AAOS MACRA Proposed Rule Summary

Merit-Based Incentive Payment System (MIPS), Advanced Alternative Payment Model (APM) Incentive, and Criteria for Physician-Focused Payment Models


The Medicare Access and CHIP Reauthorization Act (MACRA) proposed rules as referenced above proposes the principles of implementing the Quality Payment Program (QPP) which includes two pathways:

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Comments are due to CMS by June 27, 2016.

This summary is divided into three sections as follows:

Section 1: Definitions of key terms
Section 2: Summary of the major provisions
Section 3: AAOS talking points on these proposed rules

Section 1: Definitions of key terms

The following terms and definitions were established by the MACRA statute. Further, the proposed rule renames some of these:

**Additional performance threshold**: An additional level of performance, in addition to the performance threshold, for a performance period at the composite level at or above which a MIPS eligible clinician may receive an additional positive MIPS adjustment factor.

**Advanced Alternative Payment Model (Advanced APM)**: an APM that CMS determines meets the criteria set forth in §414.1415.

**Advanced APM Entity**: an APM entity that participates in an Advanced APM or Other Payer Advanced APM through a direct agreement with CMS or a non-Medicare other payer, respectively.
**Affiliated practitioner:** an eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity based at least in part on supporting the Advanced APM Entity’s quality or cost goals under the Advanced APM.

**Alternative Payment Model (APM):** Any of the following:
- A model under § 1115A of the Act (other than a health care innovation award);
- The shared savings program under § 1899 of the Act;
- A demonstration under § 1866C of the Act; or
- A demonstration required by Federal law.

**APM Entity:** an entity that participates in an APM or Other Payer APM through a direct agreement with CMS or a non-Medicare other payer, respectively.

**APM Entity group:** the group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, Taxpayer Identification Number (TIN), and National Provider Identifier (NPI) for each participating eligible clinician.

**APM Incentive Payment:** the lump sum incentive payment paid to Qualifying APM Participants.

**Attestation:** a secure mechanism, specified by CMS, with respect to a particular performance period, whereby a MIPS eligible clinician or group may submit the required data for the advancing care information and/or CPIA performance categories of MIPS in a manner specified by CMS.

**Attributed beneficiary:** a beneficiary attributed, according to the Advanced APM’s attribution rules, to the Advanced APM Entity on the latest available list of attributed beneficiaries during the QP Performance Period (see below for definition).

**Attribution-eligible beneficiary:** A beneficiary who during the QP performance period:
- Is not enrolled in Medicare Advantage or a Medicare cost plan;
- Does not have Medicare as a secondary payer;
- Is enrolled in both Medicare Parts A and B;
- Is at least 18 years of age;
- Is a United States resident; and
- Has a minimum of one claim for evaluation and management services furnished by an eligible clinician in the APM Entity group for any period during the QP Performance Period. For APMs that CMS determines to be focused on specific specialties or conditions or to have an attribution methodology that is not based on evaluation and
management services, CMS uses a comparable standard related to the APM-specific attribution methodology for identifying beneficiaries as potential candidates for attribution.

**Certified Electronic Health Record Technology (CEHRT):**
For any calendar year before 2018, EHR technology – which could include multiple technologies – certified under the ONC Health IT Certification Program that meets the 2014 Edition Base EHR definition and that has met the certification criteria necessary to report on applicable objectives and measures specified for the MIPS advancing care information performance category or for all certification criteria that support a meaningful use objective with a percentage-based measure; or

For 2018 and subsequent years, EHR technology – which could include multiple technologies – certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition and has been certified to the 2015 Edition health IT certification criteria and reports on applicable objectives and measures specified for the MIPS advancing care information performance category or for all certification criteria that support a meaningful use objective with a percentage-based measure.

For additional information on CEHRT as it relates to MIPS, please visit pp. 693 – 696 of the MACRA proposed rule: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf

**Clinical Practice Improvement Activity (CPIA):** an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

**Composite Performance Score (CPS):** a composite assessment (using a scoring scale of 0 to 100) for each MIPS eligible clinician for a specific performance period determined using the methodology for assessing the total performance for a MIPS eligible clinician according to performance standards for applicable measures and activities for each performance category. The CPS is the sum of each of the products of each performance category score and each performance category’s assigned weight.

**Eligible Clinician:** “eligible professional” as defined in §1848(k) (3) of the Act, is identified by a unique TIN and NPI combination and means any of the following:

- A physician;
- A practitioner described in §1842(b)(18)(C) of the Act;
- A physical or occupational therapist or a qualified speech-language pathologist; or
- A qualified audiologist (as defined in §1861(ll)(3)(B) of the Act).
**Episode Payment Model:** An APM or other payer arrangement that incentivizes improving the efficiency and quality of care for an episode of care by bundling payment for services furnished to an individual over a defined period of time for a specific clinical condition or conditions.

**Estimated Aggregate Payment Amounts:** The total payments to a QP for Medicare Part B covered professional services for a year estimated by CMS as described in §414.1450(b).

**Group:** A single TIN with two or more MIPS eligible clinicians, as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN.

**High Priority Measure:** An outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination quality measure.

**Hospital-based MIPS eligible clinician:** A MIPS eligible clinician who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the performance period.

**Incentive Payment Base Period:** The calendar year prior to the year in which CMS disburses the APM Incentive Payment. CMS uses estimated aggregate payments to a QP for Medicare Part B covered professional services during this period as the basis for determining the Estimated Aggregate Expenditures described in §414.1450(b)(3).

**Low-volume Threshold:** An individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

**Meaningful EHR User for MIPS:** A MIPS eligible clinician who possesses CEHRT, uses the functionality of CEHRT, and reports on applicable objectives and measures specified for the advancing care information performance category for a performance period in the form and manner specified by CMS.

**Measure Benchmark:** The level of performance that the MIPS eligible clinician is assessed on for a specific performance period at the measures and activities level.

**Medicaid APM:** Meets the criteria to be an Other Payer Advanced APM, must meet three requirements similar to the CMS Advanced APM requirements: (1) require participants to use certified EHR technology; (2) provide payment based on quality measures comparable to those used in the quality performance category of MIPS; and (3) be either a Medicaid Medical Home Model that is comparable to Medical Home Models expanded under § 1115A of the Act or bear more than a nominal amount of risk for monetary loses.
**Medical Home Model:** Proposes to define the terms “Medical Home Model” and “Medicaid Medical Home Model” as subsets of APMs and Other Payer APMs. Must have the following elements at a minimum:

- Model participants include primary care practices or multispecialty practices that include primary care physician and practitioners and offer primary care services.
- Empanelment of each patient to a primary clinician. In addition to these elements, we propose that a Medical Home Model must have at least four of the following elements:
  - Planned coordination of chronic and preventive care;
  - Patient access and continuity of care;
  - Risk-stratified care management;
  - Coordination of care across the medical neighborhood;
  - Patient and caregiver engagement;
  - Shared decision-making;
  - Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings, population-based payments).

An APM cannot be a Medical Home Model unless it has a primary care focus with an explicit relationship between patients and their practitioners.

**Medicaid Medical Home Model:** Proposes to define the terms “Medical Home Model” and “Medicaid Medical Home Model” as subsets of APMs and Other Payer APMs. Proposed definition of Medicaid Medical Home Model is identical to Medical Home Model, except that it specifically describes a payment arrangement operated by a State Merit-Based Incentive Payment System (MIPS): New program for certain Medicare-participating practitioners. MIPS would consolidate components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals (EPs), and would continue the focus on quality, resource use, and use of certified EHR technology in a cohesive program that avoids redundancies.

**MIPS APM:** An APM for which the APM scoring standard applies

**MIPS eligible clinician:** As identified by a unique TIN and NPI combination, means any of the following:

1. A physician as defined in § 1861(r) of the Act. (from 1861(r) of the Act: The term “physician”, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine
and surgery by the State in which he performs such function or action, (2) a doctor of
dental surgery or of dental medicine who is legally authorized to practice dentistry by
the State in which he performs such function and who is acting within the scope of his
license when he performs such functions, (3) a doctor of podiatric medicine but only
with respect to functions which he is legally authorized to perform as such by the
State in which he performs them, (4) a doctor of optometry, but only with respect to
the provision of items or services described in subsection(s) which he is legally
authorized to perform as a doctor of optometry by the State in which he performs
them, or (5) a chiropractor who is licensed as such by the State (or in a State which
does not license chiropractors as such, is legally authorized to perform the services of
a chiropractor in the jurisdiction in which he performs such services), and who meets
uniform minimum standards promulgated by the Secretary, but only with respect to
treatment by means of manual manipulation of the spine (to correct a subluxation)
which he is legally authorized to perform by the State or jurisdiction in which such
treatment is provided.

2. A physician assistant, a nurse practitioner, and clinical nurse specialist as such terms
are defined in §1861(aa)(5) of the Act.
3. A certified registered nurse anesthetist as defined in §1861(bb)(2) of the Act.
4. A group that includes such clinicians.

MIPS payment year: The calendar year in which MIPS payment adjustments are applied.

New Medicare-Enrolled MIPS eligible clinician: An eligible clinician who first becomes a
Medicare-enrolled eligible clinician within the Provider Enrollment, Chain and Ownership
System (PECOS) during the performance period for a year and who had not previously
submitted claims as a Medicare-enrolled eligible clinician either as an individual, an entity, or a
part of a physician group or under a different billing number or tax identifier

Non-patient-facing MIPS eligible clinician: An individual MIPS eligible clinician or group that
bills 25 or fewer patient-facing encounters during a performance period.

Other Payer Advanced APM: A commercial or Medicaid APM must meet three requirements
similar to the CMS Advanced APM requirements: (1) require participants to use certified EHR
technology; (2) provide payment based on quality measures comparable to those used in the
quality performance category of MIPS; and (3) be either a Medicaid Medical Home Model that
is comparable to Medical Home Models or bear more than a nominal amount of risk for
monetary loses.

Partial Qualifying APM Participant (Partial QP): An eligible clinician determined by CMS to
have met the relevant Partial QP Threshold for a year.
**Partial QP patient count threshold:** The minimum threshold score an eligible clinician must attain through a patient count methodology to become a Partial QP for a year.

**Partial QP payment amount threshold:** The minimum threshold score in §414.1430(a)(2) and (b)(2) an eligible clinician must attain through a payment amount methodology described §§414.1435(a) and414.1440(b) to become a Partial QP for a year.

**Qualified Clinical Data Registry (QCDR):** A CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

**Qualified registry:** A medical registry, a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties or other data intermediary that, with respect to a particular performance period, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the MIPS qualification requirements specified by CMS for that performance period.

**QP patient count threshold:** The minimum threshold score in §414.1430(a)(3) and (b)(3) an eligible clinician must attain through a patient count methodology described in §§414.1435(b) and 414.1440(c) to become a QP for a year.

**QP payment amount threshold** - The minimum threshold score in §414.1430(a)(1) and (b)(1) an eligible clinician must attain through the payment amount methodology described in §§414.1435(a) and 414.1440(b) to become a QP for a year.

**QP Performance Period:** The period of time that CMS will analyze to assess eligible clinician participation in Advanced APMs and Other Payer Advanced APMs for purposes of making the QP determinations in §414.1425.

**Qualifying APM Participant (QP):** An eligible clinician determined by CMS to have met or exceeded the relevant payment amount or patient count QP threshold under §414.1430(a)(1), (a)(3), (b)(1) or (b)(3) for a year based on participation in an Advanced APM Entity.

**Small practices:** Practices consisting of 15 or fewer clinicians.

**Threshold Score:** The percentage value that CMS determines for an eligible clinician based on the calculations described in §§414.1435 or 414.1440.
Topped out measure: A measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors; or median value for a process measure that is 95 percent or greater.

Section 2: Summary of the major provisions

Merit-based Incentive Payment System (MIPS) Implementation

Each performance period will consist of a calendar year (Jan 1 to Dec 31). The first performance year will begin on Jan 1, 2017 for payment adjustments in 2019. There are four proposed pillars of MIPS composite performance scores [consolidating and sunsetting the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals (EPs)]:

- Quality
- Resource Use/Cost
- Clinical Practice Improvement Activities
- Advancing Care Information

Clinicians’ MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent. The positive adjustments will be scaled up or down to achieve budget neutrality, meaning that the maximum positive adjustment could be lower or higher than 4 percent. Per MACRA, both positive and negative adjustments would increase over time. Additionally, in the first five payment years of the program, the law allows for $500 million in an additional performance bonus that is exempt from budget neutrality for exceptional performance. This exceptional performance bonus will provide high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent. The maximum negative adjustments for each year are: 2019: 4 percent, 2020: 5 percent; 2021: 7 percent; 2022 and after: 9 percent.

