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Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models
[CMS-5517-P]

Summary of Proposed Rule

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I. Introduction and Background

On April 27, 2016 the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule establishing the Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under the Physician Fee Schedule (PFS). The proposed rule also establishes incentives for participation in certain alternative payment models (APMs). The proposed rule is slated for publication in the May 9, 2016 issue of the *Federal Register*. If finalized, policies in the proposed rule generally would take effect on January 1, 2017. **The 60-day comment period ends at close of business on June 27, 2016.**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the SGR, creates a new pay-for-performance program for physicians, and encourages physician participation in alternative payment models. MACRA provides for a 0.5 percent update for 2016 through 2019, and then zero percent updates for 2020 through 2025; after 2025 the update is 0.75 percent for qualifying APM participants, and 0.25 percent for others. Physicians' participation in MIPS or qualifying APMs largely determines their annual update in most years.

In the proposed rule, CMS establishes the MIPS and proposes the standards for the four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities and Resource Use. The first performance period for MIPS will be 2017 and the first payment adjustments under MIPS will be 2019.

This table below summarizes the key features of the MIPS. Performance on these components will determine MIPS payment adjustment to what would have otherwise received under Medicare Part B; the percent payment adjustments can be positive or negative and range up to 4 percent for 2019, 5 percent for 2020, 7 percent for 2021 and 9 percent for 2022 and later years. For payment in 2019 through 2024, an additional positive adjustment is provided for exceptional performance.

Summary of MIPS Performance Categories		
Performance Category	Points Need to Get a Full Score per Performance Category ¹	Maximum Possible Points per Performance Category
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 Percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 Points	25 Percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.	60 Points	15 Percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all attributed resource measures.	10 percent

¹Exemptions or adjustments may apply in some clinicians' circumstances that change the total category score.

CMS also proposes the standards for Advanced APM models and the requirements for MIPS eligible clinicians to be considered Qualifying APM Participants (QPs) or Partial QPs through their participation in Advanced APMs (Medicare) and Other Payer Advanced APMs. Eligible clinicians considered QPs for a given performance year would receive a 5 percent incentive payment or bonus; those clinicians considered partial QPs would receive no bonus, but would not be subject to MIPS. This incentive payment is available during 2019 through 2024.

II. Provisions of the Proposed Regulations

A. Changes to Existing Programs

1. Sunsetting of Current Payment Adjustment Programs

MACRA requires sunsets payment adjustments under the three existing programs for Medicare enrolled physicians and other practitioners: the Physician Quality Report System (PQRS), the Value-based Payment Modifier (VM,) and the Medicare EHR Incentive Program.

For PQRS, CMS proposes to amend their regulations to continue payment adjustments through 2018. For the VM, CMS makes no proposal because the program is already limited to certain years. For the Medicare EHR Incentive Program, CMS proposes to amend their regulations to remove references to the payment adjustment percentage for years after the 2018 payment adjustment year and add a terminal limit of the 2018 payment adjustment year.

2. Meaningful Use Prevention of Information Blocking and Surveillance Demonstrations for MIPS Eligible Clinicians, EPs, Eligible Hospitals, and Critical Access Hospitals (CAHs)

a. Cooperation with Surveillance and Direct Review of Certified EHR Technology

CMS proposes that eligible clinicians, EPs, eligible hospitals, and CAHs would be required to attest that they have cooperated in good faith with the surveillance and ONC direct review of their health IT certified under the ONC Health IT Certification Program, to the extent that such technology meets (or can be used to meet) the definition of CEHRT. Cooperation under the attestation would include the following:

- Responding in a timely manner and in good faith to requests for information about the performance of the certified EHR technology capabilities in use by the provider.
- Accommodating requests (from ONC-Authorized Certification Bodies or from ONC) for access to the provider's certified EHR technology as deployed by the provider in its production environment, for the purpose of carrying out authorized surveillance, and demonstrating capabilities and other aspects of the technology that are the focus of such efforts.

b. Support for Health Information Exchange and the Prevention of Information Blocking

Effective April 16, 2016 MACRA requires that to be a meaningful EHR user, an EP, hospital, or CAH must demonstrate that they have not knowingly and willingly taken action (such as to disable functionality) to limit or restrict the compatibility of certified technology.

To meet these requirements, a provider would need to submit a three part attestation that it:

1. Did not knowingly and willfully take action to limit or restrict the compatibility or interoperability of certified EHR technology.
2. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times:
 - Connected in accordance with applicable law;
 - Compliant with all standards applicable to the exchange of information;
 - Implemented in a manner that allowed for timely access by patients to their electronic health information; and
 - Implemented in a manner that allowed for the timely bi-directional exchange of electronic health information with other health providers, including unaffiliated providers and with disparate certified EHR technology and vendors.
3. It responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information.

B. MIPS Program Details

1. MIPS Eligible Clinicians

a. Definition of a MIPS Eligible Clinician

CMS makes the following proposals:

- Define a MIPS eligible clinician as a physician, a physician assistant (PA), nurse practitioner (NP), and clinical nurse specialist (CNS) (as such terms are defined in section, a certified registered nurse anesthetist (CRNA), and a group that includes such professional.
- Qualifying APM Participants, Partial Qualifying APM participants who do not report data under MIPS, low-volume threshold eligible clinicians, and new Medicare-enrolled eligible clinicians would be excluded from this definition per the statutory exclusions.

b. Non-Patient-Facing MIPS Eligible Clinicians

CMS proposes to define a non-patient-facing MIPS eligible clinician for MIPS as an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period. CMS considers a patient-facing encounter to include general office visits, outpatient visits, surgical procedure codes, and telehealth services

The proposed rule states that although non-patient-facing MIPS eligible clinicians will not be exempt from any performance category under MIPS. To ensure that MIPS eligible clinicians, including non-patient facing, that do not have sufficient alternative measures that are applicable and available in a performance category are scored appropriately, CMS proposes to reweight a performance category to zero and reallocate the points to other categories with sufficient measures if there is no performance category score or to lower the weight of the quality performance category score if there are not at least three scored measures.

c. MIPS Eligible Clinicians Who Practice In CAHs Billing Under Method II (Method II CAHs)

MIPS eligible clinicians who practice in CAHs that bill under Method I would have the MIPS adjustment apply to payments made for items and services billed by these clinicians under the PFS. The MIPS adjustment would not apply to the facility payment to the CAH. MIPS eligible clinicians who practice in Method II CAHs and have not assigned their billing rights to the CAH would have the MIPS adjustment also apply to payments made for items and services, similar to MIPS eligible clinicians who practice in Method I CAHs.

CMS proposes the MIPS adjustment would not apply to Method II CAH payments when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights to the CAH.

d. MIPS Eligible Clinicians Who Practice In RHCs and/or FQHCs

If a MIPS eligible clinician furnishes services in an RHC and/or FQHC that bills for these services under their all-inclusive payment methodology, the MIPS adjustment would not apply to the facility payment to the RHC or FQHC. If the clinician, however, bills for these services under the PFS and meets the applicable MIPS reporting requirements, the MIPS adjustment would apply to their payments.

e. Group Practice

CMS proposes to define a group as a single Taxpayer Identification number (TIN) with two or more MIPS eligible clinicians, as identified by their National Provider Identifier (NPI), who have assigned their Medicare billing rights to the TIN. CMS also proposes to define an APM Entity group by a unique APM participant identifier.

2. MIPS Eligible Clinician Identifier

As discussed below, CMS proposes to use multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance and that the same identifier would be used for all four performance categories.

Individual Identifiers. CMS proposes to use a combination of billing TIN/NPI as the identifier to assess performance of an individual MIPS eligible clinician. Similar to PQRS, each unique TIN/NPI combination would be considered a different eligible clinician, and MIPS performance would be assessed separately for each TIN under which an individual bills.

Group Identifiers for Performance. Similar to PQRS and the VM, CMS proposes to use a group's billing TIN to identify a group.

APM Entity Group Identifier for Performance. CMS proposes that each eligible clinician who is a participant of an APM Entity would be identified by a unique APM participant identifier that would be a combination of four identifiers: (1) APM Identifier (established by CMS); (2) APM Entity Identifier (established under the APM by CMS); (3) TIN(s); and (4) the MIPS eligible clinician's NPI.

3. Exclusions

a. New Medicare-Enrolled Eligible Clinician

New Medicare-enrolled eligible clinicians is not MIPS eligible until the subsequent year and the performance period. For example, an eligible clinician who newly enrolls in PECOS in 2017 would not be required to participate in MIPS in 2017 and would not receive a MIPS adjustment in 2019. This same clinician would be required to participate in MIPS in 2018 and would receive a MIPS adjustment in 2020.

b. Qualifying APM Participants (QP) and Partial Qualifying APM Participant (Partial QP)

CMS proposes that the definition of a MIPS eligible clinician does not include QPs and Partial QPs who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period. Partial QPs will have the option to elect whether or not to report under MIPS, and be subject to MIPS adjustments.

c. Low-Volume Threshold

MACRA excludes low volume providers from MIPs. CMS proposes define low volume threshold as clinician who during the performance period, has Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

d. Group Reporting

In order to have its performance assessed as a group, CMS proposes a group must meet the proposed definition of a group at all times during the performance period. In addition, CMS proposes in order to have their performance assessed as a group:

- Individual MIPS eligible clinicians within a group must aggregate their performance data across the TIN, and
- The group would be assessed as a group across all four MIPS performance categories.

CMS proposes to eliminate a registration process for groups submitting data using third party entities.

CMS proposes only to require groups to register to have their performance assessed as a group when the group is submitting via the CMS Web Interface or the group elects to report the CAHPS for MIPS survey. CMS also proposes that these groups must register by June 30 of the applicable 12-month performance period, i.e. June 30, 2017 for performance periods occurring in 2017.

e. Virtual Groups

CMS proposes that individual MIPS eligible clinicians and groups electing to be a virtual group would be required to register in order to submit reportable data. Virtual groups would be assessed across all four MIPS performance categories.

4. Performance Period

CMS proposes that for 2019 and subsequent payment adjustment years, the performance period under MIPs would be the year (January 1 through December 31) that is 2 years prior to the year in which the MIPS adjustment is applied.

- The performance period for the 2019 MIPS adjustment would be January 1, 2017 through December 31, 2017.

CMS proposes to use claims that are processed within 90 days, if operationally feasible, after the end of the performance period for purposes of assessing performance and computing the MIPS payment adjustment. If CMS determines that it is not operationally feasible to have a claims data run-out for the 90-day timeframe, then CMS would utilize a 60-day duration.

For individual MIPS eligible clinicians and group practices with less than 12 months of performance data to report, CMS proposes that the individual MIPS eligible clinician or group would be required to report all performance data available from the performance period.

5. MIPS Category Measures and Reporting

a. Performance Category Measures and Reporting

CMS proposes that individual MIPS eligible clinicians and groups would be required to submit data on measures and activities for the quality, clinical process improvement activity (CPIA), and advancing care information performance categories. For the resource use performance category, CMS proposes calculating the resource use performance using administrative claims data. In addition, CMS would use administrative claims data to calculate performance on a subset of the MIPS quality measures and the CPIA performance category.

CMS proposes multiple data submissions for MIPS as outlined in Table 1 and Table 2 in the proposed rule and reproduced below.

TABLE 1: Proposed Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI

Performance Category/Submission Combination Accepted	Individual Reporting Data Submission Mechanisms
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 (no submission required)

TABLE 2: Proposed Data Submission Mechanisms for Groups

Performance Category/Submission Combination Accepted	Group Practice Reporting Data Submission Mechanisms
Quality	QCDR Qualified registry EHR CMS Web Interface (groups ≥ 25) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism) Administrative claims (no submission required)
Resource Use	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR CMS Web Interface (groups ≥ 25)
CPIA	Attestation QCDR Qualified registry EHR CMS Web Interface (groups ≥ 25) Administrative claims (no submission required)

CMS makes the following proposals related to the submission mechanisms:

- MIPS eligible clinicians and groups may elect to submit information via multiple mechanisms but they must use the same identifier for all performance categories and they may only use one submission mechanism per category (with the exception of CAHPS).
- A qualified registry, health IT vendor, or QCDR could submit data on behalf of the MIPS eligible clinician for the three performance categories: quality, CPIA, and advancing care information. These third party intermediaries would have to be qualified to submit for each of the performance categories.
- A qualified registry or health IT vendor that obtains data from a MIPS eligible clinician's CEHRT or QCDR could submit data on behalf of the group for the three performance categories: quality, CPIA or advancing care information.

CMS makes the following proposals related to the submission deadlines:

- 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 the first MIPS performance period, the data submission period would occur through January 2, 2018 through March 31, 2018 (the same time frame currently used for PQRS).
- For the Medicare Part B claims submission mechanism, claims for the performance period must be processed no later than 90 days following the close of the period.
- For the CMS Web Interface submission mechanism, the submission deadline will occur during an eight-week period following the close of the performance period that will begin no earlier than January 1 and end no later than March 31. The specific deadline during this timeframe will be published on the CMS website.

b. Quality Performance Category

(1) Contribution to Composite Performance Score (CPS)

CMS proposes for payment years 2019 (first year) and 2020 (second year), the quality performance category will account for 50 percent and 45 percent, respectively, of the CPS. For the third and future years, 30 percent of the MIPS CPS will be based on performance on the quality performance category.

CMS states that under their proposed scoring policy, a MIPS eligible clinician or group that reports on all required measures could potentially obtain the highest score possible within the performance category, presuming it performed well on all the measures reported. A MIPS eligible clinician or group that does not meet the reporting threshold would receive a zero score for the unreported items in the category which would prevent it from obtaining the highest possible score.

(2) Quality Data Submission Criteria

CMS' proposals for the submission of quality data are summarized in Table 3 in the proposed rule:

Table 3: Summary of Proposed Quality Data Submission Criteria for MIPS*

Measure Type	Submission Mechanism	Submission Criteria	Data Completeness
Individual MIPS eligible clinicians	Part B Claims	<p>Report at least six measures including one cross-cutting measure (Table C) and at least one outcome measure.</p> <ul style="list-style-type: none">• If an outcome measure is not available, report another high priority measure.• If fewer than six measures apply, then report on each measure that is applicable. <p>Measures will have to be selected from all MIPS Measures (Table A) or a set of specialty specific measures (Table E).</p>	80 percent of MIPS eligible clinician's patients.
Individual MIPS eligible clinicians or Groups	QCDR Qualified Registry EHR	<p>Report at least six measures including one cross-cutting measure (Table C) and at least one outcome measure.</p> <ul style="list-style-type: none">• If an outcome measure is not available, report another high priority measure.• If fewer than six measures apply, then report on each measure that is applicable. <p>Measures will have to be selected from all MIPS Measures (Table A) or a set of specialty specific measures (Table E).</p>	90 percent of MIPS eligible clinician's or groups patients as all-payer data
Groups	CMS Web Interface	Report on all measures included in the CMS Web Interface <u>and</u> populate data fields for the first 248 consecutively	Sampling requirements for

		<p>ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure.</p> <ul style="list-style-type: none"> • If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries. 	their Medicare Part B patients
Groups	CAHPS for MIPS Survey	<p>CMS-approved survey vendor would have to be paired with another reporting mechanism to ensure the minimum number of measures is reported.</p> <ul style="list-style-type: none"> • The survey would fulfill the requirement for one cross-cutting and/or a patient experience measure towards the MIPS quality data submission criteria. • Survey will only count for one measure. 	Sampling requirements for their Medicare Part B patients

*The proposed performance period is January 1 through December 31 of the performance period year.

