Overview of MACRA Proposed Rule:
CMS Outlines the Details of Medicare's New Quality Payment Program

On May 9, 2016, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule[1] addressing implementation of physician payment reforms included in the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA").[2] This proposed rule defines how CMS intends to shift traditional fee-for-service payments that reward physicians for the volume of services delivered to Medicare payments that reward value and patient outcomes.

The changes to the physician payment system are immense and complex. More than 1 million physicians, other practitioners, and medical suppliers receive Medicare payment under the Physician Fee Schedule. Changes in clinician behavior under this new framework are expected to yield gains in quality of care, resulting in lower morbidity and mortality, and in cost savings. Clinicians' Medicare revenue will be at risk, so clinicians must act to determine how best to participate in the various payment options established in MACRA.

Stakeholders are encouraged to provide CMS with feedback on the proposed rule to help shape how these payment reforms are implemented. Comments are due **June 27, 2016**.

Background on MACRA Physician Payment Framework

MACRA set a framework for Medicare Part B clinicians to take part in the CMS Quality Payment Program that rewards value and outcomes in one of two ways: through the Merit-Based Incentive Payment System ("MIPS") and Advanced Alternative Payment Models ("Advanced APMs").

The Quality Payment Program replaces the Sustainable Growth Rate ("SGR") mechanism that was set up by the Balanced Budget Act of 1997.[3] The SGR was intended to cap the growth in Part B outlays by lowering fee rates if total spending exceeded a global target tied to growth in the overall economy. But Congress routinely overrode the cuts the formula would have demanded starting in 2003 until new annual payment updates were put in place on July 1, 2015.

MIPS modifies and consolidates key components of the Physician Quality Reporting System ("PQRS"), the Value Modifier ("VM") and the Medicare Electronic Health Record ("EHR") Incentive Program (known as "Meaningful Use" or "MU"). Those existing quality reporting programs, for eligible providers, are combined into a single program based on performance in four categories: Quality, Resource Use, Clinical Practice Improvement Activities ("CPIA"), and Advancing Care Information (related to the electronic exchange of interoperable health information).

APMs have been undergoing testing through a variety of demonstration initiatives – such as the recently announced Comprehensive Primary Care Plus project – as well as statutory programs such as the Medicare Shared Savings Program. As discussed later, Medicare will offer a 5 percent bonus payment to

[1] 81 Fed. Reg. 28,161 (May 9, 2016).
[2] Pub. L. 114-10 (enacted Apr. 16, 2015).
[3] Pub. L. 105-33 (enacted Aug. 5, 1997).

clinicians reaching set thresholds for revenues derived from qualifying Advanced APMs – generally, ones that include more than nominal downside risk. CMS expects roughly 5 to 10 percent of clinicians will surpass the APM threshold.

MACRA provides for technical assistance to MIPS-eligible clinicians in small practices – those having fewer than 15 eligible clinicians – as well as in rural areas or designated Health Professional Shortage Areas ("HPSAs"). CMS has included a number of proposals in the proposed rule to accommodate clinicians in rural areas and designated HPSAs.

MIPS Overview

Beginning in 2019, MIPS eligible clinicians will receive a positive, neutral, or negative payment adjustment based on how their performance on MIPS-reported measures and activities compares to a baseline performance threshold.[4] MIPS eligible clinicians are incentivized to engage in proven improvement measures and activities that impact health care quality, efficiency, and patient safety and are relevant for their patient population.

MIPS Adjustment Timeline

Performance Period – full calendar year that is 2 years prior to the Payment Year

- 1st Performance Period:
  - Dates of service from Jan. 1, 2017 – Dec. 31, 2017
  - Processing dates of Jan. 1, 2017 – Mar. 31, 2018 [90-day claims run-out]

Payment Year – MIPS adjustment applied to Part B payments for items and services furnished during the full calendar year

- 1st Payment Year: Dates of service from Jan. 1, 2019 – Dec. 31, 2019

For the first two years of MIPS (payment years 2019 and 2020), MIPS eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such professionals. Starting with payment year 2021, CMS may specify other professionals as MIPS eligible clinicians, including physical or occupational therapists, speech-language pathologists, audiologists, certified nurse midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals. CMS proposes to allow clinicians who do not qualify as MIPS eligible clinicians to voluntarily report measures and activities for MIPS. These clinicians would gain experience with reporting under MIPS, but would not receive a payment adjustment under MIPS.