Beginning July 1, 2017, these rules propose providing performance feedback to MIPS eligible clinicians on the quality and resource use performance categories in the performance feedback. Initially, such performance feedback will be provided on an annual basis using a CMS designated system. In future years, CMS may consider providing performance feedback on a more frequent basis as well as adding feedback on the performance categories of CPIA and advancing care information. In the future, additional mechanisms such as health IT vendors,
registries, and QCDRs may be used to share data/information contained in the performance feedback to eligible clinicians where applicable.

Data submission deadline

The data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms would be March 31 following the close of the performance period. For example, for the first MIPS performance period, the data submission period would occur from January 2, 2018, through March 31, 2018. This submission period is the same time frame as what is currently available to eligible professionals and group practices under PQRS. CMS is seeking comments on whether it is advantageous to either (1) have a shorter time frame following the close of the performance period, or (2) have a submission period that would occur throughout the performance period, such as bi-annual or quarterly submissions; and (3) whether January 1 should also be included in the submission period. The table below [Table 1 of the proposed rules: (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf)] lays out the data submission mechanisms.

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Individual Reporting Data submission Mechanisms</th>
</tr>
</thead>
</table>
| Quality                                                | Claims  
QCDR  
Qualified registry  
EHR  
Administrative claims (no submission required) |
| Resource Use                                           | Administrative claims (no submission required) |
| Advancing Care Information                             | Attestation  
QCDR  
Qualified registry  
EHR |
| CPIA                                                   | Attestation  
QCDR  
Qualified registry  
EHR  
Administrative claims (if technically feasible, no submission required) |
**TABLE 2: Proposed Data Submission Mechanisms for Groups**

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Group Practice Reporting Data Submission Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism) and Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Resource Use</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>CPIA</td>
<td>Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) Administrative claims (if technically feasible, no submission required)</td>
</tr>
</tbody>
</table>

**Quality**

*MIPS, in contrast to PQRS, is not a pay-for-reporting program.* The stated goal for the quality performance category includes:

- Measuring performance on measures that are relevant and meaningful.
- Maximizing the benefits of CEHRT.
- Flexible scoring that recognizes all of a MIPS eligible clinician’s efforts above a minimum level of effort and rewards performance that goes above and beyond the norm.
- Measures that are built around real clinical workflows and data captured in the course of patient care activities.
- Measures and scoring that can discern meaningful differences in performance in each performance category and collectively between low and high performers.

The statute does not specify the number of quality measures on which a MIPS eligible clinician must report. However, it requires the Secretary, as feasible, to emphasize the application of outcomes-based measures and give consideration to the circumstances of non-patient-facing MIPS eligible clinicians and apply alternative measures or activities to such clinicians.
Relationship to the PQRS and VM

The PQRS, which is a pay-for-reporting program, defined standards for satisfactory reporting and satisfactory participation to earn payment incentives or to avoid a payment adjustment. EPs could choose from a number of reporting mechanisms and options. The measures had to span a set number of National Quality Strategy (NQS) domains. The VM built its policies off the PQRS criteria for avoiding the PQRS payment adjustment.

In response to commenters’ concern that the general PQRS satisfactory reporting requirement to report nine measures across three NQS domains is too high and forces eligible clinicians to report measures that are not relevant to their practices. In response to the comments, and based on CMS’ desire to simplify the MIPS reporting system, the MIPS quality criteria incorporates the following:

- To encourage meaningful measurement, CMS is proposing to allow individual MIPS eligible clinicians and groups the flexibility to determine the most meaningful measures and reporting mechanisms for their practice.
- To simplify the reporting criteria, CMS is aligning the submission criteria for several of the reporting mechanisms.
- To reduce administrative burden and focus on measures that matter, CMS is lowering the expected number of the measures for several of the reporting mechanisms, yet is still requiring that certain types of measures be reported.
- To create alignment with other payers and reduce burden on MIPS eligible clinicians, CMS is incorporating measures that align with other national payers.
- To create a more comprehensive picture of the practice performance, CMS is proposing to use all-payer data where possible.

Quality measures would be selected annually through a call for quality measures, such measures should be aligned with CMS priorities and the final measures will be published in the Federal Register by Nov 1 of each year. Clinicians can submit as an individual MIPS eligible clinician or as part of a group. A MIPS eligible clinician or group who does not meet the reporting threshold would receive a zero score for the unreported items in the category (in accordance with § 1848(q)(5)(B)(i) of the MACRA Act). The MIPS eligible clinician or group could still obtain a relatively good score by performing very well on the remaining items, but a zero score would prevent the MIPS eligible clinician or group from obtaining the highest possible score.

This performance category will account for 50 percent of the total MIPS score in year 1 (payment year 2019); 45 percent in year 2, and 30 percent for the third and future years. This replaces the PQRS and the quality component of the VM program.
Submission criteria

These rules propose at §414.1335 that individual MIPS eligible clinicians submitting data via claims and individual MIPS eligible clinicians and groups submitting via all mechanisms (excluding CMS Web Interface, and for CAHPS for MIPS survey, CMS-approved survey vendors) would choose to report 6 measures (vs the current 9 under PQRS) including one cross-cutting measure (if patient-facing) found in Table C of the proposed rules (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf) and including at least one outcome measure. CMS is requesting comments on the measures proposed under each of the specialty-specific measure sets. To keep the emphasis on outcome and care-coordination measures, requirement on reporting these may be included in future rule-making.

As an alternative, for the applicable 12-month performance period, the MIPS eligible clinician or group would report at least six measures including one cross-cutting measure (if patient-facing) found in Table C (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf) and one high priority measure (outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination measures). If fewer than six measures apply to the individual MIPS eligible clinician or group, then the MIPS eligible clinician or group must report on each measure that is applicable.

In addition, for individual clinicians and small groups (2-9 clinicians), MIPS calculates two population measures based on claims data, meaning there are no additional reporting requirements for clinicians for population measures.

For groups with 10 clinicians or more, MIPS calculates three population measures. The measures would be each worth up to ten points for a total of 80 to 90 possible points depending on group size.

In order to align with the private sector and reduce the reporting burden this proposal includes the core quality measures that private payers already use for their clinicians. When choosing the six quality measures, clinicians would choose one crosscutting measure and one outcome measure (if available) or another high quality measure. High quality measures are measures related to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination. For MIPS eligible clinicians, there will be more than 200 measures to choose from [Table A of the proposed rules (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf)] and more than 80 percent of the quality measures proposed are tailored for specialists (Table E a subgroup of Table A). Clinicians may also choose to report a specialty measure set—which are specifically designed around certain conditions and specialty-types—instead of the six measures described above. These proposed rules are requesting for comments on these measures.
Also, CMS notes that this proposal to allow reporting of specialty-specific measure sets at the subspecialty level was intended to address the fact that very specialized clinicians may only have one or two applicable measures. Further, CMS will continue to work with specialty societies and other measure developers to increase the availability of applicable measures for specialists across the board. As identified in Table A, CMS proposes to define a high priority measure at §414.1305 as an outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination quality measures. Further, measure types listed as an “intermediate outcome” are considered outcome measures for the purposes of scoring. 

There is no longer a requirement for reporting across multiple NQS domains.

CMS is requesting comments on what specific measures of over or under use should be included as appropriate use measures. CMS plans to incorporate new measures as they become available and will give the public the opportunity to comment on these provisions through future notice and comment rulemaking. They will closely examine the recommendations from HHS’ Office of the Assistant Secretary for Planning and Evaluation (ASPE) study, once they are available, on the issue of risk adjustment for socioeconomic status on quality measures and resource use as required by § 2(d) of the IMPACT Act and incorporate them as feasible and appropriate through future rulemaking.

**Data completeness**

To ensure completeness for the broadest group of patients, the proposed criteria are below. MIPS eligible clinicians and groups who do not meet the proposed reporting criteria noted below would fail the quality component of MIPS.

Individual MIPS eligible clinicians or groups submitting data on quality measures using QCDRs, qualified registries, or via EHR need to report on at least 90 percent of the MIPS eligible clinician or group’s patients that meet the measure’s denominator criteria, regardless of payer (both Medicare and non-Medicare patients) for the performance period.

Individual MIPS eligible clinicians submitting data on quality measures data using Medicare Part B claims, would report on at least 80 percent of the Medicare Part B patients seen during the performance period to which the measure applies.

Groups submitting quality measures data using the CMS Web Interface or a CMS approved survey vendor to report the CAHPS for MIPS survey would need to meet the data submission requirements on the sample of the Medicare Part B patients CMS provides.

These rules propose to include all-payer data for the QCDR, qualified registry, and EHR submission mechanisms because CMS believes this approach provides a more complete picture of each MIPS eligible clinicians scope of practice and provides more access to data about
specialties and subspecialties not currently captured in PQRS. In addition, each QCDR, qualified registry, or EHR submission must contain a minimum of one quality measure for at least one Medicare patient.

The data completeness criteria CMS is proposing are an increase in the percentage of patients to be reported by each of the mechanisms when compared to PQRS. CMS is seeking comments on these criteria especially when these might be inappropriate, such as reporting a cross-cutting measure would not always be appropriate for every telehealth service or for certain acute situations. CMS would not want a MIPS eligible clinician to fail reporting the measure in appropriate circumstances; therefore, they seek feedback data and circumstances where it would be appropriate to lower the data completeness criteria.

The table below (Table 3 of the proposed rules [https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf](https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf)) summarizes the quality data submission criteria for MIPS

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>Measure Type</th>
<th>Submission Mechanism</th>
<th>Submission Criteria</th>
<th>Data Completeness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1 – Dec 31</td>
<td>Individual MIPS eligible clinicians</td>
<td>Part B Claims</td>
<td>Report at least six measures including one cross-cutting measure and at least one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty specific measures in Table E.</td>
<td>80 percent of MIPS eligible clinician’s patients</td>
</tr>
<tr>
<td>Date Range</td>
<td>Type</td>
<td>System</td>
<td>Requirement</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Jan 1 – Dec 31</td>
<td>Individual MIPS eligible clinicians or Groups</td>
<td>QCDR Qualified Registry EHR</td>
<td>Report at least six measures including one cross-cutting measure and at least one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty specific measures in Table E.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Groups</td>
<td>CMS Web Interface</td>
<td>Report on all measures included in the CMS Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group’s sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries.</td>
<td>90 percent of MIPS eligible clinician’s or groups patients</td>
</tr>
<tr>
<td></td>
<td>Groups</td>
<td>CAHPS for MIPS Survey</td>
<td>CMS-approved survey vendor would have to be paired with another reporting mechanism to ensure the minimum number of measures are reported. CAHPS for MIPS Survey would fulfill the requirement for one cross-cutting and/or a patient experience measure towards the MIPS quality data submission criteria. CAHPS for MIPS Survey will only count for one measure.</td>
<td>Sampling requirements for their Medicare Part B patients</td>
</tr>
</tbody>
</table>
These proposed rules also include details on quality measure submission criteria for non-patient-facing clinicians applicable mainly to anesthesiology, radiology/imaging, pathology, and nuclear medicine, specifically cardiology.

CMS is seeking comments on these proposals as they consider an option for facility-based MIPS eligible clinicians to elect to use their institution’s performance rates as a proxy for the MIPS eligible clinician’s quality score. There is no proposal for an option for year 1 of MIPS because there are several operational considerations that must be addressed before this option can be implemented. CMS is requesting comment on the following issues: (1) whether they should attribute a facility’s performance to a MIPS eligible clinician for purposes of the quality and resource use performance categories and under what conditions such attribution would be appropriate and representative of the MIPS eligible clinician’s performance; (2) possible criteria for attributing a facility’s performance to a MIPS eligible clinician for purposes of the quality and resource use performance categories; and (3) the specific measures and settings for which CMS can use the facility’s quality and resource use data as a proxy for the MIPS eligible clinician’s quality and resource use performance categories; and (4) if attribution should be automatic or if a MIPS eligible clinician or group should elect for it to be done and choose the facilities through a registration process. CMS is open to considering other options as well.

**Global and Population-Based Measures**

CMS proposes to use the acute and chronic composite measures of Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) that meet a minimum sample size in the calculation of the quality measure domain for the MIPS total performance score; see Table B [https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf](https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf). As discussed above, eligible clinicians will be evaluated on their performance on these measures in addition to the six required quality measures discussed previously and summarized in Table A. Based on experience in the VM program, these measures have been determined to be reliable with a minimum case size of 20. Average reliabilities for the acute and chronic measures range from 0.64 to 0.79 for groups and individual MIPS eligible clinicians.