For submission measures, excluding the CMS Web Interface and CAHPS, CMS proposes reporting at least six measures including one cross-cutting measure (if patient-facing) found in Table C (in the proposed rule) and including at least one outcome measure. If an applicable measure is not available, CMS proposes requiring one other high priority measure that the eligible clinician or group would need to chose: appropriate use, patient safety, efficiency, patient experience, and care coordination measures. If fewer than six measures apply, then CMS proposes requiring reporting on each measure that is applicable.

CMS notes that the specialty-specific measure sets (Table E in the proposed rule) are not all inclusive of every specialty or subspecialty.

CMS notes that if a MIPS eligible clinician or group had the ability to report on the minimum required measures with sufficient sample size and elects to report on fewer than the minimum reporting measures, then the missing measures would be scored with a zero performance score.

Groups Reporting via the CMS Web Interface. CMS notes that based on its experience with using the CMS Web Interface there are groups that register for this mechanism and have zero Medicare patients assigned and sampled to them. CMS clarifies that if a group has no assigned patients, then the group or individual MIPS eligible clinicians within the group, would need to select another mechanism to submit data to MIPS.

Groups Electing to Report CAHPS for MIPS Survey. CMS proposes to allow registered groups to voluntary elect to participate in the CAHPS for MIPS survey. The group must have the survey reported on its behalf by a CMS-approved survey vendor. In addition, the group will need to use another submission mechanism to complete their quality data submission. The survey would count as one cross-cutting and/or patient experience measure, and the group would be required to submit at least five other measures through one other data submission mechanism.

CMS proposes to retain the same survey administration period as the period used for the PQRS survey (i.e., November to February of the reporting year).

Although CMS is not requiring groups to participate in the CAHPS for MIPS survey, the proposed scoring methodology would give bonus points for reporting CAHPS data

Data Completeness Criteria. MACRA provides that analysis of the quality performance category may include quality measure data from other payers, specifically services furnished to individuals who are not Medicare. For the QCDR, qualified registry, and EHR submission mechanism, CMS proposes:

- 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 the payer for the performance period. CMS states they expect to receive quality data for both Medicare and non-Medicare patients.
- The submission must contain a minimum of one quality measure for at least one Medicare patient.

(3) Application of Quality Measures to Non-Patient-Facing MIPS Eligible Clinicians

CMS proposes that non-patient-facing MIPS eligible clinicians would be required to meet applicable submission criteria but would allow the following for non-patient facing MIPS eligible clinicians:

- Report using a specialty-specific measure set, which may have fewer than the required six measures;
- Report through a QCDR that can report non-MIPS measures; and
- Be exempt from reporting a cross-cutting measure.

(4) Application of Additional System Measures

MACRA allows the Secretary to use measures used for inpatient hospitals, for purposes of the quality and resource use performance categories. Except for services furnished by emergency physicians, radiologists, and anesthesiologists, the Secretary may not use measures used for hospital outpatient departments.

(5) Global and Population-Based Measures

For MIPS, CMS proposes to use the acute and chronic composite measures of the AHRQ Prevention Quality Indicators (PQIs) that meet a sample size in the calculation of the quality measure domain for the MIPS total performance score. As listed in Table B in the proposed rule, the Acute Condition Composite measure includes bacterial pneumonia, urinary tract infection, and dehydration; and the Chronic Conditions Composite includes diabetes, chronic obstructive pulmonary disease or asthma, and heart failure. Eligible clinicians will be evaluated on their performance on these measures in addition to the six required quality measures (listed in Table A of the proposed rule). CMS states they will incorporate a clinical risk adjustment as soon as feasible to the PQI composite measures. Based on experience in the VM, these measures have been determined to be reliable with a minimum case size of 20. CMS also proposes to include

the all-cause hospital readmission measure from the VM and to limit this measure to groups with 10 or more clinicians and require 200 cases.

c. Resource Use Performance Category

(1) Background

CMS proposes starting with the total per capita costs for all attributed beneficiaries measure (total per capita cost measure) and the existing condition and episode-based measures. All resource use measures would be adjusted for geographic payment rate adjustments and beneficiary risk factors; a specialty adjustment would be applied to the total per capita cost measure. Within this category all measures would be weighted equally and there would be no minimum number of measures required to receive a score.

(2) Weighting in the Composite Performance Score

CMS proposes for payment years 2019 and 2020, the resource use performance category will account for 10 percent and 15 percent, respectively, of the CPS. For the third and future years, 30 percent of the CPS will be based on the resource use performance category.

(3) Resource Use Criteria

Performance in the resource use performance category would be assessed using measures based on administrative Medicare claims data only. MIPS eligible clinicians and groups would be assessed based on resource use only for Medicare patients attributed to them; MIPS eligible clinicians and groups would not be measured on resource use if there are not enough attributed cases to meet or exceed the proposed case minimums.

For the 2017 MIPS performance period, CMS proposes to utilize:

- The total per capita cost measure,
- The MSPB measure, and
- Episode-based measures.

(a) Value Modifier Cost Measures Proposed for the MIPS Resource Use Performance Category

CMS proposes including the total per capita cost measure. CMS is not proposing to include the VM total per capita cost measures for the four condition-specific groups (COPD, CHF, CAD, and DM); CMS is proposing to assess disease specific performance as part of the episode-based measures. CMS proposes to adopt the MSPB measure with two technical changes. For both the total per capital cost measure and the MSPB measure, CMS proposes to use the same methodologies for payment standardization and risk adjustment as are defined in the VM (for more details see 77 FR 69316 – 69318).

(i) Attribution. For the MSPB measure, CMS proposes to use attribution logic that is similar to what is used in the VM. The MSPB is attributed to the TIN that provides the plurality of Medicare Part B claims (as measured by allowable charges) during the index inpatient hospitalization.

The total per capita cost measure uses a two-step attribution methodology that focuses on the delivery of primary care services by both primary care clinicians and specialists. The VM currently defines primary care services as services identified by the following HCPCS codes: 99201 – 99215, 99304 – 99340, 99341 - 99350, G0402 (welcome to Medicare visit), and G0438 and G0439 (annual wellness visits). For MIPS, CMS proposes the following changes:

- Include transitional care management codes (99495 and 99496) and the chronic care management code (99490), and
- Exclude services billed under HCPCS codes 99304 – 99318 when the claim includes the POS 31 modifier (patients in skilled nursing facilities).

(b) Episode-based Measures Proposed for the MIPS Resource Use Performance Category

Instead of using the total per capita cost measures for populations with specific conditions that are used in the VM, CMS proposes episode-based measures for a variety of conditions and procedures that it identifies as high cost, having high variability in resource use, or are for high impact conditions. The episode-based measures include Medicare Part A and Part B payments for services determined to be related to the triggering condition or procedure.

CMS proposes 41 clinical conditions and treatment episode-based measures for the 2017 MIPS performance period: 34 are broad based measures and 7 are more narrowly focused measures (Tables 4 and 5, respectively, in the proposed rule). The broad clinical topics for the episode-based measures include breast cancer, and diseases related to cardiovascular, cerebrovascular, gastrointestinal, genitourinary, infectious, neurologic, musculoskeletal, respiratory and vascular conditions.

Although CMS is proposing 41 measures, because these measures have never been used for payment purposes, CMS states they may choose to only include a subset of these measures in the final rule.

(i) Attribution. CMS proposes to use the attribution logic used in the 2014 sQRUR with modifications to adjust for whether the performance is assessed at an individual or group level. (A full description is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methods-2014SupplementalQRURs.pdf>.)

CMS proposes that acute condition episodes would be attributed to all MIPS eligible clinicians that bill at least 30 percent of inpatient evaluation and management (IP E&M) visits during the initial treatment or “trigger event” that opens the episode. Using this methodology, CMS notes it is possible that more than one MIPS eligible clinician will be attributed to a single episode. If an acute condition episode has no IP E&M claims during the episode, then that episode will not be attributed to any MIPS eligible clinician.

CMS proposes that procedural episodes would be attributed to all MIPS eligible clinicians that bill a Part B claim with a trigger code during the trigger event of the episode.

- For inpatient procedure 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 developed 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 event.
- For outpatient procedural episodes developed using Method B, the trigger event is defined as only the day of the triggering event.

(c) Attribution for Individual and Groups

For MIPS eligible clinicians whose performance is being assessed individually, CMS proposes to attribute the resource use measures using the TIN/NPI rather than just the TIN that is currently used in the VM and sQRUR.

For eligible clinicians that choose to have their performance assessed as a group, CMS proposes to attribute resource use measures at the TIN level (the group TIN under which they report).

(d) Application of Measures to Non-Patient-Facing MIPS Eligible Clinicians.

For the 2017 MIPS performance period, CMS is not proposing any alternative measures for non-patient-facing MIPS eligible clinicians or groups. Similar to eligible clinicians or groups that do not meet the required case minimum for any resource measures, many non-patient-facing eligible clinicians may not have sufficient measures available to report and would not be scored on this category under MIPS.

d. Clinical Practice Improvement Activity (CPIA) Category

CMS proposes baseline requirements for the CPIA category and plans to revise the requirements in future years to have more stringent requirements with a focus on continuous improvement over time.

(1) Contribution to Composite Performance Score

CMS proposes that the CPIA performance will account for 15 percent of the CPS.

MACRA specifies that a MIPS eligible clinician or group that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, for a specific performance period must be given the highest potential score for the CPIA performance category for the performance period. CMS proposes a patient-centered medical home (PCMH) will be recognized if it is a nationally recognized accredited PCMH, a Medicaid Medical Home Model, or a Medical Home Model. The National Committee for Quality Assurance (NCQA) Patient-Centered Specialty Recognition will be recognized, which qualifies as a comparable specialty practice. CMS proposes a PCMH will be nationally recognized if it is accredited by: (1) the Accreditation Association for Ambulatory Health Care; (2) the NCQA PCMH recognition; (3) The Joint Commission Designation; or (4) the Utilization Review Accreditation Commission (URAC). CMS states that the criteria for being a nationally recognized accredited PCMH are that it must be national in scope and must have evidence of being used by a large number of medical organizations as the model for their PCMH.

CMS discusses that practices may receive a PCMH designation at a practice level. Thus, individual TINs may be composed of both undesignated practices and practices that have received a designation as a PCMH. For MIPS eligible clinicians reporting at the group level, reporting is required at the TIN level.

MACRA provides that MIPS eligible clinicians or groups who are participating in an APM for a performance period must earn at least one half of the highest potential score for the CPIA performance category for the performance period.

CMS notes that consistent with the statute, a MIPS eligible clinician or group is not required to perform activities in each CPIA subcategory or participate in an APM to achieve the highest potential score for the CPIA performance category. In addition, if a MIPS eligible clinician or group fails to report on an applicable CPIA that is required to be reported, they will receive the lowest potential score applicable to that CPIA.

(2) CPIA Data Submission Criteria

CMS proposed that data for the CPIA performance category could be submitted using the qualified registry, EHR, QCDR, CMS Web Interface and attestation data submission mechanism (Tables 1 and 2). All MIPS eligible clinicians or groups must select activities from from the CPIA Inventory (Table H of the proposed rule Appendix). If it is technically feasible, CMS will use administrative claims data to supplement the CPIA submission. .

CMS proposes that for the first year only, all MIPS eligible clinicians and groups, or third party entities such as health IT vendors, QCDRs and qualified registries that submit for an eligible clinician or group, must designate a yes/no response for activities on the CPIA Inventory. The MIPS eligible clinicians or groups will certify all CPIAs that have been performed, and the third party entity submits on their behalf.

(a) Weighted Scoring. The statute mandates a differentially weighted scoring model by requiring 100 percent of the potential score in the CPIA performance category for PCMH participants, and a minimum 50 percent score for APM participants. For additional activities, CMS proposes a differentially weighted model for the CPIA category with two categories: medium and high.

(b) Submission Criteria. CMS proposes that the highest potential score of 100 percent is equivalent to a CPIA performance score of 60 points and assigns 10 points for a medium-level activity and 20 points for a high-level activity. To achieve the highest potential score of 100 percent, CMS requires submission of three high-weighted CPIAs (20 points each) or six medium-weighted CPIAs (10 points each), or a combination of CPIAs to achieve a total of 60 points. MIPS eligible clinicians or groups that select less than the designated number of CPIAs to achieve 60 points will receive partial credit based on the weighting of the CPIA selected.

CMS discusses the following exception for MIPS eligible clinicians and groups:

- Eligible clinicians or groups that are small groups (≤ 15 clinicians), located in rural areas or geographic HPSAs, or non-patient-facing MIPS eligible clinicians, are required to

submit two CPIAs (either medium or high) to obtain a score of 100 percent. To obtain a score of 50 percent, only one CPIA (either medium or high) is required.

(c) Required Period of Time for Performing an Activity. CMS proposes that MIPS eligible clinicians or groups must perform CPIAs for at least 90 days during the performance period for CPIA credit.

(3) CPIA Subcategories

MACRA requires that the CPIA performance category must include the following subcategories: Expanded practice access; Population management; Care coordination; Beneficiary engagement; Patient safety and practice assessment; and Participation in an APM.

For the first year of MIPS, in addition to the CPIA subcategories required in the statute, CMS proposes adding Achieving health equity; Integrated behavioral and mental health; and Emergency preparedness and response.

e. Advancing Care Information Performance Category

The meaningful use of certified EHR technology, referred to in this proposed rule as the advancing care information performance category, is one of the four performance categories under the MIPS, which will be reported by MIPS eligible clinicians. This includes MIPS eligible clinicians who were not previously eligible for the EHR Incentive Program incentive payments or subject to the EHR Incentive Program payment adjustment. Specifically, PAs, NPs, CNSs, CRNAs and hospital-based EPs may not have prior experience with certified EHR technology and the objectives and measures under the EHR Incentive Program.