Certain clinicians are excluded from participation in MIPS: clinicians who are in their first year of Medicare Part B participation will not be treated as MIPS eligible clinicians until the subsequent year and performance period for that year. Clinicians who are Qualifying APM Participants ("QP") or Partial

[4] The applicable percentage adjustments for each year are: 4% for 2019; 5% for 2020; 7% for 2021; 9% for 2022 and beyond. Positive adjustments must be paid out in an amount equal to the total negative adjustments made to clinicians. Accordingly, MACRA allows for the application of a scaling factor to the positive adjustment percentages of up to 3 times (e.g., positive adjustments could reach up to 12% in 2019, 15% in 2020, 21% in 2021, and 27% in 2022) if the full scaling factor is applied. There is also an additional payment adjustment of up to 10% possible for "exceptional" performers.

Completeness Criteria and Submission Periods/Deadlines

Qualified Registries, QCDRs, EHRs, Attestations – 90% of patients meeting measure criteria; 3-month submission period following the close of the performance period

- 1st Performance Period: Jan. 2, 2018 – Mar. 31, 2018

Claims submissions – 80% of applicable Part B patients; deadline 90 days following the close of the performance period

- 1st Performance Period: submission by Mar. 31, 2018

CMS Web Interface – Sample of Part B patients provided by CMS; 8-week submission timeframe after the close of the performance period

- 1st Performance Period:
  - Groups must register for participation via CMS Web Interface by Jun. 30, 2017
  - Specific submission period to be determined, but will be between Jan. 1, 2018 and Mar. 31, 2018

CAHPS – Sample of Part B patients provided by CMS; November to February survey administration period

- 1st Performance Period:
  - Groups must register for CAHPS administration by Jun. 30, 2017
  - Administration period from Nov. 2017 – Feb. 2018

Qualifying APM Participants ("Partial QP") who do not report on MIPS measures and activities will not be treated as MIPS eligible clinicians. The same is true for clinicians who are below a low-volume threshold. CMS proposes to define the low-volume threshold as an individual or group that, during the performance period, has Medicare billing charges of less than or equal to $10,000 and provides care for 100 or fewer Part B enrolled Medicare beneficiaries.

MIPS Performance Categories, Reporting, and Scoring

Data Submission Mechanisms

Clinician submission mechanisms for the Quality, CPIA, and Advancing Care Information performance categories[5] would include claims, PQRS's qualified clinical data registry ("QCDR"), other qualified registries or EHRs. Clinicians must use the same identifier for all performance categories and may use only one submission mechanism per performance category (e.g., a clinician cannot submit three quality measures via claims and two quality measures via registry). In lieu of submissions, clinicians may defer to administrative claims data and attestations for certain categories. Group practices of 25 or more clinicians would have the additional option of reporting via the CMS Web Interface.[6] Qualified vendors would be permitted to submit data on behalf of clinicians or groups. Groups of two or more eligible clinicians that elect to submit CAHPS data[7] for MIPS must use a CMS-approved vendor. The proposed submission timeframes are generally the same as currently used for PQRS.

[5] CMS is not proposing data submission requirements for the Resource Use performance category, because performance will be calculated using administrative claims data.
[6] The CMS Web Interface is a web product developed by CMS that is used by groups to submit data on the MIPS measures and activities.
[7] This refers to the Consumer Assessment of Healthcare Providers and Systems ("CAHPS") Clinician & Group Survey plus additional survey questions to meet MIPS information and program needs.

Composite Performance Scoring

CMS has proposed using a unified scoring system to keep the scoring as simple as possible. The following characteristics are suggested to be incorporated into the proposed scoring methodologies for each of the 4 performance categories:

- For the Quality and Resource Use performance categories, all measures would be converted to a 10-point scoring system;
- The measure and activity performance standards would be published, where feasible, before the performance period begins;
- CMS is not looking to include an "all or nothing" reporting requirement for MIPS, but providers who fail to report on an applicable measure or activity will receive the lowest possible score (zero points);
- The scoring proposals provide incentives to invest and focus on certain measures and activities that meet high priority goals; and
- Performance at any level would receive points towards the performance category scores.

