AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Topic: Grid comparing the MACRA/QPP Proposed to Final Rule [to be updated regularly]
Date: October 28, 2016

The Centers for Medicare and Medicaid Services (CMS) on Friday, October 14, 2016, finalized the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The agency also launched an accompanying website with information at https://qpp.cms.gov/. Comments are due to CMS by December 19, 2016.

Topic	Proposed Rule	Final Rule	Comment (if any)
Start date	January 1, 2017	Finalized as proposed, *however* CMS is now defining 2017 as a collection year and 2019 as a payment year as a "transition year" with very minimal requirements (report 1 measure for 90 days) to qualify for a zero adjustment.	AAOS asked for a delay of the start date. The program was not delayed *however*, 2017 is now a 'transitional year' with considerable flexibilities to physician practices on reporting. 2018 will be a learning and development year and reporting requirements for it will be finalized in 2017. Moreover there are a number of flexibilities in reporting requirements detailed below.
Lag time	The first performance year will be 2017 with 2019 as the first payment year	Finalized as proposed	Note: Feedback to participants will be shared by CMS at the end of the performance year without any lag.
Performance period	A full calendar year	Significant reduction to 90-day reporting period in 2017 transition year	
Low volume threshold exclusions	Less than or equal to $10,000 in Medicare Part B allowed charges AND Less than or equal to 100 Medicare patients	Set at less than or equal to $30,000 in Medicare Part B allowed charges OR Less than or equal to 100 Medicare patients In addition, modified the performance threshold to 3 for the initial payment	The increase of the threshold amount and inclusion of 'either/or' is a new flexibility and in line with AAOS' request.

		year (2019), and added a performance floor on quality measure benchmarks.	
Impact on practice size	Per Table 63 (MIPS Proposed Rule Estimated Impact On Total Allowed Charges By Specialty: Mid-Point Estimate), it is quite evident that specialty physicians are more likely to have an aggregate negative adjustment on their charges. Moreover, the data in Table 64 (MIPS Proposed Rule Estimated Impact On Total Allowed Charges By Practice Size) show that physician practices of less than 10 clinicians would account for almost 70 percent of the MIPS penalties in 2019, it is even worse for solo practices with 87 percent of the penalties.	The final rule estimates evenly distributed effects across practice sizes, with at least 90% of all providers in each practice size category qualifying for bonus or having no negative adjustments and at least 80% of providers in small or solo practices qualifying for a bonus or no adjustment.	***Note: MACRA provides $20 million each year for five years ($100 million total) to train clinicians in small practices of 15 clinicians or fewer and those working in underserved areas. Beginning December 2016, local organizations will offer free, on-the-ground, specialized help to small practices using this funding. Also, CMS Regional Offices will hold listening sessions locally and will submit a report on the feedback received to the CMS Administrator in 2017.***
Data submission	Data submission and performance evaluation to be done at either the individual or group level. Physicians must choose to report as an individual	Finalized as proposed. CMS is considering virtual group submissions in 2018.	

	or group consistently across all MIPS categories.		
Non-patient facing clinician	Defined a non-patient facing clinician as an individual clinician that bills 25 or fewer patient-facing encounters.	Expanded the definition of a non-patient facing physician as an individual clinician that bills **100 or fewer patient-facing encounters** during the non-patient facing determination period.	
Merit-based Incentive Payment System (MIPS)		The final rule sets the MIPS **performance threshold at three points, meaning that clinicians who report at least one measure in the Quality performance category; OR one activity in the Clinical Practice Improvement Activities performance category; OR report the required five measures of the Advancing Care Information performance category will not get a negative payment adjustment.** Clinicians who submit 90 days of 2017 performance data to CMS will receive a neutral or small positive payment adjustment, while clinicians who submit a full year of 2017 performance data to CMS may earn a moderate positive payment adjustment. Clinicians who receive a MIPS Composite Performance Score (CPS) of 70 or higher (on a scale of 0 to 100) will be eligible for an additional payment adjustment for exceptional performance.	***Note: Reporting requirements have been made a lot more flexible than what was initially proposed but potential rewards will be proportional to the degree of participation.***