CMS plans to incorporate a clinical risk adjustment as soon as feasible to the PQI composites and continue to research ways to develop and use other population-based measures for the MIPS program that could be applied to greater numbers of MIPS eligible clinicians going forward. In addition to the acute and chronic composite measure, CMS proposes to include the all-cause hospital readmissions measure from the VM as this measure also encourages care coordination. Since this measure is not reliable for solo clinicians or practices with fewer than 10 clinicians; therefore, this measure is limited to groups with 10 or more clinicians. The proposed claims-based population measures would rely on the same two-step attribution methodology that is currently used in the VM (79 FR 67961 through 67694). The attribution focuses on the delivery
of primary care services (77 FR 69320) by both primary care physicians and specialists. This attribution logic aligns with the total per capita measure and is similar to, but not exactly the same, as the assignment methodology used for the Shared Savings Program. For example, the Shared Savings Program definition of primary care services can be found at §425.20 and excludes claims for certain Skilled Nursing Facility (SNF) services that include the POS 31 modifier.

Requirements in selecting quality measures for inclusion in the annual final list of quality measures

§ 1848(s)(1)(B) of the Act defines “quality domains” as at least the following domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. CMS believes that the five domains applicable to the quality measures under MIPS are included in the NQS’s six priorities as follows:

- **Patient Safety.** These are measures that reflect the safe delivery of clinical services in all health care settings. CMS believes that this NQS priority corresponds to the domain of safety.
- **Person and Caregiver-Centered Experience and Outcomes.** These are measures that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient-reported data and the ability to impact care at the individual patient level, as well as the population level. These are measures of organizational structures or processes that foster both the inclusion of persons and family members as active members of the health care team and collaborative partnerships with health care providers and provider organizations or can be measures of patient-reported experiences and outcomes that reflect greater involvement of patients and families in decision making, self-care, activation, and understanding of their health condition and its effective management. CMS believes this NQS priority corresponds to the domain of patient and caregiver experience.
- **Communication and Care Coordination.** These are measures that demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families to improve appropriate and timely patient and care team communication. CMS believes this NQS priority corresponds to the domain of care coordination.
- **Effective Clinical Care.** These are measures that reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines or measures of patient-centered outcomes of disease states. CMS believes this NQS priority corresponds to the domain of clinical care.
- **Community/Population Health.** These are measures that reflect the use of clinical and preventive services and achieve improvements in the health of the population served. They may be measures of processes focused on primary prevention of disease or general...
screening for early detection of disease unrelated to a current or prior condition. CMS believes this NQS priority corresponds to the domain of population health and prevention.

- Efficiency and Cost Reduction. These are measures that reflect efforts to lower costs and to significantly improve outcomes and reduce errors.

Resource Use

Overview

CMS anticipates measures in the MIPS resource use performance category would provide MIPS eligible clinicians the necessary information to provide appropriate patient care and enhance health outcomes. To implement this category, CMS proposes to begin with existing condition and episode-based measures, and the total per capita costs for all attributed beneficiaries measure (total per capita cost measure). All resource use measures would be adjusted for geographic payment rate adjustments and beneficiary risk factors. In addition, a specialty adjustment would also be applied to the total per capita cost measure, all measures attributed to a MIPS eligible clinician or group would be weighted equally within the resource use performance category, and there would be no minimum number of measures required to receive a score under this category.

Finally, all measures within the resource use performance category would be derived from Medicare administrative claims data, rendering any type of data submission mechanism unnecessary. As CMS plans to develop additional groups and categories as detailed throughout the PR, new measures will be incorporated as they become available, taking into account risk adjustment for socioeconomic status on quality measures and resource use as required by MACRA.

MACRA Requirements

§1848(q)(2)(A)(ii) establishes “resource use” as a MIPS performance category, and §1848(q)(2)(B)(ii) describes the measures of the resource use performance category as “the measurement of resource use for a MIPS performance period, using the methodology under §1848(r) of MACRA and accounting for the cost of drugs under Medicare Part D as appropriate. This section also specifies a series of steps and activities the Secretary must undertake to involve the physician, practitioner, and other stakeholder communities in augmenting the infrastructure for resource use measurement for purposes of MIPS and APMs.

To evaluate resources used to treat patients, the Secretary shall, as appropriate, use codes reported on claims to attribute patients to one or more physicians and applicable practitioners and as a basis to compare similar patients, and conduct an analysis of resource use. In measuring resource use, the Secretary shall implement per patient total allowed charges for all services.
under Parts A and B – and Part D, if appropriate – and may use other measure of allowed charges, utilization of items, and services. CMS seeks stakeholder comments regarding the resource use methodology.

**Relationship to the Value Modifier**

Currently, the physician value-based payment modifier (VM) utilizes six cost measures which address various categories of total per capita costs. Total per capita costs include payments under both Parts A and B, but do not include Medicare payments under Part D for drug expenses. All cost measures for the VM are attributed at the physician group and solo practice level. The total per capita cost measures use a two-step attribution methodology similar to the assignment methodology used for the Shared Savings Program, which focuses on primary care service delivery by primary care clinicians and specialists.

The total per capita cost measures have been used in the calculation of the VM payment adjustments beginning with the 2015 payment adjustment period, and the Medicare Spending per Beneficiary (MSPB) measure has been used in calculating the VM payment adjustments beginning with the 2016 payment adjustment period.

**Weighting in the Composite Performance Score**

As required by §1848(q)(5)(E)(ii)(bb) of the Act, the resource use performance category shall make up no more than ten percent of the composite performance score (CPS) for the first MIPS payment year (CY 2019) and not more than 15 percent of the CPS for the second MIPS payment year (CY 2020). In addition, as required by §1848(q)(5)(E)(ii)(aa) of MACRA, beginning with the third MIPS payment year and for each MIPS payment year thereafter, the resource use performance category would make up 30 percent of the CPS.

**Resource Use Criteria**

Performance in the resource use performance category would be assessed using measures based on administrative Medicare claims data. At this time, CMS is not proposing any additional data submissions for the resource use performance category. As such, MIPS eligible clinicians and groups would be assessed based on resource use for Medicare patients only and only for patients attributed to them. MIPS eligible clinicians or groups lacking the number of attributed cases to meet or exceed the case minimums would not be measured on resource use.
Value Modifier Cost Measures Proposed for the MIPS Resource Use Performance Category

For purposes of assessing performance of MIPS eligible clinicians on the resource use performance category, CMS proposes to specify resource use measures for a particular performance period. For the CY 2017 MIPS performance period, CMS proposes to utilize the total per capita cost measure, the MSPB measure, and several episode-based measures for the resource use performance category.

CMS also proposes including the total per capita cost measure, as it is a global measure of all Medicare Parts A and B resource use during the performance period and inclusive of the four condition specific measure under the VM (chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and diabetes mellitus), for which performance tends to be correlated. CMS also anticipates that MIPS eligible clinicians are familiar with the total per capita cost measure as the measure has been in the VM since 2015 and feedback has been reported through the annual QRUR to all groups as of 2014.

Finally, CMS proposes to adopt the MSPB measure as most MIPS eligible clinicians will be familiar with the measure in the VM or its variant under the Hospital Value Based Purchasing program by the beginning of the initial MIPS performance period in 2017. However, CMS proposes two technical changes to the MSPB measure calculations for purposes of its adoption in MIPS, discussed in the reliability section of this PR. In sum, CMS proposes to use the same methodologies for payment standardization, and risk adjustment for these measures for the resource use performance category as defined for the VM.

CMS is not proposing to include the VM total per capita cost measures for the four condition-specific groups noted above. Rather, they plan to assess performance as part of the episode-based measures proposed. This shift is in response to feedback received as part of the MIPS and APMs RFI, where commenters stated they do not believe the existing condition-based measures under the VM are relevant to their practice and expressed support for episode-based measures under MIPS.

Attribution

In the VM, all cost measures are attributed to a TIN. In MIPS, however, CMS proposes to evaluate performance at the individual and group levels. For the purposes of this section, CMS uses the general term “MIPS eligible clinicians” to indicate attribution for individuals or groups. For the MSPB measure, CMS proposes to use attribution logic similar to what is used in the VM. MIPS eligible clinicians with multiple claims – as measured by allowable charges – for Medicare Part B services, rendered during an inpatient hospitalization and considered an index admission for the MSPB measure during the applicable performance period would be assigned the episode.
The only difference from the VM attribution methodology would be that the MSPB measure would be assigned differently for individuals than for groups. For the total per capita cost measure, CMS intends to use a two-step attribution methodology, similar to that used in the 2017 and 2018 VM. CMS also plans to use the same two-step attribution process for the claims-based population measures in the quality performance category, CMS Web Interface measures, and CAHPS for MIPS. However, CMS proposes to make some modifications to the primary care services definition used in the attribution methodology to align with policies adopted under the Shared Savings Program.

The VM currently defines primary care services as the set of services identified by the following HCPCS/CPT codes: 99201 through 99215, 99304 through 99340, 99341 through 99350, the welcome to Medicare visit – G0402 – and the annual wellness visits – G0438 and G0439. CMS proposes to update this set to include new care coordination codes that have been implemented in the MPFS: transitional care management (TCM) codes – CPT codes 99495 and 99496 – and the chronic care management (CCM) code, CPT code 99490. These services were added to the primary care service definition used by the Shared Saving Program in June 2015; CMS contends these care coordination codes would also be appropriate for assigning services within MIPS.

In the CY 2016 MPFS final rule, the Shared Saving Program also finalized another modification to the primary care service definition: to exclude nursing visits that occur in a skilled nursing facility (SNF, POS 31 modifier). Patients in SNFs are generally shorter stay patients who are receiving continued acute medical care and rehabilitative services. While their care may be coordinated during their time in the SNF, they are then transitioned back to the community. Patients in a SNF require more frequent practitioner visits, often one to three times/week. In contrast, patients in nursing facilities (NFs, POS 32 modifier) are almost always permanent residents and generally receive their primary care services in the facility for the duration of their life. NF patients are usually seen every 30 to 60 days unless medical necessity dictates otherwise. CMS believes it would be appropriate to follow a similar policy in MIPS; therefore, they propose to exclude services billed under CPT codes 99304 through 99318 when the claim includes the POS 31 modifier. According to CMS, implementing these two modifications would align the primary care service definition between MIPS and the Shared Savings Program and would improve the results from the two-step attribution process.

Of note, however, is that while CMS is aligning the definition for primary care services, the two-step attribution for MIPS would be different than that used for the Shared Saving Program. Rationale for such differences include elimination of the primary care service pre-step, statutorily required for the Shared Savings Program from the VM. However, without the pre-step, the beneficiary attribution method would more appropriately reflect the multiple ways in which primary care services are provided, which are not limited to physician groups. As MIPS
eligible clinicians include more than physicians, CMS maintains it is appropriate to exclude the pre-step.

In the 2015 Shared Saving Program final rule, CMS finalized a policy for the Shared Savings Program not extended to the VM two-step attribution: to exclude select specialties – such as several surgical specialties – from the second attribution step. However, CMS believes it is inappropriate to restrict specialties from the second attribution step for MIPS. If such a policy were adopted under MIPS, all specialists on the exclusion list, unless they were part of a multispecialty group, would automatically be excluded from measurement on the total per capita cost measure, as well as on the claims-based population measures which rely on the same two-step attribution. While CMS does not believe many specialties would be attributed enough cases to meet or exceed the case minimum, an automatic exclusion could remove some MIPS eligible clinicians and groups that should be measured for resource use. CMS requests stakeholder comments on these proposed changes.

**Reliability**

CMS seeks to ensure MIPS eligible clinicians and groups are measured reliably; therefore, they intend to use the 0.4 reliability threshold currently applied to measures under the VM to evaluate their reliability. A 0.4 reliability threshold standard indicates the majority of MIPS eligible clinicians and groups who meet the case minimum required for scoring under a measure have measure reliability scores that exceed 0.4. CMS generally considers reliability levels between 0.4 and 0.7 to indicate “moderate” reliability and has selected the 0.4 moderate reliability standard and believes it ensures moderate reliability but does not substantially limit participation.

To ensure sufficient measure reliability for the resource use performance category in MIPS, CMS also proposes to use the minimum of 20 cases for the total per capita cost measure, the same case minimum used for the VM. CMS recognizes a case size increase of this nature also may limit the ability of MIPS eligible clinicians to be scored on MSPB, and have been evaluating alternative measure calculation strategies for potential inclusion under MIPS that better balance participation, accuracy, and reliability. As a result, CMS proposes two modifications to the MSPB measure.