(1) Clinical Quality Measurements (CQMs)

CMS is not proposing separate requirements for clinical quality measure reporting within the advancing care information category. For the quality performance category, CMS proposed requirements for the submission of quality data for specified measures and encouraged reporting of CQMs with data captured in certified EHR technology.

(2) Performance Period Definition

CMS proposes to align the performance period for the advancing care information performance category to the proposed MIP performance period of one full calendar year. Under this proposal, for the first year of MIPS, MIPS eligible clinicians would need to submit data based on a performance period starting January 1, 2017 and ending December 31, 2017. CMS states this proposal would reduce reporting burden and streamline requirements so that all performance categories have a common timeline for data submission.

CMS notes that MIPS eligible clinicians that only have data for a portion of the year can still submit data and be assessed and scored for the advancing care information performance category. Eligible clinicians would be required to submit all the data they have available for the performance period, even if the time period for which they have data is less than one full calendar year.

(3) Advancing Care Information Performance Category Data Submission and Collection

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 as specified by CMS. CMS is proposing to adopt a definition of certified EHR technology for MIPS eligible clinicians that is based on the definition that applies in the EHR Incentive Programs under 42 CFR 495.4.

For 2017, MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria as follows:

- 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 alternative objectives and measures specified for this performance category, which correlate to modified Stage 2 requirements.
- A MIPS eligible clinician who has technology certified to a combination of 2015 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 requirements; or
 2. On the alternative objectives and measures specified for this performance category, which correlate to modified Stage 2 requirements, 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 this performance category that correlate to Stage 3 requirements. These eligible clinicians would be required to report on the alternative objective and measures, which correlate to modified Stage 2 requirements.

Beginning with the 2018 performance period, MIPS eligible clinicians must only use technology certified to the 2015 Edition to meet the objective and measures for this performance category, which correlate to Stage 3.

a. *Method of Data Submission.* CMS proposes to allow the submission of advancing care information performance category data through qualified registry, EHR, QCDR, attestation and CMS Web Interface submission methods. Regardless of data submission method, all MIPS eligible clinicians must follow the reporting requirements for the objectives and measures to meet the requirements of the advancing care information performance category.

b. *Group Reporting.* CMS is proposing a group reporting mechanism for individual MIPS eligible clinicians to have their performance assessed as a group for all performance categories. Therefore, the data submission criteria for the advancing care information performance category would be the same when submitted at the individual and group level, but the data submitted would be aggregated for all MIPS eligible clinicians within the group practice.

(4) Reporting Requirements and Scoring Methodology

CMS proposes that performance in the advancing care information performance category will comprise 25 percent of a MIPS eligible clinician's CPS for payment year 2019 and each year thereafter. CMS is proposing that the score would be comprised of a score for participation and reporting, referred to as the "base score", and a score for performance at varying levels above the base score requirements, referred to as the "performance score".

(a) Base Score. As outlined below, CMS is proposing two variations of a scoring methodology for the base score, a primary and an alternative proposal. For either proposal, the base score would account for 50 percent, out of a total of 100 percent, of the advancing care information performance category score.

(i) Privacy and Security; Protect Patient Health Information. In the 2015 EHR Incentive Program Final Rule (80 FR 62832), CMS finalized the Protect Patient Health Information objective and its associated measure for Stage 3, which requires EPs to protect electronic protected health information (ePHI) created or maintained by the certified EHR technology through the implementation of appropriate technical, administrative, and physical safeguards. CMS proposes that a MIPS eligible clinician must meet this objective and measure in order to earn any score within this category. Failure to do so would result in a base score of zero, a performance score of zero, and an advancing care information performance category score of zero.

(ii) Base Score: Primary Proposal (Table 6 in the proposed rule). Under the primary proposal, 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 adopted in the 2015 EHR Incentive Program. Two objectives, Clinical Decision Support and Computerized Provider Order Entry, and their associated measures would not be required for reporting for the performance category. Reporting would be required for each measure within a subset of the following 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. Successfully submitting a numerator and denominator or yes/no measure for each measure of each objective would earn a base score of 50 percent for the category. Failure to meet the submission criteria (numerator/denominator or yes/no statement as applicable) for any measure in any of the objectives would result in a score of zero for the category.

For the Public Health and Clinical Data Registry Reporting objective, CMS is proposing that an eligible clinician would only need to complete submission on the Immunization registry reporting measure of this objective and that the measure is a yes/no statement. Completing any additional measures under this objective would earn one additional bonus point in the performance category score.

b. Performance Score (Table 9 in the proposed rule). CMS proposes that a MIPS eligible clinician would earn additional points above the base score for performance on eight associated

measures under the Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange objectives. The eight associated measures would each be assigned a total of 10 possible points. Under this proposal, an eligible clinician has the potential to earn a performance score of up to 80 percent. The combination of the performance score with the base score would provide a total score that is more than the total possible 100 percent for the advancing care information performance category.

c. Overall Advancing Care Information Performance Category Score (Table 10 in the proposed rule). CMS proposes to sum the base score, performance score and the potential Public Health and Clinical Data Registry Reporting bonus point to obtain the overall score for this performance category. If the sum of the MIPS eligible clinician's total score is greater than 100 percent, CMS would apply an advancing care information performance category score of 100 percent. The total percentage score (out of 100) would then be applied to the 25 points allocated for the advancing care information performance category and incorporated into the MIPS CPS.

d. Scoring Considerations. The statute provides that in any year in which the Secretary estimates that the proportion of EPs who are meaningful users is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the advancing care information performance category in the CPS. The reduction may not result in a weight for this category of less than 15 percent, and the increase weighting of the other performance categories must equal the total percentage points of the reduction.

(5) Advancing Care Information Performance Category Objectives and Measures Specifications

CMS proposes objectives and measures that have been adapted from the Stage 3 objectives and measures finalized in the 2015 EHR Incentive Programs Final Rule (80 FR 62829 – 62871); this proposal, however, does not maintain the previously established threshold for MIPS. CMS also proposes Modified Stage 2 objectives and measures that have been adapted from the Stage 3 objectives and measures finalized in the 2015 EHR Incentive Programs Final Rule (80 FR 62793 – 62825); this proposal also does not maintain the previously established threshold for MIPS. The reader is referred to the proposed rule for a detailed discussion of the proposed specifications.

CMS believes that the proposed MIPS exclusion criteria and the advancing care information performance category scoring methodology obviates the need for additional exclusion criteria. CMS discusses that the proposed MIPS exclusion for eligible clinicians who do not exceed the low-volume threshold (defined as eligible clinicians with Medicare billing charges less than \$10,000 and fewer than 100 Medicare patients) is sufficient for the advancing care information performance category

(6) Reweighting of the Advancing Care Information Performance Category for MIPS Eligible Clinicians without Sufficient Measures Applicable and Available

CMS proposes that an application must be submitted for reweighting the advance care information performance category by the MIPS eligible clinician or designated group representative. 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 the 2017 performance period, applications must be submitted no later than March 31, 2018 to be considered for the 2019 MIPS payment year. An application would need to be considered annually.

Hospital-Based MIPS Eligible Clinicians. CMS proposes to define a “hospital-based MIPS eligible clinician” as a MIPS eligible clinician who furnishes 90 percent or more of their covered professional services in the sites of care identified in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the performance period, the year that is three years preceding the MIPS payment year. Under this proposal, hospital-based determinations would be made for the 2019 MIPS payment year based on covered professional services furnished in 2016. CMS also proposes that it would determine which MIPS eligible clinicians qualify as “hospital-based” for a MIPS payment year. CMS notes these proposals are consistent with the policies in the EHR Incentive Program.

MIPS Eligible Clinicians Facing a Significant Hardship. CMS proposes to use the significant hardship categories they defined in the Stage 2 Final Rule (77 FR 54097 -54100):

- Insufficient internet connectivity,
- Extreme and uncontrollable circumstances,
- Lack of control over the availability of certified EHR technology, and
- Lack of face-to-face patient interaction.

To demonstrate insufficient internet connectivity and be considered for a reweighting of this performance category, CMS proposes to require MIPS eligible clinicians to demonstrate insufficient internet access through an application process. Eligible clinicians would have to demonstrate they lacked sufficient internet access during the performance period, and that there were insurmountable barriers to obtaining a necessary infrastructure, such as a high cost of extending the internet infrastructure to their facility.

Extreme and uncontrollable circumstances, such as natural disasters in which an EHR or practice buildings are destroyed, can prevent a MIPS eligible clinician to be able to access certified EHR technology. CMS proposes that to be considered for reweighting of this performance category, eligible clinicians would have to submit an application that included information about why the EHR technology is not available and the related duration the technology would be unavailable.

To demonstrate lack of control over the availability of certified EHR technology and be considered for a reweighting of this performance category, CMS proposes that 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. CMS notes that control does not imply final decision-making authority; CMS would generally view eligible clinicians practicing in a large group as having control over the availability of certified EHR technology.

Because many of the measures proposed under the advancing care information performance category require face-to-face interaction with patients, CMS does not believe there would be sufficient measures for non-patient-facing MIPS eligible clinicians. CMS proposes to

automatically reweight this performance category for a MIPS eligible clinician who is classified as a non-patient-facing MIPS eligible clinician.

Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists. CMS proposes to assign a weight of zero to this performance category if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. CMS would assign a weight of zero only in the event that these eligible clinicians do not submit any data for any of the measures specified for this performance category.

Medicaid. CMS discusses the Medicaid EHR Incentive Program for EPs and that this program was not impacted by the MACRA and the requirement to establish the MIPS program. CMS does not propose any changes to the objectives and measures previously established for the Medicaid EHR Incentive Program.

f. APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

CMS proposes to establish a scoring standard for MIPS eligible clinicians participating in certain types of APMs that will reduce participant reporting burden by eliminating the need for such APM eligible clinicians to submit data for both MIPS and their respective APMs. CMS proposes to use the APM scoring standard for MIPs eligible clinicians in APM Entity groups participating in certain APMs that meet the criteria discussed below and are identified as “MIPS APM” on the CMS website.

(1) Criteria for MIPS APM

CMS proposes that the APM scoring standard would only be applicable to certain eligible clinicians participating MIPS APMs which would be defined as APMs that meet the following criteria:

1. APM Entities participate in the APM under an agreement with CMS;
2. The APM Entities include one or more MIPS eligible clinicians on a Participation List; and
3. The APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

Eligible clinicians that have supporting or ancillary roles to the APM Entity's performance but who do not participate under the APM entity (and are therefore not on the Participation List) would not be considered eligible clinicians for the purposes of the APM Entity Group to which the APM scoring standard would apply. CMS also notes that the proposal would not accommodate certain APMs pursuant to statute or regulations rather than under an agreement with CMS.

CMS proposes that the APM scoring standard would not apply to MIPS eligible clinicians participating in APMs that are not MIPS APMs. In addition, based on the proposed policy, the APM scoring standard would not apply to MIPS eligible clinicians involved in APMs that include facilities as participants (such as the Comprehensive Care for Joint Replacement Model) and to APMs that do not base payment on cost/utilization and quality measures (such as the Accountable Health Communities Model).

CMS acknowledges that the proposed APM scoring standards would still require MIPS eligible clinicians to report certain data under MIPS regardless of whether they ultimately become Qualifying APM Participants (QPs) or Partial Qualifying APM Participants (Partial QPs) through their participation in Advanced APMs. Although QPs and Partial QPs who elect not to participate in MIPS would be excluded from MIPS payment adjustments, CMS believes for operational and administrative reasons, it is necessary to treat these eligible clinicians as MIPS eligible clinicians unless and until the QP or Partial QP determination is made.

(2) APM Scoring Standard Performance Period

CMS proposes that the performance period for MIPS eligible clinicians participating in MIPS APMs would generally match the applicable calendar year performance period proposed for MIPS.

(3) How the APM Scoring Standard Differs from the Assessment of Groups and Individual MIPS Eligible Clinicians Under MIPS

CMS states that the proposed APM scoring standard is similar to the proposed group assessment under MIPS except for the following:

- Depending on the terms and conditions of the MIPS APM, an APM Entity could be comprised of a sole MIPS eligible clinician;
- The APM Entity could include more than one unique TIN, as long as the MIPS eligible clinicians are identified as participants in the APM by their unique APM participant identifiers; and
- The composition of the APM Entity group could include APM participant identifiers with TIN/NPI combinations such that some MIPS eligible clinicians in a TIN are APM participants and other MIPS eligible clinicians in the same TIN are not APM participants.

In contrast, assessment as a group under MIPS requires a group to be comprised of at least two MIPS eligible clinicians who have assigned their billing rights to a TIN. In addition all MIPS eligible clinicians in the group use the same TIN.

For the APM scoring standard, CMS proposes to generate a MIPS CPS by aggregating all scores for eligible clinicians in the APM Entity that is participating in the MIPS APM to the level of the APM Entity.

CMS also proposes that depending on the type of MIPS APM, the weights associated with performance categories may be different than the generally applicable weights for MIPS eligible clinicians. As discussed below:

- CMS proposes that under the APM scoring standard, the weight for the resource use performance category will be zero.
- CMS proposes that for certain APMs, the weight for the quality performance category will be zero for the 2019 payment year. Neither the APM Entity or the eligible clinicians would need to report quality performance data.

CMS would redistribute the weights for the quality and resource use performance categories to the CPIA and advancing care information performance categories to maintain a CPS of 100 percent.

(4) APM Participant Identifier and Participant Database

CMS plans to establish and maintain an APM participant database that will include all of the MIPS eligible clinicians who are part of the APM Entity.

CMS proposes that each APM Entity would be identified in the MIPS program by a unique APM Entity identifier, and that the unique APM participant identifier for a MIPS eligible clinician would be a combination of four identifiers, including (1) APM identifier (established by CMS); (2) APM Entity identifier (established by CMS); (3) the eligible clinician's billing TIN; and (4) NPI (discussed in section II.B.2). For purposes of the APM scoring, the ACO would be the APM entity. CMS proposes to use the established criteria for determining the list of eligible clinicians participating under an ACO to determine the list of MIPS eligible clinicians included in an APM Entity group for determining the APM scoring standard. CMS would do this annually.

CMS proposes that only those MIPS eligible clinicians who are listed as participants in the APM Entity in a MIPS APM on December 31 (the last day of the proposed performance period) would be considered part of the APM Entity group for purposes of the APM scoring standard. MIPS eligible clinicians who are not listed as participants at the end of the performance period would need to submit data to MIPS and would have their performance assessed either as individual MIPS eligible clinicians or as a group for all four performance categories.

CMS proposes to calculate one MIPS CPS for each APM Entity group, and that MIPS CPS would apply to all MIPS eligible clinicians in the group. The MIPS payment adjustment would be applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity group.