Quality	6 quality measures or a specialty measure set, one of which must be an outcome measure (or, if no outcome measures are available, one high priority measure) and one cross-cutting measure. Reporting threshold: physicians reporting via registry, Electronic Health Record (EHR), or Qualified Clinical Data Registry (QCDR) had to report on 90 percent of patients to report a measure successfully, and that physicians reporting via claims had to report on 80 percent of Medicare Part B patients to report a measure successfully. 2017 category weight: 50%	Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. [Groups using the web interface: Report 15 quality measures for a full year. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through their APM. No additional reporting for MIPS quality.] Reporting threshold: In 2017, physicians have to report on a measure successfully on *50 percent* of patients, and in 2018, physicians have to report on a measure successfully on 60 percent of patients. CMS intends to increase the measure thresholds over time. 2017 category weight : 60%	Considerable reduction in burden in the number of measures (from the 9 measures required currently under PQRS) and the elimination of the cross cutting measure. Also reduction in reporting threshold. Increased MIPS performance category weight. ***Note: If a physician is only avoiding a penalty and not attempting to earn an incentive, they are only required to report on one patient in 2017.***
Resource Use/Cost	2017 category weight 10%	Category weighted to 'zero' for the transitional year of 2017. In 2018, the cost performance category is reduced to 10% and in 2019 and	Clinicians will still receive feedback on their resource use from CMS in 2017. CMS is developing patient condition groups and patient relationship codes to assist with attribution beginning in 2018,

		beyond, 30% of the composite performance score as required by MACRA.	as well as working for future years to refine risk-adjustment methodologies. ***Note: It is important to review Quality and Resource Use Reports (QRURs) for your practice. Physicians can obtain their QRURs here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html***
Improvement Activities	Physicians report three 20-point high weighted activities or six 10-point medium-weighted activities (or another combination of high and medium weighted activities equaling 60 or more points) to achieve full credit in the CPIA performance category. Small, rural, health provider shortage areas (HPSAs) or non-patient facing physicians report two CPIAs regardless of weight to receive full credit. 2017 category weight: 15%	Physicians must attest to *two* 20-point high weighted activities, *four* 10-point medium-weighted activities, or another combination of high and medium weighted activities equaling 40 points or more for a minimum of 90 days to achieve full credit in the CPIA category. [**Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.** Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.] 2017 category weight: 15%	Another reduction in reporting burden including for small, rural and HPSA practices. APM Entities participating in the 2017 MIPS APMs receive a full score for the Improvement Activities in 2017. The eligible MIPS APMs are subject to change in future years. Other APMs are eligible for at least half-credit. *Reporting something will mean avoiding the full negative penalty of 4%. E.g., one of the CPIAs is being registered for PDMP and that will imply avoidance of MIPS penalty for 2017.*

Advancing Care Information (Replaces Meaningful Use)	Required reporting on 11 measures in the Base Score. Physicians must report ACI measures for a full year beginning in 2017. Pass-fail element in the base performance score, as physicians must report on all measures in the base score in order to earn a score in the ACI performance category. 2017 category weight: 25%	Physicians must report on all required ACI measures (below) in the Base Score. The Base Score measures are met via one unique patient or attestation to a "yes" option. Fulfill the required measures for a minimum of 90 days: • Security Risk Analysis • e-Prescribing • Provide Patient Access • Send Summary of Care Request/Accept Summary of Care Up to an additional 9 optional measures in the Performance Score, for which physicians may receive additional percentage points. The Performance Score measures are eligible for partial credit. In 2017 and 2018, physicians must report the ACI measures for a *minimum of 90-days*. Retains the pass-fail element. 2017 category weight: 25%	Reduction in the number of required measures and a reduction in reporting period to 90 days. Physicians may receive preferential scoring in the Advancing Care Information (ACI) category by using CEHRT to perform one or more of 18 designated improvement activities. For bonus credit, physicians can: • Report Public Health and Clinical Data Registry Reporting measures • Use certified EHR technology to complete certain improvement activities in the improvement activities performance category OR • May not need to submit advancing care information if these measures do not apply to them. ***Note: In 2017, physicians can use 2014 or 2015 CEHRT; in 2018, CEHRT from 2015 and beyond should be used.***
Alternative Payment Models (APMs)		CMS will use an accelerated timeline for making Qualifying Participants (QP) determinations. The policy is intended to use "snapshots" at various points in time of the performance year so that clinicians will know their QP status in advance of the end of the MIPS	