The first technical proposal is to remove the specialty-adjustment from the MSPB measure’s calculation. As currently reported on the QRURs, the MSPB measure is risk adjusted to ensure these comparisons account for case-mix differences between practitioners’ patient populations and the national average. It is unclear the current additional adjustment for physician specialty improves the accounting for case-mix differences for acute care patients, and thus may be unnecessary.
The second technical proposal is to modify the cost ratio used within the MSPB equation to evaluate the difference between observed and expected episode cost at the episode level, before comparing the two at the individual or group level. CMS would take the average for the MIPS eligible clinician or group and multiply it by the average of observed costs across all episodes nationally.

CMS’ analysis, based on all Medicare Part A and B claims data for beneficiaries discharged from an acute inpatient hospital between January 1, 2013 and December 1, 2013, indicates these two changes would improve the MSPB measure’s ability to calculate costs and the accuracy with which it can be used to make clinician-level performance comparisons. CMS also believes such changes would help ensure the MSPB measure could be applied to a greater number of MIPS eligible clinicians while still maintaining its status as a reliable measure with the desired 0.4 reliability threshold used in the VM. Therefore, CMS proposes to use a minimum of 20 cases for the MSPB measure and considers expanded participation of MIPS eligible clinicians to be of great importance for the purposes of transitioning to MIPS and believes this justifies a slight decrease of the percentage of TINs meeting the reliability threshold. CMS also requests public comment on the above proposals.

**Episode-based Measures Proposed for the MIPS Resource Use Performance Category**

As previously noted, CMS proposes to calculate several episode-based measures for inclusion in the resource use performance category. Groups have received feedback on their performance on episode-based measures through the Supplemental Quality and Resource Use Report (sQRUR), which are issued as a component of the Physician Feedback Program; however, these measures have not been used for payment adjustments through the VM. Several stakeholders expressed in the MIPS and APMs RFI the desire to transition to episode-based measures and away from the general total per capita measures used in the VM. Therefore, CMS proposes episode-based measures for various conditions and procedures that are high cost, have high variability in resource use, or are for high impact conditions. As these measures are payment standardized and risk adjusted, according to CMS they meet the statutory requirements for appropriate measures of cost as defined as the methodology eliminates the effects of geographic adjustments in payment rates and takes into account risk factors.

CMS has provided performance information on episode-based measures to MIPS eligible clinicians through the sQRUR; these reports provide groups and solo practitioners with information to evaluate their resource utilization on conditions and procedures costly and prevalent in the Medicare FFS population. To accomplish this goal, various episodes are defined and attributed to one or more groups or solo practitioners most responsible for the patient’s care. The episode-based measures include Medicare Parts A and B payments for services determined to be related to the triggering condition or procedure. The payments included are standardized to remove the effect of differences in geographic adjustments in payment rates and incentive
payment programs. They are also risk adjusted for the clinical condition of beneficiaries. Notably, the calculations are not used to determine VM payment adjustments and are only used to provide feedback.

CMS proposes to include in the resource use performance category several clinical condition and treatment episode-based measures reported in the sQRUR or included in the list of the episode groups published on the CMS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html. The identified episode-based measures have been tested and previously published, and Tables 4 and 5 list 41 clinical condition and treatment episode-based measures proposed for the CY 2017 MIPS performance period, as well as whether the episodes have previously been reported in a sQRUR.

The measures listed in Table 4 were developed under §1848(n)(9)(A) of the Act, which require the Secretary to develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate, and provide reports on utilization to physicians (episode grouping Method A). The proposed measures accommodate both chronic and acute procedure episodes, and are also designed to accommodate episodes initiated by physician claims, as MACRA requires claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, to include – as determined appropriate by the Secretary – the applicable codes established for care episode groups, patient condition groups, and patient relationship categories. For the purposes of this summary we have only the musculoskeletal episodes listed below. The full list is available in Table 4 of the proposed rules document (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf).

**TABLE 4: Proposed Clinical Condition and Treatment Episode-based Measures Developed Under § 1848(n)(9)(A) of the Act (Method A)**

<table>
<thead>
<tr>
<th>Clinical Topic, File Name</th>
<th>Episode Name, File Name, and Description</th>
<th>Included in 2014 sQRUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal 23</td>
<td>Rheumatoid Arthritis gen-unsp - other-nos - rheumatoid arthritis_Method A.xls</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Rheumatoid Arthritis (RA) episode is triggered by two (2) E&amp;Ms with a principal or secondary diagnosis of any RA trigger code occurring within 30 calendar days. This episode is intended to capture all services related to the medical management and treatment of RA.</td>
<td></td>
</tr>
</tbody>
</table>
Table 5 shows a second set of proposed measures developed to complement previous CMS efforts and to provide additional episode types to report in the supplemental QRURs. These measures represent acute conditions and procedures that are costly and prevalent in the Medicare FFS population. These measures examine services independently, regardless of other episodes a patient may be experiencing, and episodes do not interact with each other (episode grouping Method B). Some of the following episode types noted in Table 5 have subtypes that provide additional clinical detail and improve the actionability of data reported on these episode types, as well as comparability to expected costs. All episode types were developed with clinical input.
and complement the existing MSPB measure currently used in the VM. In addition, all episode types were reported in 2014 sQRURs. Information about how the measures are constructed can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html.

Again, for the purposes of this summary we have only the musculoskeletal episodes listed below. The full list is available in Table 5 of the proposed rules document (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf).

TABLE 5: Additional Proposed Clinical Condition and Treatment Episode Measures

Method B

<table>
<thead>
<tr>
<th>Clinical Topic, File Name</th>
<th>Episode Name, File Name, and Description</th>
<th>Included in 2014 sQRUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Hip Replacement or Repair</strong></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Hip_Rep_or_Repair_Episode_Definitions_MethodB_2015Sept.xlsx</td>
<td></td>
</tr>
<tr>
<td>*</td>
<td>Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>Knee Arthroplasty (Replacement)</strong></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Knee_Arthroplasty_Episode_Definitions_MethodB_2015Sept.xlsx</td>
<td></td>
</tr>
</tbody>
</table>

While CMS proposes the measures listed in Tables 4 and 5 for the resource use performance category, the Agency remains uncertain as to how many of these measures will ultimately be included in the FR. As these measures have never been used for payment purposes, CMS may choose to specify a subset of these measures in the FR. CMS requests public comment on which of the measures listed in Tables 4 and 5 to include in the MACRA FR. In addition to considering public comments, CMS will consider the number of MIPS eligible clinicians capable of being measured, the episode’s impact on Medicare Parts A and B spending, and whether the measure has been reported through sQRUR. In addition, while CMS does not believe specialty adjustment is necessary for the episode-based measures, they will continue to explore this issue given the diversity of episodes and seek comments on whether they should adjust the episode-based measures for specialties.
Attribution

For the episode-based measures listed in Tables 4 and 5, CMS proposes to use the attribution logic used in the 2014 sQRUR, with modifications to adjust for whether performance is being assessed at an individual level or group level. For purposes of this section, CMS uses the general term “MIPS eligible clinicians” to indicate attribution for individuals or groups. Acute condition episodes would be attributed to all MIPS eligible clinicians who bill at least 30 percent of inpatient evaluation and management (IP E&M) visits during the initial treatment, or “trigger event” that opened the episode. E&M visits during the episode’s trigger event represent services directly related to the management of the beneficiary’s acute condition episode. MIPS eligible clinicians billing at least 30 percent of IP E&M visits are therefore likely to have been responsible for the oversight of the beneficiary’s care during the episode. It is possible for more than one MIPS eligible clinician to be attributed a single episode using this rule but if an acute condition episode has no IP E&M claims during the episode, then the episode is not attributed to any MIPS eligible clinician.

Procedural episodes would be attributed to all MIPS eligible clinicians who bill a Medicare Part B claim with a trigger code during the trigger event of the episode. For inpatient procedural episodes, the trigger event is defined as the IP stay that triggered the episode plus the day before the admission to the IP hospital. For outpatient procedural episodes constructed using Method A, the trigger event is defined as the day of the triggering claim plus the day before and two days after the trigger date. For outpatient procedural episodes constructed using Method B, the trigger event is defined as only the day of the triggering claim. Any Medicare Part B claim or line during the trigger event with the episode’s triggering procedure code is used for attribution. If more than one MIPS eligible clinician bills a triggering claim during the trigger event, the episode is attributed to each of the MIPS eligible clinicians. In addition, if co-surgeons bill the triggering claim, the episode is attributed to each MIPS eligible clinician, yet if only an assistant surgeon bills the triggering claim, the episode is attributed to the assistant surgeon or group. If an episode does not have a concurrent Part B claim with a trigger code for the episode, that episode is not attributed to any MIPS eligible clinician. To ensure moderate reliability, CMS proposes to use the minimum of 20 cases for all episode-based measures listed in Tables 4 and 5 and do not intend to include any measures that do not have average moderate reliability of at least 0.4 at 20 episodes.

Attribution for Individual and Groups

In the VM and sQRUR, all resource use measurement was attributed at the solo practitioner and group level, as identified by TIN. In MIPS, CMS proposes to evaluate performance at the individual and group levels. For MIPS eligible clinicians whose performance is being assessed individually across other MIPS performance categories, CMS proposes to attribute resource use measures using TIN/NPI rather than TIN. Attribution at the TIN/NPI level allows individual
MIPS eligible clinicians to be measured based on cases specific to their practice, rather than being measured on all cases attributed to the group TIN. For MIPS eligible clinicians who choose to have their performance assessed as a group across the other MIPS performance categories, CMS proposes to attribute resource use measures at the group TIN under which they report. The logic for attribution would be similar whether attributing to the TIN/NPI level or the TIN level.

As an alternative proposal, CMS seeks comments on whether MIPS eligible clinicians who choose to have their performance assessed as a group should first be attributed at the individual TIN/NPI level and then have all cases assigned to the individual TIN/NPIs attributed to the group under which they bill. This alternative would apply one consistent methodology to both groups and individuals, compared to having a methodology that assigns cases using TIN/NPI for assessment at the individual level and another that assigns cases using only TIN for assessment at the group level. This proposed approach would determine “plurality of claims” separately for individuals and groups. For individuals, CMS would assign the MSPB measure using plurality of claims by TIN/NPI, but for groups would determine plurality of claims by TIN. The alternative proposal, in contrast, would determine plurality of claims by TIN/NPI for both groups and individuals. However, for individuals, only the MSPB measure attributed to the TIN/NPI would be evaluated, while for groups the MSPB measure attributed to any TIN/NPI billing under the TIN would be evaluated. CMS solicits feedback on this proposal and alternatives will be considered.

Application of Measures to Non-Patient Facing MIPS Eligible Clinicians

MACRA §1848(q)(2)(C)(iv), which requires the Secretary to give consideration to the circumstances of professional types who typically furnish services without patient facing interaction – “non-patient-facing” – when determining the application of measures and activities. In addition, this section allows the Secretary to apply alternative measures or activities to non-patient facing MIPS eligible clinicians that fulfill the goals of a performance category. In addition, the Secretary is permitted to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of eligible clinician involved.

For the 2017 MIPS performance period, CMS is not proposing any alternative measures for non-patient facing MIPS eligible clinicians or groups. Therefore, non-patient facing MIPS eligible clinicians or groups may not be attributed any resource use measures that are generally attributed to clinicians who have patient facing encounters with patients. CMS anticipates that many non-patient facing MIPS eligible clinicians may not have sufficient measures and activities available to report and would not be scored on the resource use performance category under MIPS. CMS intends to work with non-patient facing MIPS eligible clinicians and specialty societies to propose alternative resource use measures for non-patient facing MIPS eligible clinicians and
groups under MIPS in future years. Lastly, CMS seeks comments on how best to incorporate appropriate alternative resource use measures for all MIPS eligible clinician types, including non-patient facing MIPS eligible clinicians.

Additional System Measures

§1848(q)(2)(C)(ii) provides the Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the quality and resource use performance categories of MIPS. The Secretary, however, may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. Finally, CMS intends to align any facility-based MIPS measure decision across the quality and resource use performance categories to ensure consistent MIPS policies for future years.

Future Modifications to Resource Use Performance Category

In the future, CMS intends to consider how best to incorporate Medicare Part D costs into the resource use performance category and seeks public comments on how to incorporate such costs under MIPS for future years. They also intend to continue developing and refining episode groups for purposes of resource use performance category measure calculations.