Quality Performance Category

Under CMS's proposed submission criteria, clinicians would be required to report at least six quality measures, including at least one outcome or other high priority measure (e.g., appropriate use, patient experience, safety and care coordination). Measures must be chosen from the MIPS measure set or specialty-specific measure set. Groups of 25 or more clinicians must report on all measures in a set. Patient-facing clinicians must include at least one cross-cutting measure, while non-patient-facing clinicians are excluded from this requirement.

Clinicians or groups that do not report, despite the ability to report with a sufficient sample size on required measures, will receive a zero performance score for the missing measures. CMS also proposes data completeness criteria that are more stringent than PQRS. Failure to adhere to these criteria would cause providers to fail the MIPS quality component. CMS seeks feedback on its proposed data completeness criteria.

As required by MACRA, in payment years 2019 and 2020, the Quality performance category will make up 50 and 45 percent of the MIPS Composite Performance Score ("CPS"), respectively. For 2021 and years thereafter, it will account for 30 percent.

Quality Measure Selection

After earlier soliciting feedback,[8] CMS sets forth a proposed approach to measure selection and applicability across clinician types. CMS would permit clinicians flexibility in choosing the measures they will report, though CMS encourages the selection of measures across multiple domains.

[8] CMS issued a Request for Information soliciting comments on implementation of certain aspects of MIPS. *See* 80 Fed. Reg. 59,102 (Oct. 1, 2015). CMS also solicited comments on the Draft CMS Measure Development Plan. The Final Measure Development Plan was published on May 2, 2016. *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf.

In the proposed rule, CMS acknowledged MedPAC's recommendation that it shift quality measurement focus toward a small set of population-based outcomes measures. In future rulemaking, CMS intends to increase the number of required outcome measures, as well as other high priority measures such as appropriate use, patient experience, safety and care coordination, and seeks feedback on the same.

The proposed measure sets are the product of the Core Quality Measure Collaborative, an effort by CMS and private payers to simplify measure sets and reduce provider reporting burden. In addition to the measures contained in the proposed sets, CMS announced that it will accept the submission of proposed quality measures and measure updates. To be considered for inclusion in the annual list of quality measures, submissions must be made prior to June 1. CMS intends to retain the majority of PQRS measures for the first year of MIPS and proposes to continue its annual "Call for Quality Measures" but CMS also seeks comments on specific measures for inclusion in measure sets in the proposed rule.

Further, CMS seeks comments on the following specific proposals and possible approaches:

- The feasibility of incorporating measures from other systems into MIPS for purposes of measuring facility-based clinicians;
- Whether health information technology ("IT") vendors, QCDRs and qualified registries should be given the capability in future rulemaking to submit data for all MIPS performance categories;
- How CMS might best encourage MIPS eligible clinicians to report on quality measures through the use of certified EHR technology ("CEHRT") and QCDRs;
- Optional use of facility-based measures as a proxy for facility-based clinician performance;
- Whether reporting on CAHPS for MIPS should be required for clinician groups of 100 or more;
- Accommodations for non-patient-facing clinicians; and
- Whether reporting at the subspecialty level might satisfy specialty reporting requirements.

Resource Use Performance Category

To measure resource use for MIPS, CMS plans to draw upon the practices of the VM program, such as methods for measure reliability, patient attribution, risk adjustment and payment standardization. Provider reporting requirements will not apply to the Resource Use performance category, as CMS proposes to use administrative claims data for this purpose.

For CY 2017, CMS proposes to use six existing global, condition and episode-based cost measures:

1. Total per capita costs for all attributed beneficiaries
2. Total per capita costs for all attributed beneficiaries with chronic obstructive pulmonary disease
3. Total per capita costs for all attributed beneficiaries with congestive heart failure
4. Total per capita costs for all attributed beneficiaries with coronary artery disease
5. Total per capita costs for all attributed beneficiaries with diabetes mellitus
6. Medicare spending per beneficiary.

Measures apply to Part A and B costs only. Measure performance will be attributed at the group and individual clinician levels, weighted equally, and adjusted for geographic payment rates and beneficiary

risk factors. For the total per capita cost measures, CMS will use a slightly modified two-step attribution methodology based on the delivery of primary care services that is similar to the methodology used for the Medicare Shared Savings Program. For the Medicare spending per beneficiary measure, the attribution is based on Part B services rendered to a patient during an inpatient hospitalization.