(5) APM Entity Group Scoring for the MIPS Performance Categories

CMS proposes to calculate one CPS that is applied to the billing TIN/NPI combination of each MIPS eligible clinician in the APM Entity group. The APM Entity group CPS would be used only for the purposes of the APM scoring standard under MIPS for the first MIPS performance period. CMS notes the APM Entity group CPS is not used to evaluate eligible clinicians or the APM Entity for purposes of incentives with the APM, shared savings payments, or other potential payments under the APM.

CMS proposes, for the first MIPS performance period, a specific scoring and reporting approach for MIPS eligible clinicians participating in MIPS APMs, which would include the Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, and other APMS that meet the criteria proposed above for a MIPS APM.

- CMS proposes that APM quality measure data submitted through the CMS Web Interface by ACOs in the MSSP and the Next Generation ACO model would be used to evaluate performance for the MIPS quality performance category. Other measures that are required by the APM would not be included in the MIPS quality performance category.
- CMS proposes that MIPS eligible clinicians participating in MIPS APMs that do not use the CMS Web Interface for submitting APM quality would not submit quality measure data to MIPS for the MIPS quality performance category until the second MIPS performance period (2018).

CMS expects that the APM Entity would continue to submit quality measure data to CMS as required under the APM. For the CPIA and advancing care information performance categories the APM Entity group's eligible clinicians would submit data using a MIPS data submission mechanism (see Table 15 in the proposed rule).

(6) MSSP

Table 12 in the proposed rule (copied below) summarizes CMS' proposals for the APM standard scoring for MIPS eligible clinicians participating in a MSSP ACO.

Table 12: MIPS Data Submission, Performance Category Score and Performance Category Weight for MIPS Eligible Clinicians Participating in the Shared Savings Program – 2017 Performance Period for the 2019 Payment Adjustment

MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Performance Category Weight
Quality	Shared Savings Program ACOs submit quality measures to the CMS Web Interface for their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to determine the quality performance category score at the ACO level.	50%
Resource Use	MIPS eligible clinicians would not be assessed	Not applicable	0%
CPIA	All MIPS eligible clinicians submit according to the MIPS requirements and have their performance assessed as a group through their billing TINs associated with the ACO.	All ACO participant group billing TINs will receive a minimum of one half of the total possible points. Any ACO participant TIN that is determined to be a PCMH or comparable specialty practice will receive the highest possible score. All of the ACO participant TIN scores for MIPS eligible clinicians in the APM Entity group will be aggregated, weighted and averaged to yield one ACO level score.	20%
Advancing Care Information	All MIPS eligible clinicians submit according to the MIPS requirements and have their performance assessed as a group through their billing TINs associated with the ACO.	All of the ACO participant group billing TIN scores will be aggregated, as a weighted score to yield one ACO group score.	30%

(7) Next Generation ACO Model

Table 13 in the proposed rule (copied below) summarizes CMS proposals for the APM scoring standard for MIPS eligible clinicians participating in a Next Generation ACO Model

Table 13: MIPS Data Submission, Performance Category Score and Performance Category Weight for MIPS Eligible Clinicians Participating in the Next Generation ACO Model – 2017 Performance Period for the 2019 Payment Adjustment

MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Performance Category Weight
Quality	ACOs submit to the CMS Web Interface for their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to develop the ACO MIPS quality score.	50%
Resource Use	The ACO and its participating MIPS eligible clinicians would not be assessed	Not applicable	0%
CPIA	All MIPS eligible clinicians in the APM Entity group submit individual level data.	All MIPS eligible clinicians in the APM Entity group will receive a minimum of one half of the total possible points. Any MIPS eligible clinician that participates in a PCMH or comparable specialty practice will receive the highest possible score. All of the MIPS eligible clinician scores will be aggregated and averaged to yield one ACO level score. An ACO eligible clinician that does not report CPIA would contribute a score of zero.	20%
Advancing Care Information	All MIPS eligible clinicians in the APM Entity group submit individual level data.	All of the MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	30%

(8) Other MIPS APMs

Table 14 in the proposed rule (copied below) summarizes CMS proposals for the APM scoring standard for MIPS eligible clinicians participating in other MIPS APMs (not Next Gen or MSSP).

Table 14: APMs Other Than the Shared Savings Program and Next Generation ACO Model – 2017 Performance Period for the 2019 Payment Adjustment

MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Performance Category Weight
Quality	The APM Entity group would not be assessed on quality under MIPS in the first performance period. The APM Entity group would submit quality measures to CMS required by the APM.	Not applicable	0%
Resource Use	The APM Entity group would not be assessed on resource use under MIPS in the first performance period.	Not applicable	0%
CPIA	All MIPS eligible clinicians in the APM Entity group submit individual level data.	All MIPS eligible clinicians in the APM Entity group will receive a minimum of one half of the total possible points. Any eligible clinician in the APM Entity group that participates in a PCMH or comparable specialty practice will receive the highest possible score. All APM Entity group eligible clinician scores will be aggregated and averaged to yield one APM Entity score. Any MIPS eligible clinician in the APM entity group who does not submit data would contribute a score of zero.	25%
Advancing Care Information	All MIPS eligible clinicians in the APM Entity group submit individual level data.	All APM Entity group eligible clinician scores will be aggregated and averaged to yield one APM Entity score level score. Any MIPS eligible clinician in the APM entity group who does not submit data would contribute a score of zero	75%

(9) MIPS APM Performance Feedback

For the first MIPS performance feedback to be published by July 1, 2017, CMS proposes that all MIPS eligible clinicians participating in MIPS APMs would receive the same historical information prepared for all MIPS eligible clinicians except the report would indicate that this information is only for informational purposes. CMS proposes that the performance feedback would consist only of the scores applicable to the APM Entity group for the specific MIPS

performance period. For example, the MIPS eligible clinicians participating in the MSSP and Next Generation ACO Model would receive performance feedback for the quality, CPIA, and advancing care information performance categories for the 2017 performance period; however, since these eligible clinicians would not be assessed for the resource use performance category, they would not receive information about this category.

CMS proposes that the performance feedback would be available to the eligible clinicians at the following levels:

- For the MSSP, the feedback would be available at the group billing TIN level.
- For the Next Generation ACO Model, the feedback would be available at the MIPS APM Entity level.
- For all other MIPS APMs, the feedback would be available at the APM Entity level.

6. MIPS Composite Performance Score Methodology (§414.1380)

a. General approach

MACRA requires that performance standards be published for the measures and activities in each of the four MIPS performance categories. The performance standards are to be established considering historical performance, improvement, and the opportunity for continued improvement. MIPS-eligible clinicians would know the performance standards for a MIPS payment year (defined as the calendar year in which MIPS payment adjustments are applied) in advance of the performance period for that MIPS payment year.

The proposed scoring methodologies would be applied in the same manner regardless for submissions by individuals, the proposed TIN/NPI, or group submissions using the TIN identifier. The scoring standards would apply to MIPS eligible clinicians who participate in APMs that are not MIPS APMs and who therefore report to MIPS as an individual or a group. The scoring standards proposed in this section do not affect the APM scoring standard.

CMS proposes a unified scoring system for the four MIPS performance categories. CMS proposes and seeks comment on the following characteristics for the unified scoring system:

- For the quality and resource use performance categories, all measures would be converted to a 10-point scoring system to permit comparison across measures and different types of MIPS eligible clinicians.
- Measure and activity performance standards would be published, where feasible, before the performance period begins, so that MIPS eligible clinicians can track their performance.
- Unlike the PQRS or the EHR Incentive Program, “all-or-nothing” reporting requirements would generally not be included. However, failure to report on a required measure or activity would result in zero points for that measure or activity.
- The scoring system would ensure sufficient reliability and validity, by only scoring the measures that meet certain standards (such as required case minimum).
- The scoring proposals would provide incentives for MIPS eligible clinicians to invest and focus on certain measures and activities that meet high priority policy goals such as

- improving beneficiary health, improving care coordination through health information exchange, or encouraging APM Entity participation.
- Performance at any level would receive points towards the performance category scores.

With respect to submission mechanisms, CMS proposes that a MIPS eligible clinician may elect to submit information via multiple mechanisms, but must use the same identifier for all performance categories and may only use one submission mechanism for each performance category. For example, an eligible clinician could use one mechanism for submitting quality measures and a different one for CPIA data, but all quality measures must be submitted using the same mechanism. In rare cases where multiple reporting mechanisms are used for a single category CMS says it would score all the options and use the highest performance score for the category.

CMS discusses the requirements for scoring both achievement and improvement. Achievement is how an eligible clinician performs compared to other clinicians for each measure and activity in a performance category. CMS considers improvement to mean how an eligible clinician performs compared with the eligible clinician's own previous performance. Improvement would not be scored in the first year of MIPS implementation, and would begin in the second year if sufficient data are available.

A baseline period would be established for each performance category, and used to calculate performance standards and announce them prior to the performance period. (similar to the hospital value-based purchasing (HVBP) program.) CMS intends that the baseline period for a MIPS payment year be as close as possible in duration to the performance period for that year. Specifically, CMS proposes that the baseline period be two years prior to the performance period for a MIPS payment year. For the 2019 payment year, the proposed baseline period is 2015, which is two years prior to the proposed performance period of 2017. CMS notes that the baseline period would generally be used to set performance standards ("measure benchmarks") for the quality performance category. For new measures performance levels during the performance period would be used. The measure benchmark is the level of performance that the eligible clinician would be assessed on for a measure for a performance period. For the resource use category, as described below, CMS proposes to set benchmarks during the performance period and not the baseline period.

Table 16, reproduced from the proposed rule, describes the performance standards proposed for each of the four MIPS performance categories. Details on these proposed performance standards are described in items b through e of this section of this summary.

TABLE 16: Performance Category Performance Standards

Performance Category	Performance Standard
Quality	Measure benchmarks to assign points, plus bonus points.
Resource Use	Measure benchmarks to assign points.
CPIA	Based on participation in activities that align with the patient-centered medical home. The number of points from reported activities compared against a static highest potential score of 60 points.
Advancing Care Information	Based on participation (base score) and performance (performance score). Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure. Performance score: decile scale for additional achievement on measures above the base score requirements.

b. Scoring the Quality Performance Category

Overview

One to ten points would be assigned to each measure, based on a clinician's performance compared to benchmarks. For each measure, a case minimum would have to be met for a clinician to receive a score. Zero points are awarded if the clinician fails to submit data on a required measure. If data submission is completed, the clinician would either receive a score or the measure would not be counted because the case minimum is not met or for another reason the measure cannot be scored. Points are awarded based on the methodology described below; bonus points are available for reporting high priority measures.

The total domain score would be the sum of all the points assigned for the scored measures plus bonus points (up to a cap) divided by the sum of total possible points. In general, clinicians would be required to submit six measures and would also be scored on up to three population-based measures calculated from administrative claims data. The total possible points for the quality performance category would be 90 points (6 submitted measures x 10 points + 3 population-based measures x 10 points =90). The total possible points would differ, however, for some groups (groups reporting via CMS Web Interface).

Quality Measure Benchmarks

Measure-specific benchmarks would be computed based on performance during the baseline period. Baseline performance data would be divided into deciles (benchmarks), and an eligible clinician's points for a performance period would be assigned based on where it falls among

these baseline period benchmarks. If baseline data are not available for a measure, or if the measure specifications have changed substantially since the baseline period, then the decile-based benchmarks would be determined using performance period data. CMS proposes that separate benchmarks be created for submission mechanisms that do not have comparable measure specifications: EHR, claims, QCDR, and qualified registry.

However, for CMS Web Interface reporting, CMS proposes to use the benchmarks from the Medicare Shared Savings Program (MSSP). For example, for the 2017 MIPS performance year benchmarks for the 2017 MSSP performance year would be used. Using the MSSP benchmarks, the MIPS method of assigning 1 to 10 points to each measure would be used. All scores below the 30th percentile (for which MSSP creates no benchmarks) would be assigned a value of 2 points.

CMS proposes to use the same approach as the VM to calculate benchmarks across all eligible clinicians using the same submission mechanism. That is, the performance rate of each eligible clinician and group submitting data on a measure would be weighted by the number of beneficiaries used to calculate the performance rate. APM Entities would be included in calculating the benchmark but would not be scored using this methodology. In order to calculate a benchmark for a measure, CMS would require that a minimum of 20 MIPS eligible clinicians met the case minimum criteria and data completeness requirements for the measure. This is intended to ensure the robustness of the benchmark calculation.

CMS proposes to exclude from the benchmark calculation data from eligible clinicians who report measures with a performance rate of 0 percent. It is concerned that these are clinicians who are not actively engaging in that measurement activity, possibly submitting these data unintentionally.

Assigning Achievement Points

Once decile benchmarks are calculated using performance from the baseline period or the performance period, CMS proposes to assign from 1 to 10 points for a measure based on which benchmark decile range the MIPS eligible clinician's performance rate on the measure falls between. For example, eligible clinicians in the top decile would receive 10 points for the measure, and MIPS eligible clinicians in the next lower decile would receive points ranging from 9 to 9.9. CMS proposes to assign partial points to prevent performance cliffs for eligible clinicians with measure scores near the decile breaks. Table 17 reproduced below from the proposed rule illustrates for a sample quality measure how decile achievement points would generally be assigned.

TABLE 17: Example of Using Benchmarks for a Single Measure to Assign Points

Decile	Sample Quality Measure Benchmarks	Possible Points
Benchmark Decile 1	0-6.9%	1.0-1.9
Benchmark Decile 2	7.0-15.9%	2.0-2.9
Benchmark Decile 3	16.0-22.9%	3.0-3.9
Benchmark Decile 4	23.0-35.9%	4.0-4.9
Benchmark Decile 5	36.0-40.9%	5.0-5.9
Benchmark Decile 6	41.0-61.9%	6.0-6.9
Benchmark Decile 7	62.0-68.9%	7.0-7.9
Benchmark Decile 8	69.0-78.9%	8.0-8.9
Benchmark Decile 9	79.0-84.9%	9.0-9.9
Benchmark Decile 10	85.0%-100%	10

In the case of a measure for which performance shows little variation and is clustered at the top end, or “topped out,” CMS proposes an alternative scoring approach, which is illustrated in Table 18 reproduced below. Under this approach, CMS proposes to limit the maximum number of points given for the measure based on how “clustered” the scores are. All clinicians within a cluster of the same value would be given the number of points equal to the midpoint of the cluster. In the Table 18 hypothetical example, performance for the top five deciles is clustered at 100 percent. CMS would identify the midpoint of the cluster, which in this example is the top 25 percent or the middle of the eighth decile, and assign all eligible clinicians in this cluster with a score of 8.5 points. CMS does not believe that high performance on a topped out measure conveys the same meaning as high performance on other measures, so the same score should not be awarded.