Clinical Practice Improvement Activity (CPIA)

One of four categories of the new MIPS “Quality Payment Program” under MACRA, the clinical practice improvement activity (CPIA) performance category focuses on the MIPS strategic goal to utilize a patient-centered approach to developing incentives and policies that drive improved patient health outcomes. This performance category, which comprises 15 percent of the total score in year one of the program, also focuses on the strategic goal to use design incentives that drive movement toward delivery system reform principles and APMs.

Under the CPIA category, clinicians would be rewarded for activities focusing on care coordination, beneficiary engagement, and patient safety. Notably, clinicians are permitted to select activities congruent with their practices’ goals from a list of more than 90 options, and CMS is not requiring a minimum number of CPIAs at this time. However, CMS is proposing baseline requirements that will become more stringent in future years, laying the groundwork for continuous improvement over time.

MACRA Requirements

§1848(q)(2)(C)(v)(III) of MACRA defines a CPIA as “an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care
delivery, and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.” The Secretary is also required to specify CPIAs under subcategories for the performance period, which must include at least the subcategories specified in the Act, and in doing so give consideration to small practices consisting of 15 or fewer clinicians and those located in rural areas and geographic health professional shortage areas (HPSAs).

**CPIA Contribution to the Composite Performance Score (CPS)**

§1848(q)(5)(E)(i)(III) specifies the CPIA performance category will account for 15 percent of the CPS, subject to the Secretary’s authority to assign various scoring weights; CMS proposes the category to account for 15 percent of the CPS as noted above. MACRA also states that a MIPS eligible clinician or group certified as a patient-centered medical home (PCMH) or similar specialty practice as determined by the Secretary, must be given the highest potential score for the CPIA category for the performance period of one calendar year (January 01 through December 31, 2017). CMS is proposing that 2017 be the first performance period under MACRA and would be used for payment adjustments beginning in 2019.

The proposed rule outlines the criteria necessary for an APM to be recognized as a PCMH, and includes but is not limited to models such as a Medicaid Medical Home Model or a nationally recognized and accredited PCMH. Examples include those accredited by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). Notably, the PCMH must be national in scope and have utilization evidence consisting of a large number of medical organizations using a particular model as a PCMH. CMS is seeking comments on their proposal for determining which practices would qualify as PCMHs, as well as on how to provide credit for PCMH designations and for calculating the CPIA score for groups when the designation applies to only a portion of the TIN.

In addition, MIPS eligible clinicians or groups participating in an APM for a performance period must earn at least one-half of the highest potential CPIA score for the performance period (p. 164, refer to APM scoring standards). §1848(q)(5)(C)(iii) provides that a MIPS eligible clinician or group must not be a MIPS eligible clinician or group required to perform activities in each CPIA subcategory or participate in an APM to achieve the highest potential score for the CPIA performance category. Finally, any MIPS eligible clinician or group that fails to report an applicable and required measure or activity will receive the lowest potential CPIA score relevant to the measure or activity as required by the Secretary.

**CPIA Data Submission**

CMS proposes to allow for submission of data for the CPIA performance category via the qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms. Regardless of the data submission method, all MIPS eligible clinicians or groups
must select activities from the CPIA Inventory provided in Table H of the Appendices and entitled “Table H: Proposed Clinical Practice Improvement Activities Inventory.” (pp. 946-962 of PR filed on 04/27/2016: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf). For the first year of MACRA implementation only – as CMS is not requiring a minimum number of CPIA – all entities submitting CPIA performance category data must designate a “yes/no” response for all activities listed in the CPIA Inventory.

CPIA Weighted Scoring

While CMS considered various scoring methodologies in this performance category, the statute requires 100 percent of the potential score for PCMH participants, and a minimum 50 percent score for APM participants. For additional activities in this category, CMS proposes and is soliciting comments on a differentially weighted model for the CPIA performance categories using two classifications: medium and high. CMS justifies including these two weights to provide flexible scoring due to the undefined nature of activities – CPIA standards are not nationally recognized and there is currently no entity established to do so. CPIAs are weighted as high based on alignment with CMS national priorities and programs such as the Comprehensive Primary Care Initiative.

CPIA Submission Criteria

CMS proposes to set the CPIA submission criteria under MIPS to achieve the highest potential score of 100 percent, at three high-weighted CPIAs – worth 20 points each – or six medium-weighted CPIAs worth ten points each. CMS is also proposing a combination of high- and medium-weighted CPIAs to achieve a total of 60 points for MIPS eligible clinicians participating as individuals or groups. Those selecting less than the designated number of CPIAs will receive partial credit based on the weighting of the CPIA selected. To achieve a score of 50 percent, one high-weighted and one-medium weighted CPIA or three-medium weighted CPIAs are required, with various exceptions for selected groups including MIPS small groups or those groups participating in an APM and/or a PCMH submitting through MIPS, for example.

MIPS eligible clinicians or groups participating in APMs are considered eligible to participate in the CPIA performance category unless they are in an Advanced APM and have met the Qualifying APM Participant (QP) thresholds or are Partial QPs that elect not to report information. A MIPS eligible clinician or group participating in an APM and under the CPIA performance category will receive 50 percent of the total CPIA score of 30 points subsequent to participating in an APM. To achieve 100 percent of the total CPIA score, MIPS eligible clinicians or groups must identify their participation in an APM – which is worth 30 points – and also select additional CPIAs for an additional 30 points to reach the highest CPIA score of 60 points.
As CMS cannot measure performance within a single CPIA, they are proposing to compare points associated with reported activities against the highest number of points achievable under the CPIA performance category, which is 60 points. CMS proposes that the highest score of 100 percent may be achieved by selecting activities that add to 60 points or by selecting activities equal to the 60-point maximum. However, if a MIPS eligible clinician or group reports only one CPIA, CMS will score the activity accordingly: ten points will be awarded for a medium-level activity and 20 points for a high-level activity. If no CPIAs are reported, the MIPS eligible clinician or group would receive a score of zero for the CPIA performance category, which CMS contends allows for capture of variation in the total CPIAs reported.

CMS states in the PR the criteria noted above are reasonable for MIPS eligible clinicians or groups to accomplish within the first year of program implementation as: 1) CMS is not recommending a minimum number of hours for performance of any activity; 2) they are offering a wide range of activities from which MIPS eligible clinicians or groups may select; and 3) they are proposing an activity must be performed for a minimum of 90 days during the performance period to receive CPIA credit. CMS will reassess the requirement threshold in future years. This proposal aligns with §1848(q)(2)(C)(iii) MACRA requirements that state MIPS eligible clinicians or groups are not required to perform activities in each subcategory. Finally, CMS recognizes that working with a QCDR would allow a MIPS eligible clinician or group to meet the measure and activity criteria for multiple CPIAs. While credit will not be granted for multiple activities for selecting only one activity that includes QCDR participation, CMS is soliciting comments on what restrictions, if any, should be placed on CPIA measures and activities that incorporate QCDR participation.

**Required Activity Performance Period**

CMS proposes that MIPS eligible clinicians or groups must perform CPIAs for a minimum of 90 days during the performance period to receive CPIA credit. CMS believes 90 days to be a reasonable amount of time while acknowledging some activities are ongoing whereas others are episodic. CMS’ rationale for the 90-day threshold is based on their review of clinical practice improvements in areas such as anesthesia and opioid dispensing management. CMS provides additional clarification in Table H of the Appendices and proposes that activities – where applicable – may be continuing or be adopted within the performance period as long as the activity is being performed for at least 90 days during the performance period. CMS is requesting comments on this section of the proposed rule and anticipates that extended CPIA time periods will be required for certain activities in the future to generate better patient outcomes.
CPIA Subcategories

§1848(q)(2)(B)(iii) requires each CPIA performance category to include at least the following subcategories and also provides the Secretary discretion to specify additional subcategories:

- Expanded practice access, such as same-day appointments and after-hours access to clinician advice;
- Population management, such as monitoring individual health conditions to provide timely health care interventions or participation in a QCDR;
- Care coordination, such as timely communication of test results and use of remote monitoring or telehealth;
- Beneficiary engagement to include establish care plans for individuals with complex care needs;
- Patient safety and practice assessment via the utilization of clinical and/or surgical checklists; and

Participation in an APM as defined by §1848(z)(3)(C) of MACRA

In addition, CMS requested recommendations on the inclusion of potential new subcategories. The agency recognizes quality improvement as a critical aspect of improving individual health and that of the health care delivery system overall. CMS also recognizes this will be the first time MIPS eligible clinicians or groups will be measured on quality improvement work on a national scale, and has approached the CPIA performance category with these principles in mind with the overarching principle for the MIPS program that they are building a process that will incorporate increasingly more rigorous requirements over time.

Thus, for the first year of the MIPS, CMS proposes that the CPIA performance categories include the following subcategories: 1) “Achieving Health Equity”; 2) “Integrated Behavioral and Mental Health”; and 3) “Emergency Preparedness and Response.” Notably, CMS is proposing to include the “Achieving Health Equity” subcategory in response to multiple MIPS and APM RFI comments requesting its inclusion as: 1) It may require targeted effort to achieve and therefore should be recognized when accomplished; 2) Supports CMS’ national priorities and programs, such as Reducing Health Disparities; and 3) Encourages “use of plans, strategies, and practices that consider the social determinants that may contribute to poor health outcomes.” Similarly, MIPS and APM RFI comments strongly supported including the subcategories of “Integrated Behavioral and Mental Health” and “Emergency Preparedness and Response” in the Act. Additionally, commenters provided a sufficient number of recommended activities that could be included in the CPIA Inventory in all of the above proposed subcategories and the subcategories included under §1848(q)(2)(B)(iii) of the Act.
CMS also seeks comments on two additional subcategories for future consideration: 1) Promoting Health Equity and Continuity; and 2) Social and Community Involvement. For these subcategories, CMS requests activities that would demonstrate improvement over time while going beyond current practice expectations.

**CPIA Inventory**

CMS is required to create a CPIA Inventory to implement the MIPS program. Consistent with MIPS’ strategic goals, CMS emphasizes the importance of creating a broad list of activities that can be used by various practice types to validate CPIAs and those activities that may lend themselves to measurement improvement in subsequent years.

CMS took various steps to ensure the initial CPIA Inventory is inclusive of activities congruent with statutory intent. CMS’ evaluation included interviews with multiple high-performing organizations, identifying existing models, activities, or measures that met all or part of the CPIA performance category, including PCMHs and the Transforming Clinical Practice Initiative (TCPI). CMS also reviewed the CY 2016 Physician Fee Schedule (PFS) final rule and comments received in response to the MIPS/APMs RFI related to the CPIA performance category. The CPIA Inventory was compiled from information garnered from the activities above, as well as from working sessions with AHRQ and ONC and communications with CDC, SAMHSA, and HRSA. Furthermore, CMS established CPIA performance category inclusion guidelines based on one or more of the following:

- Relevance to an existing CPIA subcategory or proposed new subcategory;
- Activity importance as relevant to achieving improved beneficiary health outcome(s);
- Activity importance as relevant to practice improvement to reduce health disparities;
- Alignment with PCMHs;
- Representative of activities that multiple MIPS eligible clinicians or groups could perform;
- Implementation feasibility, recognizing the importance of minimizing practice burden;
- CMS ability to validate the activity; and/or
- Evidence supporting the activity has a high probability of contributing to improved beneficiary health outcomes.

Activities overlapping with other performance categories were excluded with the exception of those with a strong policy rationale to remain in the CPIA Inventory. CMS proposes to implement the CPIA Inventory for the first year of MIPS as provided in Table H of the Appendices (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf) and requests comments on the inventory as well as suggestions for CPIAs for future years.
CPIA Performance Category and Measurement Study

To better understand current processes and limitations, CMS proposes to conduct a study on CPIAs and measurement to examine clinical quality workflows and data capture using a simpler approach to quality measures. The study will permit a limited number of selected MIPS eligible clinicians and groups to receive full credit – 60 points – for the CPIA performance category. Goals of the study include assessing whether there will be improved outcomes, reduced burden in reporting, and enhancements in clinical care by selected MIPS eligible clinicians.

Study Participation: Credit and Requirements

Eligible clinicians and groups who participate in the study will receive full credit for the CPIA performance category of MIPS after successfully electing, participating, and submitting data to CMS. Study data will be available to CMS throughout the study on at least a quarterly basis, and all study participants will be required to attend a monthly focus group to provide survey feedback to monitor effectiveness.

For the 2017 performance period, participating MIPS eligible clinicians or groups would submit data and workflows for a minimum of three MIPS clinical quality measures relevant to and prioritized by their practice, and may calculate the measures working with a QCDR or qualified registry. One measure must be an outcome measure while the other must be a patient experience measure. Study participants may elect to report on additional measures, which would provide more options from which to select in subsequent years for measuring improvement.

