December 1 of the calendar year that is 2 years prior to the payment year, which is referred to as the QP Determination Submission Deadline. CMS requires this because they do not have access to the Other APM Entities data since private payer data is not usually shared in the public domain.

The ACR's MACRA Committee and staff are further analyzing and digesting this rule for the membership to prepare future tools and materials. ACR will also submit comments on the final rule before the December deadline.