As required by MACRA, in payment years 2019 and 2020, the Resource Use performance category will make up 10 and 15 percent of the MIPS CPS, respectively. For 2021 and thereafter, it will account for 30 percent, thereby giving the Quality and Resource Use performance categories equal weight in later years of the program.

CPIA Performance Category

The CPIA performance category emphasizes practice activities associated with improved outcomes. CMS proposes baseline requirements under this performance category and will develop more stringent criteria in future years.

MACRA prioritizes patient-centered medical homes as a high-value CPIA. CMS seeks comments on the proposed criteria for determining which entities qualify as patient-centered medical homes, as well as how to credit these entities for the CPIA performance category.

Patient-Centered Medical Home Criteria to Achieve Highest Potential Score for CPIA Performance Category

- Nationally recognized accredited patient-centered medical home
  - Must be national in scope
  - Must be used by a large number of medical organizations
- Medicaid Medical Home Model
- Medical Home Model
- NCQA Patient-Centered Specialty Recognition (comparable specialty practice)

Proposed CPIA subcategories include expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an APM, promoting health equity and continuity, social and community involvement, achieving health equity, emergency preparedness and response, and integration of primary care and behavioral health. MACRA requires CMS to create an inventory of CPIAs. CMS seeks comments on the above subcategories and associated qualifying activities, as well as the CPIA inventory. CMS has identified more than 90 activities with associated activity weighting (e.g., high, medium). In future years, CMS plans to develop a call for measures and activities process for the CPIA inventory.

As proposed, the CPIA performance category will make up 15 percent of the MIPS CPS. CMS proposes to accommodate non-patient-facing clinicians and those in rural areas and HPSAs by allowing these groups to submit a minimum of one activity to achieve partial credit or two activities to achieve full credit for the CPIA performance category.

Advancing Care Information Performance Category

MACRA transitions the Meaningful Use program to a new performance category – Advancing Care Information. To accomplish this transition, CMS proposes a more flexible approach to measuring use of EHR technology, with a greater emphasis on high impact measures (e.g., interoperability, information exchange, and security measures). CMS's proposed methodology would deemphasize measures where physicians are already performing at over 90 percent.

While the Meaningful Use program featured clinical quality measures, CMS only plans to apply clinical quality measurement in the Quality performance category (described above). Further, rather than apply the Meaningful Use program's 90-day EHR reporting period, CMS intends to align reporting periods across performance categories, which will be for one year. For the first performance year (2017), CMS has proposed that MIPS eligible clinicians would be able to use 2014 or 2015 Edition EHR technology certification criteria.[9] Beginning with the 2018 performance year, MIPS eligible clinicians must use 2015 Edition criteria.

In calculating the overall performance category score, CMS proposes to use a base score, performance score and a potential bonus point for Public Health and Clinical Data Registry Reporting. CMS proposes to provide a primary and alternative option for scoring under the base score. MIPS eligible clinicians would earn additional points above the base score for performance on measures such as Patient Electronic Access, Coordination of Care Through Patient Engagement, and Health Information Exchange.

CMS proposes specific measures for each of the six objectives[10] under the Advancing Care Information performance category and invites comments on the same.

APM Overview

Beginning in 2019 through 2024, clinicians participating in Advanced APMs may become QPs who are eligible for an annual lump-sum bonus equal to 5 percent of their prior year's payments for Part B covered professional services.[11] This bonus payment would be in addition to any payment incentives that the clinicians receive through participation in the Advanced APM itself. In addition to the bonus payment, benefits to QP status include exemption from the MIPS payment adjustments and, beginning in 2026, QPs receive a higher annual payment update than non-QPs (e.g., 0.75 percent vs. 0.25 percent).

[9] The Office of the National Coordinator ("ONC") Health IT Certification Program Standards and Certification Criteria are available at https://www.healthit.gov/policy-researchers-implementers/standards-and-certification-regulations.

[10] The six objectives are (1) Protect Patient Health Information; (2) Electronic Prescribing; (3) Patient Electronic Access; (4) Coordination of Care Through Patient Engagement; (5) Health Information Exchange; and (6) Public Health and Clinical Data Registry Reporting.