In future years, participating MIPS eligible clinicians or groups would select three measures for which they have baseline data from the 2017 performance period to compare against subsequent performance years. Participants electing to continue in future years will be afforded the opportunity to opt in or out following successful data submission to CMS, while those who fail to submit the required data will be removed from the study and then subject to the full requirements of the CPIA category.

Study Participation Eligibility

Participation will be open to a limited number of MIPS eligible clinicians and groups in rural and non-rural settings and group size is variable; two specialist groups of MIPS eligible clinicians will also be included. The application period to participate in the study begins January 01, 2017 and commences on January 31, 2017; eligible participants will be approved on a first come, first served basis. CMS requests stakeholder comments on the study and welcomes suggestions on future study topics.
CPIA Policies for Future Years of the MIPS Program

CMS proposes for future years of MIPS, to consider adding a new subcategory or activity to the CPIA Inventory only when the following criteria are met:

- The new subcategory represents an area that could highlight improved beneficiary health outcomes, patient engagement, and safety based on evidence;
- The new subcategory has a designated number of activities that meet the criteria for a CPIA activity and cannot be classified under existing subcategories; and
- Newly identified subcategories would contribute to improvement in patient care practices or improvement in performance on quality measures and resource use performance categories.

In future years, MIPS eligible clinicians or groups may nominate additional subcategories with those activities associated with the relevant subcategory and based on criteria specified for such activities, as noted above. CMS also requests feedback on this proposal.

Request for Comments for Measures and Activities Process for Adding New Activities and New Subcategories

CMS plans to develop a call for measures and activities process for future years of MIPS, where MIPS eligible clinicians or groups and other relevant stakeholders may recommend activities for potential inclusion in the CPIA Inventory. As part of the process, MIPS eligible clinicians or groups would be able to nominate additional activities for CMS to consider adding to the CPIA Inventory. This nomination and acceptance process would, to the best extent possible, parallel the annual call for measures process already conducted by CMS for quality measures. The final CPIA Inventory for the performance year would be published in accordance with the overall MIPS rulemaking timeline and in future years CMS anticipates developing a process and establishing criteria to remove or add new activities to CPIA.

Request for Comments on Use of QCDRs for Identification and Tracking of Future Activities

In future years, CMS expects to learn more about CPIAs and how the inclusion of additional measures and activities captured by QCDRs could enhance the ability of MIPS eligible clinicians or groups to capture and report on more meaningful activities, particularly in regards to specialty groups. In the future, CMS may propose using QCDRs for identification and acceptance of additional measures and activities in alignment with §1848(q)(1)(E) of MACRA which encourages the use of QCDRs, as well as under §1848(q)(2)(B)(iii)(II), related to the population management subcategory. CMS recognizes, through the MIPS and APMs RFI comments and interviews that QCDRs may provide for a more diverse set of measures and activities under
CPIA than are possible to list under the current CPIA Inventory. This diverse set of measures and activities, which can be validated, affords specialty practices additional opportunity to report on more meaningful activities in future years. QCDRs may also provide the opportunity for longer-term data collection processes, necessary for future year submissions on improvement and achievement. QCDR use also supports ongoing performance feedback and allows for implementation of continuous process improvements. CMS contends that for future years, QCDRs will be allowed to define specific CPIAs for specialty and non-patient-facing MIPS eligible clinicians or groups through the already-established QCDR approval process for measures and activities. CMS also requests stakeholder feedback regarding this approach.

Advancing Care Information

Key Points

- 25 percent of the MIPS CPS shall be based on performance for the advancing care information performance category.
- Same measures from MU Stage 3 and Modified Stage 2, but thresholds have been removed. Customizable so clinicians can choose which best measures fit their practice.
- Clinical Decision Support and Computerized Provider Order Entry are no longer required.
- Scoring:
  - Base score (50 Points):
    - Objectives & Measures: Protect Patient Health Information (required), Electronic Prescribing, Patient Electronic Access to Health Information, Care of Coordination Through Patient Engagement, Health Information Exchange, and Public Health and Clinical Data Registry Reporting
  - Public Health Registry Bonus Point (1 Point):
    - To earn points in the base score, only need to complete submission on the Immunization Registry Reporting
    - Exclusion: may report a null value (if the previously established exclusions apply) for purposes of reporting the base score
    - Completing any additional measures under this objective would earn one additional bonus point
  - Performance score (80 Points)
    - Objectives & Measures: Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange
  - Earn 100 or more points and receive Full 25 MIPS CPS points
- First performance period is proposed to be from January 1, 2017- December 31, 2017 for first payment year 2019
Advancing Care Information Summary

Meaningful use of certified EHR technology is referred to in this proposed rule as “advancing care information.”

CMS is proposing to revise the definition of a meaningful EHR user and the attestation requirements to provide that, for attestations submitted on or after April 16, 2016. The attestation they are proposing would consist of three statements related to health information exchange and information blocking.

MIPS Category Measures and Activities - Performance Category Measures and Reporting

While CMS allows MIPS eligible clinicians and groups to submit data for different performance categories via multiple submission mechanisms, they encourage MIPS eligible clinicians to submit MIPS information for the CPIA and advancing care information performance categories through the same reporting mechanism that is used for quality reporting (p 85: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf). Seeking comments on whether CMS should propose requiring health IT vendors, QCDRs and qualified registries to have the capability to submit data for all MIPS performance categories.

CMS has multiple policies to encourage the usage of QCDRs and CEHRT. In part, they are promoting the use of CEHRT by awarding bonus points in the quality scoring section for measures gathered and reported electronically via the QCDR, qualified registry, Web Interface, or CEHRT submission mechanisms.

Submission Deadlines

CMS proposes the data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms would be March 31 following the close of the performance period.

Advancing Care Information Performance Category (p. 187- 248)

MACRA Changes

Includes MIPS eligible clinicians who were not previously eligible for the EHR Incentive Program incentive payments or subject to the EHR Incentive Program payment adjustments of the Act, such as physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and hospital-based EPs.
They have also proposed to reweight the advancing care information performance category to zero in the MIPS composite performance score for certain hospital-based and other MIPS eligible clinicians where the measures proposed for this performance category may not be available or applicable to these types of MIPS eligible clinicians.

CMS’s increased flexibility and removal of previously established thresholds for reporting, is geared toward increasing participation and EHR adoption.

Potential changes may include establishing benchmarks for MIPS eligible clinician performance on the advancing care information performance category measures, and using these benchmarks as a baseline or threshold for future reporting. This may include scoring for performance improvement over time and the potential to reevaluate the efficacy of measures based on these analyses (p. 194). For example, in future years CMS may use a MIPS eligible clinician’s prior performance as comparison for the subsequent year’s performance category score to drive continuous improvement over time through the adoption of more stringent performance standards. Seeking comment on further methods to increase the stringency of the advancing care information performance category measures in the future.

Additionally seeking comment on the concept of a holistic approach to health IT – similar to the concept of outcome measures in the quality performance in the sense that MIPS eligible clinicians could potentially be measured more directly on how the use of health IT contributes to the overall health of their patients.

CMS would like to move MIPS beyond the measurement of EHR adoption and process measurement and into a more patient-focused health IT program (p.195). They are seeking comments on what this type of measurement would look like under MIPS, including the type of measures that would be needed within the advancing care information performance category and the other performance categories to measure this type of outcome, what functionalities with certified EHR technology would be needed, and how such an approach could be implemented.

Under MIPS, CMS proposes to align the performance period for the advancing care information performance category to the proposed MIPS performance period of one full calendar year (p.197). CMS notes that MIPS eligible clinicians would be required to submit all of the data they have available for the performance period, even if the time period they have data for is less than one full calendar year.

- **Certified health IT**: the full range of potential technologies, functions, standards, and systems for which ONC has established certification criteria
- **Certified EHR technology**: is a statutory and regulatory term that defines the technology that MIPS eligible clinicians and participants in Advanced APMs must use.
Certified EHR technology is a subset of the broader definition of certified health IT (p. 198).

For 2017, the first MIPS performance period, MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria as follows (p. 200):

- A MIPS eligible clinician who only has technology certified to the 2015 Edition may choose to report: (1) on the objectives and measures specified for the advancing care information performance category, which correlate to Stage 3 requirements; or (2) on the alternate objectives and measures specified for the advancing care information performance category, which correlate to modified Stage 2 requirements.

- A MIPS eligible clinician who has technology certified to a combination of 2015 Edition and 2014 Edition may choose to report: (1) on the objectives and measures specified for the advancing care information performance category, which correlate to Stage 3; or (2) on the alternate objectives and measures specified for the advancing care information performance category, which correlate to modified Stage 2, if they have the appropriate mix of technologies to support each measure selected.

- A MIPS eligible clinician who only has technology certified to the 2014 Edition would not be able to report on any of the measures specified for the advancing care information performance category that correlate to a Stage 3 measure that requires the support of technology certified to the 2015 Edition. These MIPS eligible clinicians would be required to report on the alternate objectives and measures specified for the advancing care information performance category, which correlate to modified Stage 2 objectives and measures.

Beginning with the performance period in 2018, MIPS eligible clinicians:

- Must only use technology certified to the 2015 Edition to meet the objectives and measures specified for the advancing care information performance category, which correlate to Stage 3.

CMS proposes to define a meaningful EHR user under MIPS as a MIPS eligible clinician who possesses certified EHR technology, uses the functionality of certified EHR technology, and reports on applicable objectives and measures specified for the advancing care information performance category for a performance period in the form and manner specified by CMS.

**Method of Data Submission**

For the purpose of reporting advancing care information performance category objectives and measures under the MIPS, CMS proposes to allow for MIPS eligible clinicians to submit advancing care information performance category data through qualified registry, EHR, QCDR, attestation and CMS Web Interface submission methods. 2017 would be the first year that EHRs
(through the QRDA submission method), QCDRs and qualified registries would be able to submit EHR Incentive Program objectives and measures (as adopted for the advancing care information performance category) to CMS, and the first time this data would be reported through the CMS Web Interface.

**Group Reporting**

Proposing a group reporting mechanism for individual MIPS eligible clinicians to have their performance assessed as a group for all performance categories. Proposing that performance on advancing care information performance category objectives and measures would be assessed and reported at the group level, as opposed to the individual MIPS eligible clinician level. CMS notes that the data submission criteria would be the same when submitted at the group-level as if submitted at the individual-level, but the data submitted would be aggregated for all MIPS eligible clinicians within the group practice.

**Scoring Method**

25 percent of the MIPS CPS shall be based on performance for the advancing care information performance category. CMS is proposing that the score for the advancing care information performance category would be comprised of a score for participation and reporting, hereinafter referred to as the “base score,” and a score for performance at varying levels above the base score requirements, hereinafter referred to as the “performance score” (p. 204).

1. **Base Score**

To earn points toward the base score, a MIPS eligible clinician must report the numerator and denominator of certain measures specified for the advancing care information performance category, which are based on the measures adopted by the EHR Incentive Programs for Stage 3, to account for 50 percent (out of a total 100 percent) of the advancing care information performance category score. CMS would not require percentage based thresholds to be met for MIPS, but would instead require MIPS eligible clinicians to report the numerator (of at least one) and denominator (or a yes/no statement for applicable measures, which would be submitted together with data for the other measures) for each measure being reported. CMS is proposing two variations of a scoring methodology for the base score, a primary and an alternate proposal.

   a. **Primary Proposal**

   Given the consistently high performance, two objectives (Clinical Decision Support and Computerized Provider Order Entry) and their associated measures would not be required. Note that the removed objectives and associated measures would still be required as part of ONC’s functionality standards for certified EHR technology.
b. **Alternate Proposal**

The alternate proposal would require a MIPS eligible clinician to report the numerator (of at least one) and denominator or yes/no statement (only a yes statement would qualify for credit under the base score) for all objectives and measures adopted for Stage 3 in the 2015 EHR Incentive Programs Final Rule to earn the base score portion of the advancing care information performance category, which would include reporting a yes/no statement for Clinical Decision Support and a numerator and denominator for Computerized Provider Order Entry objectives.

○ **Privacy and Security; Protect Patient Health Information**

The Protect Patient Health Information objective and measure would be an overarching requirement for the base score under both the primary proposal and alternate proposal. CMS proposes that a MIPS eligible clinician must meet this objective and measure in order to earn any score within the advancing care information performance category. Failure to do so would result in a base score of zero under either the primary proposal or alternate proposal outlined below, as well as a performance score of zero.