TABLE 18: Example of Using Benchmarks for Topped Out Measures

Decile	Sample Quality Measure Benchmarks	Possible Points
Benchmark Decile 1	0%-74.9%	1.0-1.9
Benchmark Decile 2	75%-79.9%	2.0-2.9
Benchmark Decile 3	80%-84.9%	3.0-3.9
Benchmark Decile 4	85%-94.9%	4.0-4.9
Benchmark Decile 5	95%-99.9%	5.0-5.9
Benchmark Deciles 6-10	100%	Midpoint value = 8.5 points

In its modeling of the proposed benchmark methodology using 2014 PQRS measures, CMS found that about half the measures proposed under the quality performance category are topped out. While CMS anticipates replacing topped out measures over time it does not believe that removing topped out measures would be appropriate at this time because a large volume of measures would be involved, and removing them may make it difficult for some specialties to have sufficient measures to report.

Case Minimum Requirements

CMS proposes to use the case minimum requirements that are in place for the quality measures used in the 2018 VM: 20 cases for all quality measures, with the exception of the all-cause

hospital readmissions measure, which has a minimum of 200 cases. Eligible clinicians that report measures with fewer than 20 cases would receive recognition for submitting the measure, but it would not be included in the quality performance category score. CMS proposes that the all-cause hospital readmissions measure would only be included in the quality performance scores for groups of ten or more eligible clinicians.

Incentives to Report High Priority Measures

High priority measures are defined as outcome, appropriate use, patient safety efficiency, patient experience and care coordination measures. They are listed in the proposed rule Appendix Tables A-D.

Specifically, two bonus points would be provided for each outcome and patient experience measure and one bonus point for other high priority measures reported in addition to the one that would already be required under the proposed quality performance category criteria.

For groups reporting through the CMS Web Interface, bonus points would be based on the finalized set of measures. Two bonus points would be assigned for each outcome measure (after the first required outcome measure) and for each patient experience measure. One additional bonus point would be assigned for each other high priority measure (patient safety, efficiency, appropriate use, and care coordination). In the final rule, CMS will publish the number of available bonus points the CMS Web Interface measure set would have based on the final list of measures.

Bonus points for high priority measures would be capped at 5 percent of the denominator of the quality performance category score.

Incentives to Use CEHRT

MACRA requires the Secretary to encourage clinicians to report on quality measures through use of CEHRT and QCDRs and to treat an eligible clinician who reports quality performance category measures using CEHRT as satisfying the quality reporting requirement for the performance period.

CMS proposes that one bonus point would be awarded under the quality performance category score, up to a maximum of 5 percent of the denominator of the quality performance category score, if requirements for “end-to-end electronic reporting are met. Specifically, if:

- CEHRT is used by the eligible clinician to record the measure’s demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not limited to the standards included in the proposed CEHRT definition;
- The measure data is exported and transmitted by the eligible clinician electronically to a third party using relevant standards or directly to CMS; and
- The third party intermediary (for example, a QCDR) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data,

and submit the data electronically to CMS in accordance with data submission requirements.

This bonus would be in addition to the high priority bonus; separate bonus caps would apply to each..

The proposed CEHRT bonus would be available under all submission mechanisms except claims submissions (qualified registries, QCDRs, EHR submission mechanisms, and CMS Web Interface), and would also be available for MIPS APMs reporting through the CMS Web Interface.

Calculating the Quality Performance Category Score

A general methodology is proposed for calculating the quality performance category score; a modified version would apply for CMS Web Interface reporters. In general, under the methodology, the sum of the weighted points assigned to measures required by the quality performance category criteria would be added to any bonus points earned. That total would be divided by the weighted sum of total possible points to equal the quality performance category score.

An example of the scoring methodology is presented in Table 19, which is reproduced here. In this example an eligible clinician has submitted individually via registry three process measures, one outcome measure, and one other high priority measure. No cross-cutting measure was submitted, which results in zero points for that measure. One claims measure falls below the case minimum and is therefore left out of the scoring. The readmissions measure does not apply because the clinician is reporting as an individual. Therefore, the maximum number of possible points in this example is 70 points. Based on performance, the clinician has earned 48.2 points. One bonus point is awarded for reporting an additional high priority patient safety measure and three bonus points are awarded for end-to-end electronic reporting. The quality performance category score for this MIPS eligible clinician is $(48.2 \text{ points} + 4 \text{ bonus points} = 52.2) / 70 \text{ total possible points} = 74.6 \text{ percent}$. CMS notes that the quality performance category score would be capped at 100 percent.

TABLE 19: Quality Performance Category Example with High Priority and CEHRT Bonus Points

Measure	Measure Type	Number of Cases	Points Based on Performance	Total Possible Points	Quality Bonus Points For High Priority	Quality Bonus Points for CEHRT
Measure 1	Outcome Measure using CEHRT	20	4.1	10	0 (required)	1
Measure 2	Process using CEHR	21	9.3	10	N/A	1

TABLE 19: Quality Performance Category Example with High Priority and CEHRT Bonus Points

Measure	Measure Type	Number of Cases	Points Based on Performance	Total Possible Points	Quality Bonus Points For High Priority	Quality Bonus Points for CEHRT
Measure 3	Process via CEHRT	22	10	10	N/A	1
Measure 4	Process	50	10	10	N/A	N/A
Measure 5	High Priority-Patient Safety	43	8.5	10	1	N/A
Measure 6 (Missing)	Cross-Cutting	N/A	0	10	N/A	N/A
Acute Composite	Claims	10	Not scored: below required case minimum	N/A	N/A	N/A
Chronic Composit	Claims	20	6.3	10	N/A	N/A
All-Cause Hospital	Claims	N/A to individual	N/A	N/A	N/A	N/A
Total Points			48.2	70	1	3

A second scoring example is provided in proposed rule Table 20 (not reproduced here) to illustrate how the bonus cap would work.

For CMS Web Interface reporters, the scoring would be the same except that instead of scoring the top six measures, all applicable measures would be scored. If the group does not meet the reporting requirements for a measure, it would receive a zero score for that measure. CMS notes that most of the required measures for these groups are high priority measures so they would receive bonus points if all measures are reported as required.

Measuring Improvement

As noted earlier, in the first year of MIPS, no improvement points would be awarded. CMS solicits comments on how to incorporate improvement into the scoring methodology in future years

c. Scoring the Resource Use Performance Category

In general, scoring of measures in the resource use performance category would be similar to scoring of measures in the quality performance category: benchmarks would be calculated as deciles and from 1 to 10 achievement points awarded depending on where the clinician's performance falls within the benchmarks. The measure scores would be averaged and then divided by the total number of potential points to determine the clinician's performance category score.

Resource Measure Benchmarks

Unlike the measures in the quality performance category, for the resource measures CMS proposes to use data from the performance period to calculate the benchmarks rather than using performance from an earlier baseline period due to issues with changes in payment policy and developing an adequate trend factor for historical data. Although ideally benchmarks should be published prior to the start of the performance period, CMS says that it would continue to provide performance feedback to clinicians on their relative performance.

Similar to the quality performance category, a minimum of 20 MIPS eligible clinicians or groups meeting the case minimum would be required to calculate benchmarks for a measure.

Assigning Achievement Points

CMS notes that for the resource used category, lower costs represent better performance, so that in assigning achievement points, eligible clinicians in the top decile would be those with the lowest resource use.

Case Minimum Requirements

A 20 case minimum is proposed for each resource use measure, including the Medicare Spending per Beneficiary measure.

Calculating the Resource Use Performance Category Score

To calculate the resource use performance category score, CMS proposes to average the scores of all the category measures, weighting them equally. If an eligible clinician has a score for only one measure, that score would become the category score. Because these are measures are calculated based on claims and not separate information submitted by a clinician, a zero score is not possible on any of these measures. An eligible clinician would not receive a resource use performance category score if the case minimums are not met for any of the category measures. Performance feedback would be provided on these measures, and CMS says that over time this may include a list of cases attributed to the eligible clinician for each measure.

As with the quality performance category scoring, the resource use category score is calculated as a percentage of the maximum possible points for the eligible clinician or group. Table 22 in the proposed rule (not shown here) provides an example of how the resource use score would be calculated. In that example, the category includes 6 measures but the clinician did not meet the case minimum for two measures. The total possible points would therefore be 4×10 points = 40 points. A performance score of 22.3 in that example would yield a resource use category score of $22.3/40 = 55.8$ percent. No bonus points are proposed for the resource use performance category.

d. Scoring the Clinical Practice Improvement Activities Performance Category

For this category, CMS notes that the statute requires specific scoring rules. In particular, a MIPS eligible clinician who practices in a certified PCMH or comparable specialty practice for a performance period must receive the highest potential score for the CPIA category. Further, eligible clinicians participating in an APM for a performance period must receive a score equal to at least one half of the highest potential score for the category.

Further, CMS notes that because this category has not been in place in prior programs, for the MIPS first year it cannot assess how well a clinician has performance on an activity, only whether the clinician has participated sufficiently to receive credit for the CPIA category. Table H in the Appendices to the proposed rule lists the 94 proposed CPIAs.

Assigning Points to CPIAs

CMS proposes that for scoring purposes CPIAs would be divided into two categories: medium-weighted activities worth 10 points each and high-weighted activities worth 20 points each. Table 23 in the proposed rule (not included here) lists 11 proposed high-weighted activities worth 20 points each. As shown in proposed rule Table H (not included here), the other 83 proposed CPIAs would be considered medium weight activities worth 10 points each. CMS says it assigned the high-weighted activities based on the extent to which they align with activities that support a patient-centered medical home.

CMS proposes to calculate the score for this category by comparing points earned for CPIAs to the highest potential score.

Highest Potential Score

CMS proposes that 60 points be the highest potential score for the CPIA category. Alternative requirements are proposed for certain practices. CMS believes that clinician(s) in a top performing small practice (15 or fewer professionals), a practice in a rural or health professional shortage area, or a non-patient-facing eligible clinician would be able to report on at least two CPIAs. For these clinicians, reporting of one CPIA (medium or high weight) would result in 50 percent of the highest potential score (30 points) and reporting of two CPIAs would result in the maximum score of 60 points.

Calculating the CPIA Category Score

Consistent with scoring for the quality and resource use categories, CMS proposes to calculate the CPIA category score as the sum of points earned on CPIAs divided by the maximum possible 60 points. The score would be capped at 100 percent.

e. Scoring the Advancing Care Information Performance Category

Base score points (maximum score of 50 percent) would be earned by reporting certain measures adopted by the EHR Incentive Programs in the 2015 EHR Incentive Programs Final Rule.

Specifically, for the base score, MIPS eligible clinicians or groups must meet Objective 1: Protect Patient Health Information and its associated measure in 2015 EHR Incentive Programs Final Rule and must report the numerator and denominator, or a yes/no statement as appropriate, for each measure for Electronic Prescribing, Patient Electronic Access to Health Information, Coordination of Care Through Patient Engagement, Health Information Exchange, and Public Health and Clinical Data Registry Reporting—as adopted in the 2015 EHR Incentive Programs Final Rule. Failure to meet any of the objectives would result in a base score of zero and an advancing care information performance category score of zero. CMS notes that for the Public Health and Clinical Data Registry Reporting objective, an eligible clinician or group must only report on the Immunization Registry Reporting measure. Completing additional measures under this objective would earn one additional bonus point.

The performance score (maximum score of 80 percent) would use a decile-based scale like that used in the quality performance and resource use category scoring. Points would reflect performance on the objectives and measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. Eight measures fall under these three objectives; each has a maximum of ten percentage points available.

While the maximum score for advancing care information performance category is 100 percent, the combination of maximum base and performance scores exceeds 100 percent, which CMS says it has taken to provide flexibility toward achieving the maximum score.

f. Calculating the Composite Performance Score

To calculate a CPS, CMS proposes to multiply the score for each of the four performance categories by the weight assigned in the statute to that category. Table 25 reproduced here shows the proposed weights for the MIPS payment years 2019-2021.

TABLE 25: Weights by Performance Category			
Performance Category	2019 MIPS Payment	2020 MIPS Payment Year	2021 MIPS Payment Year and beyond
Quality	50%	45%	30%
Resource Use	10%	15%	30%
CPIA	15%	15%	15%
Advancing Care Information*	25%	25%	25%

*The weight could decrease (not below 15 percent) if the proportion of physicians who are meaningful EHR users 75% or more. Remaining weights would be reallocated to other performance categories.

The statute requires that risk factors be considered in the scoring methodology. CMS proposes that for the MIPS first year, for the quality and resource use performance categories, measure-specific risk adjustment be used for all measures where applicable and the specialty adjustment for the measure of total per capita cost for attributed beneficiaries. CMS will consider for future rulemaking the work ongoing by the Assistant Secretary for Planning and Evaluation regarding risk adjustment of quality measures for socioeconomic status.

Flexibility in Weighting Categories

CMS proposes that in cases where an eligible clinician does not receive a score for a performance category, it would use its authority under §1848(q)(5)(F) to re-distribute the weight for that category among the remaining categories. (This proposed approach for redistribution is detailed in the next item below.) This circumstance would occur when a clinician submits quality measures and none of them meet the case minimums required, or the measures do not have sufficient reporting among eligible clinicians to calculate a benchmark.

Additionally, CMS proposes that if an eligible clinician has fewer than three scored quality measures for a performance period, the weight of the quality performance category would be reduced and redistributed proportionately among the categories for which the clinician is scored.

In these cases where only one or two quality measures are scored for the 2019 payment year, CMS would reduce the weight of the quality category as follows: from 50 percent to 40 percent if only two measures and from 50 percent to 30 percent. The balance of the weights would be redistributed proportionately among the categories for which the clinician is scored.

Redistribution of Category Weights/ CPS if Only One Category Score

Where no performance score can be assigned for a category or where, as proposed for 2019 payment, there are insufficient quality measures, CMS proposes to redistribute the category weights as follows:

- If no score for the resource use or advancing care information categories and there are at least three measures scored in the quality performance category, CMS proposes to reassign the weights from the missing categories to the quality performance category.
- If no score for the resource use or advancing care information categories and there are fewer than three measures scored in the quality performance category, CMS proposes to reassign the weights from the missing categories proportionately to the other categories with a score.
- If a clinician receives a performance score for only one category, it would be assigned a CPS that is equal to the performance threshold, providing for a zero MIPS adjustment factor for the performance year.