[11] There are three distinct roles in the Advanced APM program structure: the Advanced APM (the health care payment and/or delivery model), the Advanced APM Entity (the entity participating in the Advanced APM), and the Eligible Clinician (the individual or group participating in the Advanced APM Entity).

Steps to Determine QP Status

CMS has proposed a multi-step process for determining if a clinician qualifies as a QP who is eligible for the APM bonus payment for a given performance period.

Step 1: Is the Clinician Participating in an APM that is an "Advanced APM"?

CMS determines whether the design of an APM meets three specified criteria for it to be deemed an Advanced APM. Namely, the APM must:

- Require participants to use CEHRT;
- Provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS; and
- Either require that participating APM Entities bear more than nominal risk for financial losses under the APM, or be a Medical Home Model.

APM Bonus Timeline

QP Performance Period – full calendar year that is 2 years prior to the Payment Year

- 1st Performance Period: Jan. 1, 2017 – Dec. 31, 2017
- APM participants for 1st Performance Period determined as of Dec. 31, 2017

Base Period – 5% bonus calculated based on services furnished in the calendar year prior to the Payment Year

- 1st Base Period:
  - Dates of service from Jan. 1, 2018 – Dec. 31, 2018
  - Processing dates of Jan. 1, 2018 – Mar. 31, 2019 [3-month claims run-out]

Payment Year – one-time 5% bonus paid during calendar year

- 1st Payment Year: 2019

Step 2: Is the Clinician Identified as Part of the Advanced APM Entity?

QP determinations apply to all of the individual eligible clinicians who are identified as part of the Advanced APM Entity. An eligible clinician would have to be listed on December 31 of the QP Performance Period as part of an Advanced APM Entity to attain QP status. CMS proposes to use the Advanced APM Entity's Participation List to identify eligible clinicians, or if not available, CMS will use an Affiliated Practitioner List.

Advanced APM Criteria

CEHRT must be used to document care and communicate with patients and other health care professionals

- 1st Performance Period (2017): at least 50% of eligible clinicians must use CEHRT
- 2nd Performance Period (2018) and beyond: the threshold increases to 75%
- MSSP Participants: criterion met if program holds APM Entities accountable for eligible clinicians' use of CEHRT

Quality Measure results must be a factor in determining payment to participants under the terms of the APM

- To be comparable to MIPS measures, the measures used by the APM should:
  - Have an evidence-based focus, and be reliable and valid
  - Target certain priorities such as clinical outcomes, use, and overuse
- The APM must include at least one of the following:
  - Measures included on the proposed annual list of MIPS quality measures
  - Measures that are endorsed by a consensus-based entity
  - Measures developed under the CMS Measure Development Plan
  - Measures submitted in response to the MIPS Call for Quality Measures
  - Any other measures approved by CMS
- The APM must include at least one outcome measure, if available

Financial Risk or Participation in Medical Home Model required under the APM

- "More than nominal" financial risk is defined as:
  - Marginal risk of at least 30%
  - Minimum loss rate of no more than 4%
  - Total (potential risk) of at least 4% of expected expenditures

Step 3: Have the Eligible Clinicians in the Advanced APM Entity Collectively Received at Least a Specified Percentage of Payments or Patients Through the Advanced APM?

To qualify for the APM bonus, clinicians participating in an Advanced APM must over time receive an increasing share of their revenue, or see an increasing percentage of their patients, through the Advanced APM. CMS proposes a payment amount model and a patient count model for calculating the threshold percentages that eligible clinicians participating in an Advanced APM Entity must meet in order to be QPs. CMS proposes to calculate the threshold percentages for the Advanced APM Entity under both the payment amount and the patient count methods simultaneously, and determine which method is most favorable for determination of QP status.

In the first two years of the program (2019 and 2020), the percentage of revenue or patients received through an Advanced APM must be from Medicare only. Starting in payment year 2021, an Advanced APM Entity can meet the threshold based on either Medicare-only revenue/patient count or revenue/patient count from all payers, as long as at least a certain percentage of the all-payer count is from Medicare. Other payer revenue applicable to the all-payer threshold could include revenue from Medicaid programs and commercial payers, including Medicare Advantage plans.