II. **Public Health and Clinical Data Registry Reporting**

For the Public Health and Clinical Data Registry Reporting objective there is no numerator and denominator to measure, so CMS is therefore proposing that MIPS eligible clinicians would include a yes/no statement in lieu of the numerator/denominator statement. To earn points in the base score, a MIPS eligible clinician would only need to complete submission on the Immunization Registry Reporting measure of this objective. Completing any additional measures under this objective would earn one additional bonus point in the advancing care information performance category score.

Exclusions for the Immunization Registry Reporting measure, CMS is proposing that the MIPS eligible clinicians may elect to report their yes/no statement if applicable, or they may report a null value (if the previously established exclusions apply) for purposes of reporting the base score.

**Advancing Care Information Performance Category Base Score Primary Proposal**

For the base score of the advancing care information performance category, MIPS eligible clinicians would be required to submit the numerator (of at least one) and denominator, or yes/no statement as appropriate (only a yes statement would qualify for credit under the base score), for each measure within a subset of objectives (Electronic Prescribing, Patient Electronic Access to
Health Information, Care of Coordination Through Patient Engagement, Health Information Exchange, and Public Health and Clinical Data Registry Reporting) adopted in the 2015 EHR Incentive Programs Final Rule for Stage 3 as outlined in Table 6 to account for the base score of 50 percent of the advancing care information performance category score (p. 208).

TABLE 6: Base Score Primary Proposal Advancing Care Information Objective and Measure Reporting

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure*</th>
<th>Total Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>50%</td>
</tr>
<tr>
<td>2 Electronic Prescribing</td>
<td>ePrescribing</td>
<td></td>
</tr>
<tr>
<td>3 Patient Electronic Access</td>
<td>Patient Access</td>
<td></td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Coordination of Care Through Patient Engagement</td>
<td>View/Download or Transmit (VDT)</td>
<td></td>
</tr>
<tr>
<td>Secure Messaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Health Information Exchange</td>
<td>Patient Care Record Exchange</td>
<td></td>
</tr>
<tr>
<td>Request/Accept Patient Care Record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
<td></td>
</tr>
<tr>
<td>(Optional) Syndromic Surveillance Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Optional) Electronic Case Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Optional) Public Health Registry Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Optional) Clinical Data Registry Reporting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Advancing Care Information Performance Category Base Score Alternate Proposal

Under the alternate proposal for the base score of the advancing care information performance category, a MIPS eligible clinician would be required to submit the numerator (of at least one) and denominator, or yes/no statement as appropriate, for each measure, for all objectives and measures for Stage 3 in the 2015 EHR Incentives Program Final Rule. CMS proposes the same approach in the alternate proposal for the Public Health and Clinical Data Registry Reporting objective as for the primary proposal as outlined in Table 7.
Modified Stage 2 in 2017

CMS proposes modified primary and alternate proposals for the base score for those MIPS eligible clinicians utilizing EHR technology certified to the 2014 Edition. They note that these modified proposals are the same as the primary and alternate proposals outlined above in regard to scoring and data submission, but vary in the measures required under the Coordination of Care Through Patient Engagement and Health Information Exchange objectives as demonstrated in Table 8 on p 213.
III. Performance Score

A MIPS eligible clinician would earn additional points above the base score for performance in the objectives and measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. CMS is proposing that, for the performance score, the eight associated measures under these three objectives would each be assigned a total of 10 possible points. For example, a performance rate of 95 percent on a given measure would earn 9.5 percentage points of the performance score for the advancing care information performance category (p. 214). In this methodology, a MIPS eligible clinician has the potential to earn a performance score of up to 80 percent, which, in combination with the base score would be greater than the total possible 100 percent for the advancing care information performance category.

Overall Advancing Care Information Performance Category Score

To determine the MIPS eligible clinician’s overall advancing care information performance category score, CMS proposes to use the sum of the base score, performance score, and the potential Public Health and Clinical Data Registry Reporting bonus point. So if the sum of the MIPS eligible profession’s base score (50 percent) and performance score (out of a possible 80 percent) with the Public Health and Clinical Data Registry Reporting bonus point are greater than 100 percent, CMS would apply an advancing care information performance category score of 100 percent. The total percentage score (out of 100) for the advancing care information performance category would then be applied to the 25 points allocated for the advancing care information performance category and incorporated into the MIPS CPS.

Scoring Considerations

In any year in which the Secretary estimates that the proportion of EPs who are meaningful EHR users is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the advancing care information performance category in the MIPS CPS, but not below 15 percent, and increase the weightings of the other performance categories.

CMS proposes to estimate the proportion of physicians, who are meaningful EHR users as those physician MIPS eligible clinicians who earn an advancing care information performance category score of at least 75 percent under our proposed scoring methodology for the advancing care information performance category for a performance period. Which would mean earn the base score of 50 percent, performance score of at least 25 percent (or 24 percent plus the Public Health and Clinical Data Registry Reporting bonus point) for an overall performance category score of 75 percent. Alternatively, CMS is proposing to estimate the proportion of physicians who are meaningful EHR users as those physician MIPS eligible clinicians who earn a performance category score of 50 percent (which would only require the MIPS eligible clinician
to earn the advancing care information base score). CMS is seeking comments on both of these proposed thresholds.

**Exclusions**

By excluding from MIPS those clinicians who do not exceed the low-volume threshold (MIPS eligible clinicians who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provide care for 100 or fewer Part B-enrolled Medicare beneficiaries), CMS believes exclusions for most of the individual advancing care information measures are no longer necessary. Seeking comment on whether other exclusions should be considered.

**Additional Considerations**

There may not be sufficient measures that are applicable and available to certain types of MIPS eligible clinicians (some of whom may have qualified for a statutory exception to the meaningful use payment adjustment), and CMS has proposed to assign a weight of zero to the advancing care information performance category for purposes of calculating a MIPS CPS for these MIPS eligible clinicians.

If MIPS eligible clinicians lack control over the EHR technology in their practice locations (in the case of surgeons using ambulatory surgery centers), then the measures specified for the advancing care information performance category may not be available to them for reporting. To be considered for a reweighting of the advancing care information performance category, CMS proposes that these MIPS eligible clinicians would need to submit an application demonstrating that a majority (50 percent or more) of their outpatient encounters occur in locations where they have no control over the health IT decisions of the facility, and request their advancing care information performance category score be reweighted to zero (p 241).

CMS proposes that all applications for reweighting the advancing care information performance category be submitted by the MIPS eligible clinician or designated group representative in the form and manner specified by CMS. Propose that all applications may be submitted on a rolling basis, but must be received by CMS no later than the close of the submission period for the relevant performance period, or a later date specified by CMS. For example, for the 2017 performance period, applications must be submitted no later than March 31, 2018 (or later date as specified by CMS) to be considered for reweighting the advancing care information performance category for the 2019 MIPS payment year. An application would need to be submitted annually to be considered for reweighting each year.
Alternative Payment Model Provisions

As discussed above, the MACRA proposed rule posted on April 27, 2016 outlines two streams for practitioners to qualify for payment adjustments. The first is through the Merit-based Incentive Payment System (MIPS) which would have four performance categories—quality, advancing care information, clinical practice improvement activities and cost, each weighted differently across implementation years. The second stream available under the proposed is the Advanced Alternative Payment Model (APM).

The rule does not define how an APM should reward quality and value, but rather embeds incentives for practitioners to adopt and participate in APMs. Qualification as a significant APM participant exempts practitioners and practices from the MIPS framework. For years 2019 through 2024, a clinician who meets the standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

The MACRA legislation provided a broad definition of an APM, as those in which clinicians accept risk for providing coordinated, high quality care. Under the proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures. The rule provides guidance on how much risk, etc. Specifically, the rule provides the following measures of risk.

- Total risk (maximum amount of losses possible under the Advanced APM) must be at least 4 percent of the APM spending target.
- Marginal risk (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM Entity is responsible (i.e., sharing rate) must be at least 30 percent.
- Minimum loss rate (the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM Entity has responsibility for losses) must be no greater than 4 percent.

The proposed rule also specifies that the advanced APM much base payments on quality measures comparable to those used in the MIPS quality performance category. The rule proposes that an Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one such measure must be an outcome measure if an outcome measure appropriate to the Advanced APM is available on the MIPS measure list.
The propose rule also calls for Advanced APM participants to use certified EHR technology. The rule requires that an Advanced APM must require that at least 50 percent of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

The proposed rule provides an avenue for Medical Homes to be defined as Advanced APMs. This applies to primary care medical homes with 50 or fewer clinicians so that these arrangements can qualify as Advanced APMs even if they bear less financial risk.

The proposed rule includes a list of models that qualify as Advanced APMs under the terms of the proposed rule for the first performance year and proposes to update annually for following years. The existing programs identified as qualified for Advanced APM status are:

- Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program—Track 2
- Medicare Shared Savings Program—Track 3 Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

(Please note that they did not include the Comprehensive Care for Joint Replacement (CJR) as a qualified Advanced Alternative Payment Model for year 1. The proposed rule stated that CJR does have sufficient quality measure and financial risk criteria. The rule also defines BCPI models II, III and IV as not having sufficient financial risk).

Under the proposal, to qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. Clinicians will also have the option to be assessed as a group to qualify for incentive payments under the proposed rule.

In 2019 and 2020, the participation requirements for Advanced APMs are only for Medicare payments or patients. Starting in 2021, the participation requirements for Advanced APMs may include non-Medicare payers and patients.

Over time, the requirements would increase to require greater commitment to Advanced APM participation measured either as percentage of payments received through an Advanced APM or percentage of patients seen through an Advanced APM.

The rule lays out the following requirements by payment year.

- 2019: 25% of payments or 20% of patients
• 2020: 25% of payments or 20% of patients
• 2021: 50% of payments or 35% of patients
• 2022: 50% of payments or 50% of patients
• 2023: 75% of payments or 50% of patients
• 2024 and later: 75% of payments or 50% of patients

The rule provides guidance for the Physician-focused Payment Technical Advisory Committee (PTAC) to review and assess additional physician-focused payment models. The eleven members of the Committee were appointed in October 2015 by the US Comptroller General based on their expertise in physician-focused payment models and related delivery of care. The Committee will meet on a quarterly basis, and may meet more frequently as it starts to receive payment model proposals. The rule proposes criteria for the Committee to use in making comments and recommendations on proposed physician-focused payment models. The criteria require that proposed physician-focused payment models further the goals outlined by the law, as well as reduce cost, improve care or both.

The proposed rule also provides an option for an All-Payer combination option starting in performance year 2019. Clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, either private insurers or state Medicaid programs. This “All-Payer” option is only if a physician does not meet the required percentage of payments provided or patients cared for through an Advanced APM through Medicare alone. In those cases, then payments and patients under payers beside Medicare called “Other Payer Advanced APMs” will also be able to count towards their participation status. The proposed criteria for Other Payer Advanced APMs are similar to those proposed for Advanced APMs. This section also specifies standards for Medicaid medical home models.

The proposed rule also creates Intermediate options for physicians that participate to some extent in APMs, but may not meet the law’s criteria for sufficient participation in the most advanced models. The proposed rule provides financial rewards under the MIPS framework, and makes it easy for physicians to move between the components of the Quality Payment Program.

Importantly, the rule proposes to only accept participants in the identified Medicare programs as qualified for the Advanced APM in the first year. For all other APM participants, the Advanced APM track starts the second full year (2019). The stated rationale for having all physicians fall under the MIPS framework for the first year is to allow the agency that year to determine whether clinicians met the requirements for the Advanced APM track, all clinicians will report through MIPS in the first year. The rule repeatedly states that the agency expects that the number of physicians who qualify as participating in Advanced APMs will grow as the program matures and as physicians take advantage of the intermediate tracks of the Quality Payment Program to experiment with participation in APMs.
The bonus payments are set to 5% of fee-for-service (FFS) payments. However, the agency also proposes to develop a bonus incentive not tied to FFS payments since, by definition, Advanced APMs are using non FFS structures. For these components of payments, the rule proposes to calculate aggregate spending and pay bonuses based on aggregate spending.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Background

Stakeholders may submit proposals to the PTAC on an ongoing basis for PFPMs. The PTAC, is an independent committee comprised of 11 members. Appointments to the PTAC are made by the Comptroller General on October 9, 2015. CMS does not have the authority to appoint members of the PTAC. The terms of the first appointed members of the PTAC are intended to be staggered, with the first set of appointments for terms of 1, 2, or 3 years. After the initial appointments, all subsequent appointments would be for terms of 3 years. PTAC members who were among the initial appointments may be reappointed for subsequent 3-year terms. There are no limitations for how many terms a PTAC member may serve. No end date for the PTAC is specified.