7. MIPS Payment Adjustments

The MIPS adjustment factor would be applied to Part B payments as a percentage adjustment for a payment year. Part B amounts otherwise payable would be multiplied by 1 plus the MIPS adjustment percentage.

a. Payment Adjustment Identifier/Assignment of CPS

As discussed earlier, CMS proposes to use the single identifier TIN/NPI for the MIPS payment adjustment, regardless of whether performance is measured as an individual, group identified by TIN, or APM Entity group. CMS proposes to use the CPS that is associated with the TIN/NPI combination in the performance period. For groups submitting data using the TIN identifier, the group CPS would be applied to all the TIN/NPI combinations that bill under that TIN during the performance period. For individual clinicians submitting data using TIN/NPI, the CPS would be the one associated with the TIN/NPI that is used during the performance period. For eligible clinicians in MIPS APMs, the APM Entity group's CPS would be assigned to all the APM Entity Participant Identifiers associated with the APM Entity on December 31 of the performance period. For eligible clinicians that participate in APMs for which the APM scoring standard does not apply, the CPS would be assigned using either the individual or group assignments.

In cases where for a payment period a clinician switches practices or otherwise establishes a new TIN that did not exist during the performance period, CMS proposes to use the NPI's performance for the TIN the NPI was billing under during the performance period. If only one CPS is associated with the NPI for a performance period, that CPS would apply. If the clinician billed under more than one TIN during the performance period, CMS proposes to use a weighted average CPS, based on total allowed charges during the performance period.

In some cases a TIN/NPI may have more than one associated CPS during the performance period. For example, a clinician may have a CPS for an APM Entity and a CPS for a group TIN. CMS proposes that for these cases, the following approach would be used:

- If a MIPS eligible clinician is a participant in MIPS APM, then the APM Entity CPS would be used instead of any other CPS; if more than one APM Entity CPS applies to the same TIN, the highest APM Entity CPS would be applied to the eligible clinician.
- If a MIPS eligible clinician reports as a group and as an individual, a CPS would be calculated for the group and the individual identifier and the highest CPS would be used for the TIN/NPI.

b. MIPS Adjustment Factors/Budget Neutrality

The statute provides that the MIPS adjustment factor be calculated so that eligible clinicians with a CPS at or above the performance threshold receive a zero or positive adjustment factor. The adjustment of 0 percent is assigned for a CPS at the performance threshold and a maximum adjustment factor of the “applicable percent” (4 percent for 2019) is assigned for a CPS of 100 percent; a linear sliding scale determines the adjustment for CPS that falls between these amounts. For eligible clinicians with a CPS below the performance threshold, the MIPS adjustment factor is negative, with the maximum negative adjustment of the applicable percent assigned to a CPS equal to or greater than zero but not greater than one-fourth of the performance threshold. A linear sliding scale between the CPS of zero maximum negative adjustment and the threshold adjustment of zero determines the negative adjustment for a CPS between these amounts. The “applicable percent” amounts are 5 percent for 2020, 7 percent for 2021 and 9 percent for 2022 and later years.

For payment years 2019 through 2024, an additional positive adjustment is provided for exceptional performance, defined as having a CPS that is above the additional performance threshold. For each of those years the statute provides \$500 million to be distributed among clinicians achieving performance above the additional performance threshold. The maximum additional adjustment factor a clinician may receive is 10 percent; this cap may result in less than \$500 million being distributed.

Consistent with statutory requirements, CMS proposes to establish the performance threshold and additional performance threshold for 2019 as follows.

- The threshold would be set so that approximately half of eligible clinicians would be above the threshold and half below it.
- The additional performance threshold for 2019 would equal the 25th percentile of the range of possible CPS above the performance threshold. For example, if the threshold score is 60, the range above the threshold would be 61-100, and the 25th percentile of that range is 70.

The statute requires that MIPS adjustments (excluding additional adjustments) generally be budget neutral so that the increase in aggregate allowed charges resulting from positive MIPS adjustments equals the estimated decrease resulting from the application of negative adjustments.

c. Additional Adjustment Factors/ Incentive Payments

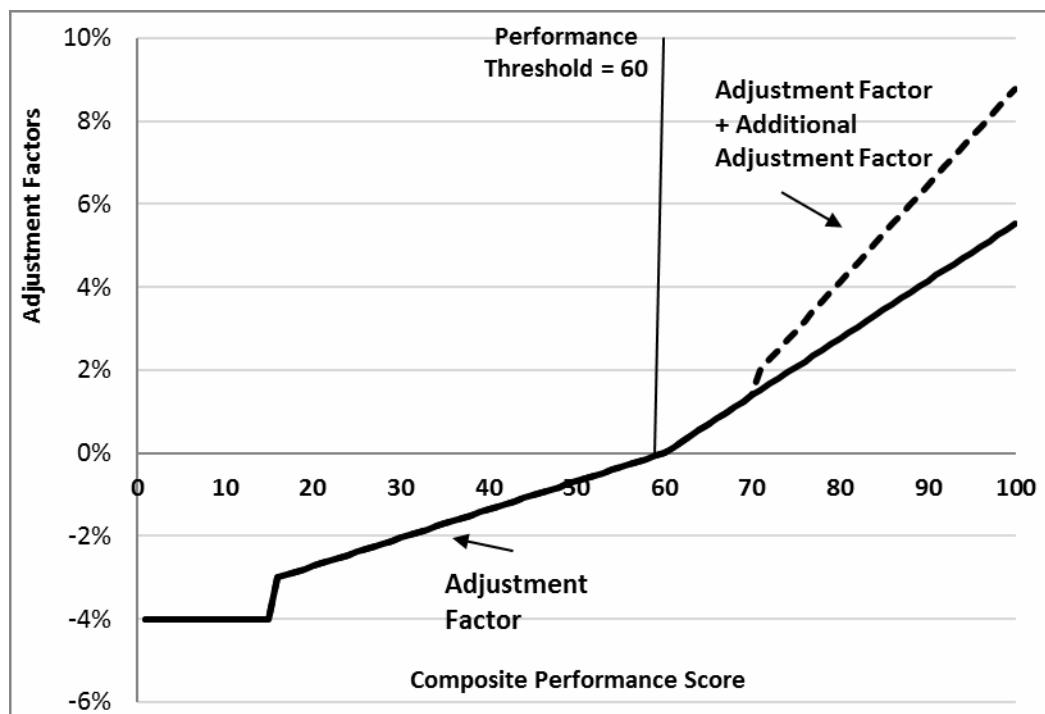
The additional adjustment factor (or “incentive payment”) would be calculated by applying a linear scale factor between 0 and 1.0 from the additional performance threshold and a CPS equal to the maximum score of 100. The incentive payment adjustment would be 0.5 percent at the threshold and 10 percent at the maximum score. A scaling factor would be applied to ensure distribution of the \$500 million in aggregate incentive payments. CMS may lower the 0.5 percent starting point if necessary to meet the constraints of distributing the \$500 million and maintaining a linear scale between 0 and 1.0.

d. Example of MIPS Adjustment Factors

Figure A reproduced from the proposed rule illustrates the MIPS adjustment factors. In the example, the performance threshold is 60, the 2019 applicable percentage is 4 percent. As shown, clinicians with a CPS equal to the threshold of 60 would receive a 0 percent adjustment. The scale for other scores is not completely linear for two reasons. First, all clinicians with a CPS between 0 and 1/4 of the performance threshold (0-15 in the example) must receive the lowest negative adjustment of -4 percent. Second, the linear sliding scale line for the positive adjustment factor is affected by the budget neutrality scaling factor. If the budget neutrality scaling factor is greater than 0 and less than or equal to 1.0, then the adjustment factor for a CPS of 100 would be less than or equal to 4 percent. If the scaling factor is above 1.0, but less than or equal to the specified limit of 3.0, then the adjustment factor for a CPS of 100 would be higher than 4 percent. In this illustration, CMS shows a budget neutrality scaling factor of 1.37 and a maximum adjustment of 5.5 percent (4 percent X 1.37).

In the illustration, the additional performance threshold is 70. A CPS of 70 would receive an additional adjustment factor of 0.5 percent and the factor would increase to 10 percent, with a scaling factor applied to ensure distribution of the \$500 million payments. In this illustrative example that scaling factor is 0.32, so clinicians with a perfect score of 100 would receive an additional adjustment factor of 3.2 percent (10 percent X 0.32). The total combined adjustments for this perfect score would be $1+0.055+0.032 = 1.087$, or 8.7 percent, in this illustrative example.

FIGURE A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)



8. Review and Correction of MIPS Composite Performance Score

CMS proposes processes for performance feedback to eligible clinicians and APM entities, announcement and review of adjustments for a payment year, and data validation and auditing.

a. Performance Feedback

CMS proposes that beginning on July 1, 2017 it would include information on the quality and resource use performance categories in the performance feedback using fields similar to those currently available in the QRURs. (Additional information on the QRURs is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.) Initial MIPS data would not be available until 2018, so in the July 2017 report CMS would provide feedback to eligible clinicians participating in MIPS using historical data as available and applicable. CMS proposes

to provide feedback annually, but as the program evolves it may consider a more frequent basis, such as quarterly.

Beginning July 1, 2018 CMS is required to make available to eligible clinicians information about the Medicare services provided to their patients by other providers. **CMS seeks comment on what type of information would be useful, mechanisms for delivering the information, and arrangements regarding the data, such as sharing among eligible clinicians.**

b. Announcement of MIPS Adjustments

CMS must make the payment adjustment applicable to an eligible clinician available to them no later than 30 days prior to January 1 of the payment year. If technically feasible CMS proposes to include the MIPS adjustment as part of the performance feedback. If this is not technically feasible the information would be made available through another mechanism. The first such announcement must be made by December 1, 2018.

c. Targeted Review of MIPS Adjustments

CMS proposes to adopt a targeted review process under which a clinician may seek review of the MIPS adjustment factors. CMS says that a clinician may seek a targeted review if they believe that there are errors or data quality issues with the measures or activities submitted to CMS and used in the calculations or if they believe CMS made errors in calculating the performance scores.

CMS proposes that the following targeted review process:

- An eligible clinician may request a targeted review within 60 days (or a longer period specified by CMS) after the close of the data submission period. All requests for targeted review must be submitted by July 31 after the close of the data submission period or by a later date specified in guidance.
- CMS will first respond with a decision as to whether a targeted review is warranted.
- No hearing process will be included as this process is informal and the statute does not require a formal appeals process.
- If CMS requests additional information to assist in the review, the supporting information must be received within 10 calendar days of the request. Non-responsiveness to the request for additional information will result in the closure of that targeted review request, although another review request may be submitted if submission deadline has not passed.
- Decisions based on the targeted review will be final, and there will be no further review or appeal.

d. Data Validation and Auditing

CMS proposes to selectively audit eligible clinicians on a yearly basis. An eligible clinician or group selected for audit must:

- Provide all data as requested to CMS (or its contractor) within 10 business days or an alternate time frame that is agreed to by CMS and the clinician.
- Provide substantive, primary source documents as requested.

CMS also proposes to monitor MIPS eligible clinicians and groups on an ongoing basis for data validation, auditing, program integrity issues and instances of non-compliance with MIPS requirements. If an eligible clinician or group is found to have submitted inaccurate data for MIPS, CMS proposes that it would reopen, revise, and recoup any resulting overpayments in accordance with existing rules set forth at §405.980 (re-opening rules), §450.982 and §450.984 (revising rules); and §405.370 and §405.373 (recoupment rules).

9. Third Party Data Submissions

The proposed requirements for third party data submission are set forth at §414.1400. MIPS data may be submitted on behalf of an eligible clinician or group by:

- A qualified registry
- A QCDR
- A health IT vendor that obtains data from the eligible clinician's CEHRT
- A CMS-approved survey vendor (for the CAHPS for MIPS survey)

General requirements for all third-party intermediaries are that all data must be submitted in the form and manner specified by CMS and, if the data are derived from CEHRT, they must be able to indicate the data source.

a. Requirements for QCDRs

The qualification process for becoming a QCDR for MIPS is described. CMS intends to compile and post on its website a list of QCDRs for MIPS. A QCDR is defined as an entity that has self-nominated and successfully completed a qualification process.

CMS notes that although the statute encourages the use of QCDRs for the quality performance category, in order to reduce burden on eligible clinicians, the proposed rule would allow QCDRs to submit data on the CPIA and advancing care information performance categories as well.

For the 2017 performance period, CMS proposes that QCDRs must self-nominate between November 15, 2016 and January 15, 2017. For future performance periods the self-nomination period would be September 1 through November 1 of the prior year. CMS notes that self-nomination is an annual requirement – having qualified as a QCDR in the past does not automatically qualify the entity for future performance periods.

b. Requirements of Health IT Vendors using CEHRT

CMS proposes to maintain use of the Office of National Coordinator certification requirement for EHR-based data submission of quality measures, advancing care information and CPIA data for MIPS. This CEHRT requirement applies to individual clinicians and groups submitting electronically as well as health IT vendors. With respect to the form and manner of submission

requirements for health IT vendors, CMS says that it expects that for the initial years of MIPS the requirements will be similar to those used for the PQRS program. CMS plans to issue subregulatory guidance to identify required CEHRT formats.

However, one important change from the PQRS program is that CMS proposed that clinicians and Health IT Vendors may submit data on the CPIA or advancing care information categories as well as for the quality performance category.

c. Requirements of Qualified Registries

Proposed information required for self-nomination applications and general requirements for qualified registries parallel those described above in item 'a' for QCDRs, except that the QCDR requirements pertaining to non-MIPS measures (submission of specifications, benchmarking capability, etc.) would not apply to qualified registries. In addition, the requirement for providing timely feedback to eligible clinicians is at least 4 times a year instead of the minimum 6 times a year proposed for QDCs.

d. Requirements of CMS-Approved Survey Vendors

Data collected on the CAHPS for MIPS survey measure would be transmitted via a CMS-approved survey vendor, and CMS proposes that vendors would undergo the approval process each year. The same policies and procedures used for survey vendors under PQRS would be continued.

10. Public Reporting on Physician Compare

CMS reviews the requirements regarding public reporting on the Physician Compare website under MACRA and the Affordable Care Act, and in accordance with these requirements proposes the following information be included on Physician Compare.

- For each MIPS eligible clinician, composite scores and performance by category
- Aggregate information on the range of MIPS composite scores and range of performance by category

These data would be added on the profile pages or in the downloadable database, as technically feasible. CMS proposes that statistical testing, consumer testing, and consultation with the Physician Compare Technical Expert Panel would determine how and where the data are reported.

All MIPS quality performance category measures reported for individual clinicians and groups via all submission methods would be available for public reporting on Physician Compare. Consistent with current policy, not all measures would be made available on the consumer-facing website pages. First year measures would not be publicly reported.

With respect to the resource use category, CMS says that it has found that resource use data are not well understood by consumers, and proposes to include on Physician Compare a subset of resource use measures selected using statistical testing and consumer testing.

All CPIA category data would be available for public reporting on Physician Compare. CMS proposes to identify a subset of data that meet public reporting standards. An indicator that a clinician has successfully met CPIA category requirements may be posted. Because CPIA is a new category CMS intends to employ consumer testing as well as statistical testing in identifying data for public reporting.