These two threshold options are described in the following two tables:

Medicare Option – Payment Amount Model Aggregate of All Medicare Part B Payments for Services Furnished to Attributed Beneficiaries by Eligible Clinicians / Aggregate of All Medicare Part B Payments for Services Furnished to Attribution-Eligible Beneficiaries by Eligible Clinicians						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024 and beyond**
QP Payment Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Threshold	20%	20%	40%	40%	50%	50%
Medicare Option – Patient Count Model Number of Unique Attributed Beneficiaries to whom Eligible Clinicians Furnished Medicare Part B Covered Services / Number of Attribution-Eligible Beneficiaries to whom Eligible Clinicians Furnished Medicare Part B Covered Services						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024 and beyond**
QP Patient Threshold	20%	20%	35%	35%	50%	50%
Partial QP Patient Threshold	10%	10%	25%	25%	35%	35%

All-Payer Combination Option – Payment Amount Model Aggregate of All Payments from Other Payers (With Certain Exceptions) for Services Furnished to Patients by Eligible Clinicians Under the Other Payer Advanced APM / Aggregate of All Payments from Other Payers (With Certain Exceptions) to Eligible Clinicians **+** Aggregate of All Medicare Part B Payments for Services Furnished to Attributed Beneficiaries by Eligible Clinicians / Aggregate of All Medicare Part B Payments for Services Furnished to Attribution-Eligible Beneficiaries by Eligible Clinicians								
Payment Year	**2021**		**2022**		**2023**		**2024 and beyond**	
	Total	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**
QP Payment Threshold	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Threshold	40%	20%	40%	20%	50%	20%	50%	20%
All-Payer Combination Option – Patient Count Model Number of Unique Patients to whom Eligible Clinicians Furnished Services Under the Other Payer Advanced APM / Number of Unique Patients to whom Eligible Clinicians Furnished Services Under All Non-Excluded Payers **+** Number of Unique Attributed Beneficiaries to whom Eligible Clinicians Furnished Medicare Part B Covered Services / Number of Attribution-Eligible Beneficiaries to whom Eligible Clinicians Furnished Medicare Part B Covered Services								
Payment Year	**2021**		**2022**		**2023**		**2024 and beyond**	
	Total	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**	**Total**	**Medicare**
QP Patient Threshold	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Threshold	25%	10%	25%	10%	35%	10%	35%	10%

In sum, if an APM is deemed an Advanced APM, an eligible clinician is identified as a participant in an Advanced APM Entity that is participating in the Advanced APM, and applicable revenue or patient counts reach the specified QP percentage thresholds identified above, then all of the eligible clinicians in the Advanced APM Entity will be designated as QPs for the payment year associated with the QP Performance Period. Those clinicians would receive the 5 percent lump-sum APM bonus payment. For the individual clinician participants in the Advanced APM Entity, QP status is applied to the clinician's National Provider Identifier ("NPI") across all of the Tax Identification Numbers ("TINs") to which the clinician has reassigned the right to receive Medicare payment, not just the billing TIN affiliated with the Advanced APM Entity.

If an Advanced APM Entity does not meet the QP percentage thresholds, the eligible clinicians within the Advanced APM Entity may qualify as Partial QPs instead, if their revenues or patient counts reach the applicable Partial QP percentage thresholds. Partial QPs do not qualify for the APM bonus payment, but they can choose whether to report under MIPS for a performance year. Partial QPs that elect not to report under MIPS are exempted from the MIPS payment adjustment for that year.

Program Integrity

Finally, as a reminder that these are federal dollars at stake, CMS proposes that it will monitor Advanced APM Entities and eligible clinicians on an ongoing basis for non-compliance with the conditions of participation for Medicare and the terms of the relevant Advanced APMs in which they participate during the QP Performance Period. If an Advanced APM terminates an Advanced APM Entity or eligible clinician during the QP Performance Period for program integrity reasons, or if the Advanced APM Entity or eligible clinician is out of compliance with program requirements, CMS may reduce or deny the APM bonus payment to such eligible clinicians. In addition, if the APM Incentive Payment is paid during the QP Performance Period and the Advanced APM Entity or eligible clinician is later terminated due to a program integrity matter arising during the QP Performance Period, CMS may recoup all or a portion of the amount of the payment from the entity to which CMS made the payment.

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