Overview of the roles of the Secretary, the PTAC, and CMS

CMS does not propose to evaluate PFPM proposals prior to their submission to the PTAC because it might interfere with the PTAC’s independent review process. CMS is not in a position to propose a commitment to test all models the PTAC recommends. Section 1868(c) of the Act does not require CMS to test models that are recommended by the PTAC and given a favorable response by the Secretary. However, this does not imply that CMS would not give serious consideration to proposed PFPMs recommended by the PTAC.

The decision to test a model recommended by the PTAC would not require a second application. CMS would review the proposal submitted to the PTAC along with comments from the PTAC. Proposed PFPMs that the PTAC recommends to the Secretary but that are not immediately tested by CMS may be considered for testing at a later time.

Deadlines for the duties of the Secretary, the PTAC, and CMS

CMS does not propose to set deadlines through regulations for the PTAC’s comments and recommendations on proposed PFPMs, the Secretary’s response to the PTAC’s comments and recommendations, and CMS’s testing of PFPMs.
Definition of physician-focused payment model (PFPM)

Proposed Definition of PFPM: An Alternative Payment Model wherein Medicare is a payer, which includes physician group practices (PGPs) or individual physicians as APM Entities and targets the quality and costs of physician services. CMS proposes to require a PFPM to target physician services such as physician behaviors or clinical decision-making.

Propose to require that PFPMs be designed to be tested as APMs with Medicare as a payer. A PFPM may include other payers in addition to Medicare. CMS does not propose to define PFPM as a payment model that exclusively addresses Medicare FFS payments. A proposed PFPM may also include other payers in addition to Medicare, including Medicaid, Medicare Advantage, CHIP, and private payers, which may promote broader participation in PFPMs and greater potential for cost reduction.

Relationship between PFPMs and Advanced APMs

CMS does not propose to define PFPMs solely as Advanced APMs. Stakeholders may therefore propose either Advanced APMs or other PFPMs.

Proposed PFPM Criteria (p.611, 616)

Propose PFPM criteria organized into three categories:

1. Incentives: Pay for higher-value care.
   a. Value over volume: provide incentives to practitioners to deliver high-quality health care.
   b. Flexibility: provide the flexibility needed for practitioners to deliver high-quality health care.
   c. Quality and Cost: are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
   d. Payment methodology: pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
   e. Scope: aim to either directly address an issue in payment policy that broadens and expands the APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
f. Ability to be evaluated: have evaluable goals for quality of care, cost, and any other goals of the Physician-focused Payment Model.

2. Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement.
   a. Integration and Care Coordination: encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the Physician-focused Payment Model.
   b. Patient Choice: encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
   c. Patient Safety: aim to maintain or improve standards of patient safety.

3. Information Enhancements: Improving the availability of information to guide decision-making.
   a. Health Information Technology: encourage use of health information technology to inform care.

Facilitating CMS Consideration of Models Recommended by the PTAC

Suggest “supplemental information elements” stakeholders may include in their PFPM proposals to assist CMS review. Many factors are typically used in the selection of models to be tested, and can be viewed on the Innovation Center Web site at https://innovation.cms.gov/Files/x/rfiwebsitepreamble.pdf.

CMS also chooses not to include certain of these factors, including the size of investment required and waiver authority, in the suggested supplemental information elements because CMS believes the burden to evaluate how these factors apply to potential APMs should be on CMS, not stakeholders.

Supplemental Information Elements Considered Essential to CMS Consideration of New Models

- A description of the anticipated size and scope of the model in terms of eligible clinicians, beneficiaries, and services.
- A description of the burden of disease, illness or disability on the target patient population.
- An assessment of the financial opportunity for APM Entities, including a business case for how their participation in the model could be more beneficial to them than participation in traditional fee-for-service Medicare
Recommend that proposed PFPMs submitted to the PTAC include information about whether the stakeholder or individual submitting the proposal believes it would meet the criteria to be an Advanced APM.

**MIPS and APMs RFI Comments on PFPM Criteria**

CMS does not believe that they should limit proposed PFPMs by adding specialty-specific criteria. CMS agrees with comments that physicians and practitioners that have had the opportunity to participate in previous APMs should not be excluded from future proposals for PFPMs because current or previous APMs are not exhaustive of all possible APMs for any given specialty or issue, so long as the proposed PFPM instead aims to solve an issue in payment policy that broadens and expands the CMS APM portfolio at the time it is tested as stated in section.

CMS does not believe PTAC is the proper forum for considering modifications or extensions of current models. CMS does not believe it would be appropriate to limit proposed PFPMs to include specific quality measures. CMS encourages stakeholders to submit their proposed PFPMs to the PTAC.

---

**Section 3: AAOS talking points on the MACRA proposed rules**

On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule detailing for the first time the physician reimbursement framework required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The American Association of Orthopaedic Surgeons (AAOS) has previously communicated with CMS on the implementation of select provisions of MACRA, including episode groups, aspects of the Merit-based Incentive Payment System (MIPS), developing alternative payment models (APMs), and encouraging creation of physician-focused payment models. AAOS leadership and staff are closely reviewing today’s proposed rule and will be providing CMS with detailed comments. “The importance of this proposed rule cannot be overstated,” said AAOS President Gerald R. Williams, Jr., MD.

“This is a significant and complex regulation that alters physician reimbursement and implements a number of new initiatives to decrease cost and improve quality of care for Medicare beneficiaries. Physician involvement in the development and implementation of MACRA is critical. As specialty physicians, orthopaedic surgeons face unique challenges and require specialty-specific tools, measures, and other considerations in order to successfully participate in quality performance programs and APMs. We look forward to working closely with CMS to refine MACRA provisions and ensure physician payment reform ultimately improves the care of musculoskeletal patients.”
MIPS OVERVIEW – As outlined in MACRA, MIPS would consolidate three currently separate Medicare quality programs: (1) the Physician Quality Reporting System; (2) the Value-Based Modifier Program; and, (3) the “Meaningful Use” of electronic health records (EHRs). The MIPS composite score will be based on four performance categories:

- **Quality**: 50 percent of total score in year 1 (45 percent in year 2 and 30 percent thereafter), replaces Physician Quality Reporting System (PQRS);
- **Advancing Care Information**: 25 percent of total score in year 1, formerly EHR Meaningful Use (MU) and includes the same measures from MU Stage 3 and Modified Stage 2, but thresholds have been removed;
- **Clinical Practice Improvement Activities**: 15 percent of total score in year 1, this is essentially the “new” domain added to the previously existing other three, focuses on the MIPS strategic goal to use a patient-centered approach to developing incentives and policies that drives improved patient health outcomes; and,
- **Cost or Resource Use**: 10 percent of total score in year 1, based on Medicare claims data — no reporting necessary.

ADVANCED APM OVERVIEW – On the APM track, per the MACRA statute, Advanced APMs must meet three proposed requirements:

1. Required use of certified EHRs;
2. Payment for covered professional services based on comparable quality measures; and,
3. Either being an enhanced medical home or bearing more than “nominal risk” for losses.

POSITIVE PROVISIONS – AAOS recognizes CMS’ efforts to address needed flexibility and specialty-specific concerns, especially in areas of quality reporting. The removal of an “all-or-nothing” approach is significant as is the decreased number of measures. AAOS is also pleased to see attention focused on setting aside quality measures tailored for specialists.

ADDED FLEXIBILITY

Under the “Advancing Care Information” category (formerly Meaningful Use), there is no longer an all-or-nothing requirement.

- Additionally, clinicians now can select measures “that reflect how technology best suits their day-to-day practice” and CMS is decreasing the number of measures to 11, down from 18 measures.
- CMS is no longer requiring reporting on the Clinical Decision Support [CDS] and the Computerized Provider Order Entry [CPOE] measures.
For the “Quality” category under MIPS, clinicians choose six measures instead of the nine measures currently required under PQRS.

- There will also be more than 200 measures to pick from and more than 80 percent of the quality measures proposed are tailored for specialists. Additionally, clinicians can report a specialty measure set instead.
- Under MIPS generally, clinicians will have the option to be assessed as a group across all four MIPS performance categories.

RISK ADJUSTMENT

- This proposal refers to ongoing work to assess the issue of risk adjustment for socioeconomic status (SES) on quality measures, with a report due to Congress on this front by October 2016. AAOS is supportive of including risk adjustment measures and have requested for appropriate rule-making.

Other positive provisions:

- The MIPS resource/cost category measures come from claims data, allowing CMS to calculate performance independently. There is no reporting necessary.
- The MIPS score measures clinicians’ overall care delivery, so clinicians do not need to limit their MIPS reporting to the care provided to Medicare beneficiaries.
- Under the APM track, “other payer advanced APMs” may qualify starting in 2019 performance year provided they meet some tests.
- The rule aligns standards between two parts of the Quality Payment Program (MIPS and the Advanced APM track) in order to make it easy for clinicians to move between them.
- CMS estimates that in 2019, the first payment year for MIPS performance, $500 million in “exceptional performance payments” will be distributed to eligible clinicians. Further, the agency will make around $200 million in APM incentive payments that year. This is over and above the payment adjustments.
- The rule proposes criteria for the Physician Technical Advisory Committee (PTAC) to use in making comments and recommendations on proposed Physician-focused Payment Models. This is an opportunity to provide comments on the criteria for qualifying APMs.

CONCERNS – However, there are a number of serious concerns that still need to be addressed. Specifically, AAOS has concerns about the timing of implementation and infrastructure readiness, the restrictive requirements for Advanced Alternative Payment Models (APMs), and access to Medicare claims data. AAOS will be coordinating formal written comments with state
and specialty societies to refine MACRA provisions and ensure these reforms ultimately improve the care of musculoskeletal patients.

TIMING AND INFRASTRUCTURE READINESS

- The MACRA rule sets 2017 as the first performance year, with penalties for that performance year being applied in 2019 (up to 4% penalty). This is a very tight turnaround for physician practices (seven months from now and roughly two months after the rules are finalized in late October), especially considering that infrastructural support remains incomplete, with meaningful use (MU) attestation at 18% and 48% for physicians and hospitals, respectively. Small practices, especially, may still struggle to learn the details and implement the necessary infrastructure in time for the January 1, 2017 start date. Additionally, some specialties have no applicable QCDR and appropriate measures may still need to be developed/identified, then quickly incorporated into IT systems.

SOLO AND SMALL PRACTICES ADVERSELY AFFECTED

- CMS estimates 87 percent of solo practices will be penalized 4 percent under MIPS starting in 2019. That’s roughly $300 million in penalties for nearly 100,000 doctors. See “New Medicare Penalty Hits Small Groups, Solo Physicians Hardest” http://www.medscape.com/viewarticle/862642.

RESTRICTIVE REQUIREMENTS FOR ADVANCED APMS

- CJR and BPCI bundled payments do not count as advanced APMs (and CMS has set a high bar on requirements for APM track).
- There are lots of unanswered questions in terms of requirements for Advanced APMs. In summary, physicians will find it difficult to work through the contracting issues. The upside incentives in the two-sided risk models may not justify the efforts necessary to set up Advanced APMs. Advanced APMs for orthopaedics maybe piloted in 2018 and there will not be any significant movement on that until 2021-2023.
- MACRA expecting as little as 4% of those eligible will be in APM for 2019?

Note: CMS will continue to modify models in coming years to help them qualify as Advanced APMs, and starting in performance year 2019, clinicians can qualify for incentive payments based, in part, on participation in Advanced APMs developed by non-Medicare payers (private insurers, state Medicaid programs). AAOS will be commenting specifically on how to make the CJR model a qualifying APM.
ACCESS TO MEDICARE CLAIMS DATA

- CMS did not adopt the MACRA directive to provide a Qualified Clinical Data Registry (QCDR) with access to Medicare claims data. While clinicians are encouraged to use QCDRs and given bonus payments to do so, new and onerous restrictions are placed on QCDRs. For example, mandatory monthly calls with CMS are required as are new reporting requirements (if data submissions are inaccurate 3% of the time you are expelled from the program, etc.).

Other concerns:

- MIPS requires clinicians to comply with information blocking surveillance and actively open EHR, but info blocking is more about hospitals (e.g. ADT feeds) and vendors.
- APMs under MIPS (specifically, the Clinical Practice Improvement Activities Category) are different from Advanced APMs, which may lead to confusion among clinicians.
- Also, a number of new terminology have been introduced (for example, Meaningful Use is now Advancing Care Information, without any substantial change in measures).