With respect to the advancing care information category, CMS proposes to expand the information provided on Physician Compare regarding clinicians' performance on measures of meaningful use. Currently, a green check mark on the profile page indicates that an EP has successfully participated in the EHR Incentive Program. To the extent it is feasible, and subject to statistical testing and consumer testing, CMS proposes to include an indicator for any eligible clinician or group that successfully meets the advancing care information performance category.

CMS proposes to continue plans finalized in previous rulemaking to include utilization data in the Physician Compare downloadable data base beginning in late 2016.

With respect to APM data, CMS proposes to indicate on the profile pages when an eligible clinician or group is participating in an APM, and to provide links to APM data for both Advanced and non-eligible APMs. CMS notes that APMs are a new concept for consumers and intends to test language for explaining the concept.

C. Incentive Payments in Advanced APMs

1. Background, Policy Principles and Policy Proposal Overview

MACRA mandates that Qualifying Participants (QPs) who participate in eligible alternative payment models (now termed Advanced APMs or Other Payer Advanced APMs) receive incentive payments. The proposed rule addresses key statutory elements of the incentive payment program and proposes the definitions, requirements, procedures, and thresholds of participation governing the program.

Key statutory elements of the incentive payment program include:

- Beginning in 2019, eligible clinicians who participate in Advanced APMs may become QPs each year by meeting certain thresholds; upon becoming QPs, they are excluded from the MIPS program for any years in which they qualify as QPs.
- For 2019 and 2020, eligible clinicians may become QPs only by participating in Advanced APMs; Medicare is the payer for all Advanced APMs.
- For 2021 and beyond, eligible clinicians may continue to become QPs by participating solely in Advanced APMs (Medicare only), but they also can achieve QP status by participating in a combination of Advanced APMs and APMs with other payers (Other Payer Advanced APMs).

- For 2019 through 2024, while the Medicare annual physician fee schedule (PFS) conversion factor update is zero (0.0%) for QPs and for MIPS clinicians, each QP receives a lump sum incentive payment (5 percent of the QP's prior year Part B covered professional services payments).
- Starting in 2026, the PFS annual update will be set higher for QPs (0.75%) than for eligible clinicians who are not QPs.

CMS outlines its proposed APM policy process as follows:

1. Determine whether an APM meets criteria to be deemed an Advanced APM or an Other Payer Advanced APM.
2. Identify the related Advanced APM Entity or Other Payer Advanced APM Entity (through which payment flows) and the group of eligible clinicians participating in the APM through its related Entity.
3. Determine whether the percentage of Part B covered professional services payments received (or number of patients so served) by group members collectively through the APM meets or exceeds the specified percentage threshold for incentive eligibility for each payment year (Medicare Option threshold or All-Payer Combination Option threshold).¹
4. Designate the group members as QPs and calculate their incentive payments for each payment year.

2. Clarification of Key Terms and Definitions

A lengthy list of APM program definitions is proposed. Some key terms appearing regularly in the proposed rule have been revised from their original MACRA usage or further clarified.

Changes in key terms

Revised or clarified key terms include the following:

- “Eligible” APM is replaced by “Advanced” APM
 - The defining criteria for an APM are unchanged
 - CMS is the payer for all Advanced APMs
- APMs for which CMS is not the payer are termed “Other Payer APMs”
 - CMS may determine that some Other Payer APMs meet criteria to be termed “Other Payer Advanced APMs”
- “APM entity” is defined as any entity participating in an APM
- “Eligible alternative payment model entity” is replaced by “Advanced APM entity”
 - The defining criteria for an alternative payment model entity are unchanged

¹For 2019 and 2020: at least 25% of the eligible clinician group's Medicare Part B fee-for-service (FFS) covered professional services payments; for 2021 and 2022: at least 50% of Medicare Part B FFS covered professional services payments (Medicare Option) or at least 50 percent of all payer payments (with at least 25% of Medicare payments) (All-Payer Option); for 2023 and beyond: at least 75% of Medicare payments (Medicare Option) OR 75% of all payer payments (with at least 25% of Medicare payments) (All-Payer Option).

- “Advanced APM entity” is one participating in an APM determined to be an Advanced APM by CMS
- “Medical homes” are APM entities that are associated with their respective APMs; such APMs are termed “medical home models”
- “Medicaid Medical Home Model” is a type of “Other Payer APM”.

Medical Home Model and Medicaid Home Model

CMS proposes two mandatory elements for a Medical Home Model:

- Participants include primary care practices or multispecialty practices containing primary care practitioners and offering primary care services
- Each patient is assigned to the panel of a primary clinician.

Additionally, a Medical Home Model must have at least four additional elements chosen from the following seven:

- 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, FFS payments (e.g., population-based).

CMS proposes that these mandatory and discretionary elements are consistent with medical home standards and accreditation across the health care market.

CMS further proposes that a Medical Home Model must demonstrate a primary care focus through model design elements related to eligible clinicians using at least one of the following Physician Specialty Codes:

- 01 General Practice
- 08 Family Medicine
- 11 Internal Medicine
- 37 Pediatric Medicine
- 38 Geriatric Medicine
- 50 Nurse Practitioner
- 89 Clinical Nurse Specialist
- 97 Physician Assistant.

Finally, CMS states that the definition of a Medicaid Home Model should include all of the requirements for design elements and practitioner specialty participants of the Medical Home Model plus require that the payment arrangement be operated by a State under title XIX.

3. Advanced APMs

Introduction

Participation in an Advanced APM gives an eligible clinician the chance to become a QP. Given the central importance of this model to the incentive program, CMS discusses it at length. First, an Advanced APM must meet the MACRA criteria to be an APM. As described in section 1833(z)(3)(C) of the Act, an APM is any of the following:

- a CMMI model (other than an innovation award)
- a MSSP
- a demonstration under section 1866C, the Medicare Health Quality Demonstration Program (e.g., Acute Care Episode Demonstration)
- a demonstration required by federal law (e.g., Physician Hospital Collaboration MMA 2003).

To be an Advanced APM, an APM through its payment entity must also meet all three MACRA criteria. The Advanced APM must:

- Require participants to use certified electronic health record technology (CEHRT)
- Provide for payment for covered professional services based on quality measures comparable to those in MIPS
- Require that the participating APM entities bear more than nominal financial risk for monetary losses under the APM or that the APM be a medical home expanded under CMS Innovation Center authority.

An APM Entity holds primary responsibility for healthcare cost and quality provided to beneficiaries as governed by its direct agreement with CMS. All entities participating in Advanced APMs are Advanced APM Entities.

Advanced APM Determination

Prior to the start of each QP Performance Period, CMS plans to identify those APMs that have been determined to be Advanced APMs, posting the list on its website. No later than January 1, 2017 the Advanced APM list applicable to the first QP Performance Period (2017) will be released. Subsequently, CMS will update the list on a rolling basis, including its Advanced APM determination as part of the first public notice of each new APM. The list will be updated at least annually. For an APM with multiple options or tracks, CMS will assess each option or track separately as a potential Advanced APM along with its associated APM Entity.

CMS also proposes to identify Other Payer Advanced APMs beginning in 2019 (applicable for payment year 2021) to align with availability of the All-Payer combination threshold option for QP eligibility determination. The proposed All-Payer determination process relies on information submission by APM entities and clinicians to CMS using formats and deadlines set by CMS (subregulatory guidance).

Advanced APM Criteria

In the proposed rule, CMS expands upon the MACRA criteria for Advanced APMs. Determination that the criteria have been met is based solely upon a potential Advanced APM's design rather than its participant performance assessments or performance results.

(a) Use of CEHRT

An Advanced APM requires that its participants use CEHRT as defined under (§414.3105) and makes payments under arrangements incorporating CEHRT. This definition also resembles that for eligible hospitals, critical access hospitals (CAHs) and eligible professionals in the current EHR Incentive Program, facilitating transitions from “meaningful use” to MIPS and APM requirements.

CMS proposes to define the ways in which CEHRT is used in Advanced APMs. CMS plans to require that at least 50 percent of eligible clinicians enrolled in Medicare (or each hospital if hospitals are the APM participants) utilize CEHRT to document and communicate clinical care with patients and other health care professionals during the first QP Performance Period (2017).² The threshold CEHRT requirement would rise to 75 percent for the second period (2018) for clinicians.

CMS outlines an alternative criterion for the Advanced APM CEHRT requirement to be applied exclusively to the MSSP. Rather than requiring a specific level of CEHRT use, usage is assessed under the quality performance standard rather than independently. Within the MSSP, certain eligible Accountable Care Organization (ACO) clinicians must use CEHRT and their usage is tracked as a quality metric; that metric factors into the overall quality score that then impacts the ACO's shared savings or losses. CMS proposes that the MSSP would now hold APMs accountable for their eligible clinicians' CEHRT through a direct financial penalty or reward based upon the extent of CEHRT use rather than the current indirect impact on savings or losses.

(b) Comparable Quality Measures

MACRA directs that Advanced APMs provide payment for covered services based upon quality measures comparable to those described for use in the MIPS performance category. CMS proposes the following principles for selecting Advanced APM measures to enhance comparability to MIPS measures:

- Measures chosen should have an evidence-based focus
- Measures chosen should harmonize high priority measures with those of MIPS (e.g., clinical outcomes)
- Measures chosen should be those most appropriate to an APM's population, as determined by the APM participants
- Some, but not all, quality measures for which an APM is assessed must be MIPS-comparable

- Some, but not all, quality-based payments made to Advanced APM entities must be contingent upon MIPS-comparable measures
- Payments not tied to quality measures are not required to be MIPS comparable.

Consistent with these principles, CMS proposes that the Advanced APM quality measure set upon which payment will be based must include at least one of the following measure types:

- Any of the measures on the proposed annual list of MIPS quality measures
- Quality measures endorsed by a consensus-based entity (e.g., National Quality Forum)
- Quality measures developed under 1848(s) of the Act
- Quality measures submitted in response to the MIPS Call for Quality Measures
- Any other quality measures determined by CMS to have an evidence-based focus.

(c) Financial Risk for Monetary Losses

Overview

To become an Advanced APM, MACRA mandates that an APM must meet what CMS terms the “financial risk criterion.” Meeting this criterion means that a) the APM is an expanded medical home model (section 1115A(c) of the Act) or b) the APM Entity “bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.” The financial risk criterion is addressed by structuring the design elements of the APM financial risk arrangement (i.e., between CMS and the participating APM Entity) to meet the proposed requirements. Meeting the criterion is not dependent upon actual savings achievement or other APM success metrics. No additional financial risk performance criteria would be applied by CMS for the purpose of meeting the criterion (e.g., risk bearing by eligible clinicians).

CMS proposes distinct Medical Home Model standards for financial risk and nominal loss that apply only to Medical Home Models whose medical home APM entities have 50 or fewer eligible clinician participants in the organization through which the medical home entity is owned and operated. CMS perceives that this threshold is supported by the following:

- The number of clinicians better reflects organizational resources due to variable physician-to-clinician ratios among organizations
- Organizational size better reflects risk-bearing capacity than APM entity size
- Limiting access to the Medical Home Standard will encourage larger organizations to participate in Advanced APMs with higher risk levels
- Larger organizations have demonstrated capacity to accept two-sided risk bearing (i.e., upside and downside risks)
- The differential financial standard will foster growth of high-value primary care delivery systems.

CMS proposes to delay implementing the size limitation for medical home standard eligibility until the second QP performance period (2018).

Bearing Financial Risk for Monetary Losses: Generally Applicable Advanced APM Standard

This standard applies if actual expenditures for which an APM entity is responsible under the APM structure exceed expected expenditures. For an Advanced APM, in such situations CMS can:

- Withhold payment for services to the APM Entity and/or the entity's eligible clinicians
- Reduce payment rates to the APM Entity and/or the entity's eligible clinicians
 - Relevant to multiple methods, including withhold subject to successful performance or discounts in payment rates retrospectively applied at reconciliation (e.g., episode-based bundles)
- Require the APM Entity to owe payment(s) directly to CMS
 - Relevant to two-sided risk arrangements (e.g., shared savings/losses models).

Reductions in bonus payments (e.g., shared savings incentive payments varying with quality performance) would not be allowed. One-sided (i.e., upside only) risk arrangements would not meet the above standard.

Bearing Financial Risk for Monetary Losses: Medical Home Model Standard

This standard applies if actual expenditures for which the APM entity is responsible under the APM structure exceed expected expenditures or if APM Entity performance on specified measures does not meet or exceed expected performance on such measures. For a Medical Home Model to be an Advanced APM, in either of these situations CMS can:

- Withhold payment for services to the APM Entity and/or the entity's eligible clinicians
- Reduce payment rates to the APM Entity and/or the entity's eligible clinicians
- Require the APM Entity to owe payment(s) directly to CMS
- Lose the right to all or part of an otherwise guaranteed payment or payments.

This standard differs from the Generally Applicable Advanced APM Standard primarily through the last provision above, which allows for reductions of “bonus-type” payments.

(d) Nominal Amount of Risk

Overview

Once an APM risk arrangement is found to meet the applicable proposed standard, CMS next considers whether the amount of the risk exceeds a nominal amount, in which case the Advanced APM financial risk criterion is met. There are different standards for Advanced APMs and qualifying Medical Home Models

Advanced APM Nominal Amount Standard

To set the generally applicable Advanced APM nominal amount standard, CMS looked for amounts that would be meaningful but not excessive to APM entities. CMS identified three dimensions of risk to incorporate into the proposed generally applicable nominal amount standard:

- Marginal risk: the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity is liable under its APM
- Minimum loss rate (MLR): a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk
- Total potential risk: the maximum potential payment for which an APM Entity could be liable under the APM structure.

Based upon the dimensions of risk, an APM can meet the generally applicable Advanced APM nominal amount standard when all of the following conditions are met:

- The specific level of marginal risk must be at least 30 percent of losses in excess of expected expenditures
- The minimum loss rate must be no greater than 4 percent of expected expenditures
- Total potential risk must be at least 4 percent of expected expenditures.

Expected expenditures are defined to be the level of expenditures reflected in the target price for episode payment models and in the APM benchmark for other models. Marginal risk is calculated as a percentage by which actual expenditures exceeded expected expenditures.³

Tables 28, 29, and 30 and Figures C and D of the proposed rule (included below) illustrate and provide examples of the application of the nominal amount standard.