		performance period so they will know whether they will need to submit performance data to CMS for purposes of MIPS.	
Nominal risk	Financial risk requirements in which physicians were expected to pay up to 4 percent of total Medicare spending (as opposed to revenue) in order to qualify as an Advanced APM.	An APM will qualify as an Advanced APM in 2019 and 2020 if the APM Entity is either (1) at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or (2) at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower. CMS states that it plans to increase the risk standard to 10 or 15 percent of revenues in future years. In 2017, 50 percent of participants in Advanced APMs would need to use CEHRT. To satisfy quality measure requirements, Advanced APM participants would be required to report quality measures similar to those used in the MIPS quality performance category.	Significant reduction in financial risk requirement. The final rule eliminated the requirements for "marginal risk" and "minimum loss rate" and retained only the requirement for total risk for Medicare APMs. CMS dropped its proposal to increase the number of physicians that must use CEHRT from 50 percent to 75 percent in the second year in Advanced APMs.
Newly qualifying Advanced APMs	Comprehensive Care for Joint Replacement Model (CJR) and Bundled Payment for Care Improvement initiative (BPCI) models did not qualify as Advanced APMs.	Additional options for clinicians to participate in advanced APMs and changes to existing programs (such as CJR and the Surgical Hip/Femur Fracture Treatment (SHFFT) model are being considered and will be published through future rulemaking (as early as January 2017). These existing models should potentially qualify as advanced	The Academy's **concerns/comments** to CMS continue to be the following: • Create voluntary bundled payment model 1. A hip fracture bundle with A) a fixation arm and B) an arthroplasty arm and 2. A joint arthroplasty bundle

		APMs beginning in 2018. A new voluntary bundled payment model starting in 2018 has been announced.	*(Voluntary bundled payment model with Advanced APM qualification announced by CMS via QPP)* • Stop mandatory models • Delay implementation of SHFFT till CJR 1st year results are out • Share data with all collaborators; provide infrastructural support • Include risk adjustment and exclusion criteria in these models • Lack of validated measures (NQF# 1550/HOOS Jr. not validated for hip fx fixation for SHFFT; no musculoskeletal care outcome measures) ***Note: The new voluntary bundled payment model is expected to replace BPCI.***

Important: Note that it is important to participate even at the MIPS minimum performance threshold of three points in 2017 (i.e., report at least one measure in the Quality performance category; OR one activity in the Clinical Practice Improvement Activities performance category; OR report the required five measures of the Advancing Care Information performance category) and gradually build up participation in the years to come. Thus, it is advisable that physicians not avoid participating in the transitional year of 2017. MIPS/QPP is based on the MACRA statute and is *not* a limited time demonstration. These rules are unlikely to change unless Congress takes legislative action.

CMS technical and other support:

1. $20 million every year for five years on technical support to small practices (15 clinicians or less) through quality improvement organizations (QIOs) and other local organizations.
2. 2017 is a transitional year and 2018 is also expected to be a transitional year with gradual ramp up requirements announced through future rule making.

3. CMS has announced clinician engagement initiatives and listening sessions through the CMS Regional Offices : https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-10-13.html

Additional resources:

- CMS Quality Payment Program
- CMS Final Rule
- Final Rule Executive Summary
- CMS announcement
- CMS announcement to improve clinician engagement
- AAOS initial statement on the Final Rule
- AAOS MACRA resource page
- AMA Payment Model Evaluator (will be updated per the MACRA/QPP Final Rule)