TABLE 28: Amounts of Risk Sufficient to Meet the Nominal Amount Standard

Marginal Risk	Maximum Potential Risk Must be equal to or greater than the following values:
<30%	N/A
30-100% of spending in excess of expected expenditures	4% of expected expenditures

TABLE 29: Examples of Shared Savings Risk Arrangements

	Benchmark	Actual	Marginal Risk (sharing rate)	Stop Loss (maximum amount at risk)	Amount owed	Is Financial Risk Criterion Met?
Example 1	\$1,000,000	\$1,100,000	50%	15%	\$50,000	Yes
Example 2	\$1,000,000	\$1,100,000	60%	10%	\$60,000	Yes
Example 3	\$1,000,000	\$1,100,000	40%	3%	\$30,000	No
Example 4	\$1,000,000	\$1,100,000	100%	5%	\$50,000	Yes
Example 5	\$1,000,000	\$1,100,000	25%	10%	\$25,000	No

³ CMS allows for an exception to the 30 percent marginal risk level when actual expenditures exceed expected by enough to trigger a payment greater than or equal to the total risk amount required under the nominal risk standards. With this exception, the standard cannot require APMs to incorporate total risk greater than the amount required by the total risk portion of the standard.

TABLE 30: Examples of Risk in Non-Shared Savings Arrangements in 2017

	Risk Arrangement	Performance Standard	Maximum Potential Loss	Is Criterion Met?
Example 1	Percent of FFS payments withheld and paid in lump sum if performance standard is met.	Quality measures	6% withheld	No
Example 2	Percent discount of FFS payments in subsequent year if performance standard is not met.	Expenditures more than 2 percent above expected expenditures	5% reduction	Yes
Example 3	Percent discount of FFS payments with lump sum payment of the difference to APM Entity.	None	10% reduction in FFS payments paid as a lump sum	No

Medical Home Model Nominal Amount Standard

Consistent with its approach to the Medical Home Model financial risk standard, CMS establishes a separate nominal amount standard for Medical Home Models. CMS elects to use Part A and Part B expenditures for medical home nominal amount assessments and to gradually increase the level of risk over time that must be accepted by a Medical Home Model to be judged an Advanced APM. The total annual amounts that an Advanced APM Medical Home Model Entity can potentially owe to CMS or can forego special payments to offset are shown below.

Proposed Medical Home Model Nominal Risk Standard Total Risk Amounts	
Performance (Calendar) Year	Amount (% of the APM Entity's total Parts A and B revenue)
2017	2.5%
2018	3.0%
2019	4.0%
2020 and beyond	5.0%

(e) Capitation

CMS proposes that full capitation risk arrangements would automatically meet the Advanced APM financial risk criterion relative to both risk-bearing and nominal risk amount.⁴ CMS outlines the elements of a capitation risk arrangement to be all of the following:

- A per capita or otherwise predetermined payment is made to an APM Entity
- The payment covers all items and services furnished to a population of beneficiaries

⁴ Medicare Advantage and other private plans paid to act as insurers on behalf of the Medicare program are not Advanced APMs.

- No settlement is performed to reconcile or to share losses incurred or savings earned by the APM Entity.

(f) Medical Home Expanded Under Section 1115A(c) of the Act

As described previously, an APM Entity seeking to become an Advanced APM entity must either satisfy MACRA's financial risk criterion or must be deemed to be a medical home expanded under section 1115A(c) of the Act. To become an expanded medical home, a Medical Home Model as defined in this proposed rule must be tested under section 1115A(b) of the Act and test results must confirm all of the following:

- Expansion is expected to reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending, as determined by the Secretary of Health and Human Services (Secretary of HHS)
- Expansion would reduce (or would not increase) net program spending under the applicable titles
- Expansion would not deny or limit coverage or benefits under the relevant title for the applicable population, as determined by the Secretary of HHS.

The expansion must occur under 1115A(c) to meet the expanded Medical Home criterion. Satisfying the criteria outside of the context of 1115A(c) does not confer Advanced APM status.

(g) Application of Criteria to Current and Recently Announced APMs

No CMS Medical Home APMs have been expanded as yet under section 1115A(c) of the Act. CMS has reviewed its sponsored APM portfolio and identified those anticipated to become Advanced APMs for the first QP performance period that begins in January 2017. Table 32 of the proposed rule presents the results of the CMS APM review and identifies the current APMs that CMS anticipates would be Advanced APMs for the first QP Performance Period. The following six APMs of the twenty-four reviewed by CMS met all of the criteria to be Advanced APMs.

- Comprehensive End Stage Renal Disease Care (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- MSSP Track 2
- MSSP Track 3
- Next Generation ACO Model
- Oncology Care Model (OCM) two-sided risk arrangement.⁵

Several notable APMs did not meet all of the proposed Advanced Payment APM criteria including the Comprehensive Care for Joint Replacement (CJR) model, the Bundled Payment for Care Improvement Models, and Track 1 participants in the MSSP.

⁵ All of these models are also MIPS APMs.

4. Qualifying APM Participant (QP) and Partial QP Determination

a. Overview

MACRA defines a MIPS-eligible professional for 2019-2021 as a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or a group containing such professionals.⁶ In 2021 and beyond, the Secretary of HHS may expand and revise this list. In the proposed rule, MIPS-eligible professional is replaced by MIPS-eligible clinician or simply eligible clinician. An eligible clinician may become a Qualified Professional (QP) or a Partial QP by participating in an Advanced APM in which the eligible clinicians as a group meet specific payment or patient thresholds. During each QP Performance Period (corresponds to a calendar year), CMS would determine if an eligible clinician met one of the thresholds to become a QP or Partial QP; each year's QP status determination is made independently, without regard to prior years. QP/Partial QP status determinations would be made collectively for all eligible clinicians participating in each Advanced APM Entity. If the collective calculations demonstrate that a group meets the QP or Partial QP Payment Amount Threshold or QP or Partial QP Patient Count Threshold, all of the group's eligible clinicians would achieve QP or Partial QP status, respectively.

The QP and Partial QP determination payment thresholds change over time:

- QP for 2019 and 2020: at least 25 percent of the eligible clinician group's Medicare Part B fee-for-service (FFS) covered professional services payments (Medicare Option)
 - The Partial QP threshold is 20 percent.
- QP for 2021 and 2022: at least 50 percent of Medicare Part B FFS covered professional services payments (Medicare Option) or at least 50 percent of All-Payer payments (with at least 25 percent of Medicare payments) (All-Payer Option)
 - The Partial QP Medicare Option threshold is 40 percent
 - The Partial QP All-Payer Option thresholds are 40 percent total, with at least 20 percent Medicare.
- QP for 2023 and beyond: at least 75 percent of Medicare payments (Medicare Option) or 75 percent of All-Payer payments (with at least 25 percent of Medicare payments) (All-Payer Option)
 - The Partial QP Medicare Option threshold is 50 percent
 - The Partial QP All-Payer Option thresholds are 50 percent total, with at least 20 percent Medicare.

CMS will also make QP and Partial QP determinations each year using patient counts. Preliminary analysis by CMS shows that the proposed QP/Partial QP payment and patient count thresholds yield results that are very similar.

Like the payment thresholds, the patient count thresholds change over time:

⁶ Excluded are physicians newly enrolled in Medicare (for their first year) and physicians meeting specific low Medicare volume thresholds, eligible clinicians who are APM participants, and partial QPs who choose not to report under MIPS.

- QP for 2019 and 2020: at least 20 percent of the eligible clinician group's attributable beneficiaries (Medicare Option)
 - The Partial QP threshold is 10 percent (Medicare Option)
- QP for 2021 and 2022: at least 35 percent of the eligible clinician's group's attributable beneficiaries (Medicare Option) or at least 35 percent of All-Payer attributable beneficiaries (with at least 20 percent of Medicare attributable beneficiaries) (All-Payer Option)
 - The Partial QP Medicare Option threshold is 25 percent
 - The Partial QP All-Payer Option thresholds are 25 percent total with at least 10 percent Medicare.
- QP for 2023 and beyond: at least 50 percent of the eligible clinician's group's attributable beneficiaries or 50 percent of All-Payer attributable beneficiaries (with at least 20 percent of Medicare) (All-Payer Option)
 - The Partial QP Medicare Option threshold is 35 percent
 - The Partial QP All-Payer Option thresholds are 35 percent total with at least 10 percent Medicare.

CMS will conduct sequential calculations to make QP/Partial QP determinations, first using the Medicare options (payments and counts) then the All-Payer combination option. CMS will make the final QP/Partial QP determination using the results of whichever method is more favorable to the eligible clinician.

The benefit of Partial QP status for an eligible clinician is the option to choose whether or not to report MIPS data and thereby be subject to a MIPS-related payment adjustment.

b. QP Performance Period

QP/Partial QP status determinations are made after each QP performance period. CMS proposes to align the QP and MIPS performance periods, reducing operational complexity. Thus the QP performance period is the full calendar year linked to the MIPS performance period (e.g., 2017 would be the QP performance period for the 2019 payment year).

c. Group QP Determination and Lists

In keeping with the group efforts expected of APM eligible clinician participants and the related group rewards, CMS proposes to assess QP and Partial QP status collectively for all eligible clinicians participating in each Advanced APM Entity. QP determination calculations would be aggregated using data for all eligible clinicians participating in an Advanced APM Entity during the QP Performance Period.

Groups Used for QP Determination

Members of eligible clinician groups would consist of all eligible clinicians identified as participants in an Advanced APM Entity during the performance period using Participation Lists provided by the entity to CMS, except when APM participants are not eligible clinicians (e.g., the participants are hospitals only). CMS proposes to define an APM “Participant” as an entity

participating in an APM under an agreement with CMS or statute or regulation; the participant may include eligible clinicians or be an eligible clinician directly tied to beneficiary attribution, quality measurement or cost tracking under the APM. CMS proposes that the participant list for each Advanced APM Entity would be drawn from CMS-maintained lists that will identify each eligible clinician by a unique TIN/NPI combination attached to the Advanced APM Entity identifier. To be part of a group's QP determination, a clinician must be officially identified using an Advanced APM Entity's participation list. When no Participation List is available, a list of affiliated practitioners who have contractual relationships with the Advanced APM Entity will be used.

Timing of Group Identification

CMS proposes that identification of eligible clinicians for each Advanced APM Entity be a single point in time assessment. CMS proposes December 31st of each QP performance period as the best single opportunity to comprehensively assess active participation by eligible clinicians in their Advanced APMs.

CMS proposes a single exception to collective group-level QP determinations. This exception would accommodate the eligible clinician who participates in multiple Advanced APMs. First, if any of the Advanced APMs in which the clinician participates achieves QP status, that clinician would also achieve QP status. If none of the entities in which the physician participates meets QP thresholds, CMS proposes to evaluate the eligible clinician individually using the physician's aggregated data from all sites.

d. Partial QP Election to Report to MIPS

CMS proposes to require that each Advanced APM Entity make an election annually on behalf of all of its identified eligible clinicians on whether to report to MIPS should the clinician group be determined to be Partial QPs for a given year. The election could be changed during the QP performance period but would be finalized at the end of the period. CMS relatedly notes that MSSP eligible clinical group members at the TIN level are all MSSP participants. CMS therefore proposes an alternative option for MSSP APM Entities wherein each individual billing TIN in the entity would make the Partial QP election on behalf of the group members rather than passing that decision to the APM entity (ACO) level.

CMS notes that when an APM Entity elects not to report under MIPS, this decision signals CMS not to score the MIPS-related information submitted by the entity. Because certain APM clinicians are subject to unique MIPS scoring policies, CMS proposes that clinicians and entities of those APMs would continue to report their data to their APMs and the APMs would decide whether the data would be forwarded to CMS. CMS further advocates for prospective decision-making about MIPS reporting by Advanced APM entities on behalf of their Partial QPs, since various CMS processes and timelines (e.g., claims adjustment) preclude delivery of notification of clinicians about their Partial QP status until after the proposed timeline for the MIPS reporting period will have ended.

e. *Notification of QP Determination*

CMS wishes to notify Advanced APM Entities and their member clinicians about their QP/Partial QP status determinations as soon as determinations have been made and validated. Necessary CMS processes (e.g., claims adjustments) will make QP status notification impossible before summer of the subsequent year. For prompt information transfer about QP status, CMS proposes to notify the APM entity and the clinicians directly plus post a notice on the CMS website. For MSSP ACOs, notifications would be sent to each billing TIN in the ACO.

5. Qualifying APM Participant Determination: Medicare Option

a. Medicare Option: Background and Definitions

CMS notes that only Medicare Part B FFS covered professional services will count in calculations of payment and patient count-based thresholds. Calculations will utilize claims data for payment-based calculations and use attributed patient counts for patient count-based thresholds.

CMS defines an “attributed beneficiary” as one attributed to the Advanced APM Entity on the latest available list of such beneficiaries during the QP performance period, with attribution following that entity’s specific attribution rules. In episode payment models, attribution is defined by beneficiaries when they trigger the care episode under the model.

Because of the variation in attribution methodologies across APMs, QP patient count threshold determinations could be affected by the impacts of various attribution logics. In markets with multiple Advanced APMs, it could become difficult for many highly engaged APM entities to reach the 50th or 75th percent patient count threshold.

In response to this concern, CMS has crafted a proposed definition of “attribution-eligible beneficiary” to add more consistency across APMs and their populations when determining QP status. CMS proposes that an attribution-eligible beneficiary would be one who:

- Is not enrolled in Medicare Advantage or a Medicare cost plan
- Does not have Medicare as a secondary payer
- Is enrolled in both Parts A and B
- Is at least 18 years of age
- Is a United States resident
- Has at least one evaluation and management service claim for one or more eligible clinicians within an APM Entity at some point within the QP performance period.

An attribution-eligible beneficiary may or may not be an attributed beneficiary, while attributed beneficiaries comprise a subset of attribution-eligible beneficiaries. Use of the attribution-eligible construct helps ensure that the denominator of QP determination calculations only include payments for services furnished to patients who could potentially be attributed to a given Advanced APM Entity of the Advanced APM and thereby also appear in the numerator.

b. *Medicare Option: Attribution*

CMS proposes to use the Advanced APM attribution lists created by each Advanced APM for making QP determinations as its source for attributed beneficiaries. The latest available list at the end of the performance period would be used. Beneficiaries triggering episodes would be deemed attributed beneficiaries.

c. *Medicare Option: Payment Amount Method*

Source data for this QP threshold calculation come from Medicare Part B FFS covered professional services claims. Any and all available Part B claims from a given QP reporting period will be used. Identical claims data processing approaches (e.g., for claims run-out and claims adjustment) will be utilized for calculating the threshold score and for determining the incentive payment amount.

The payment method calculation numerator would be the aggregate of all payments for Medicare Part B covered professional services provided by an Advanced APM Entity's eligible clinicians to attributed beneficiaries during the performance period. For episode payment models, the payments in the numerator would be those for services furnished to an attributed beneficiary by eligible clinicians during the episode.

The payment method calculation denominator would be the aggregate of all payments for Medicare Part B covered professional services provided by an Advanced APM Entity's eligible clinicians to attribution-eligible beneficiaries during the performance period. For QP determinations made at the eligible clinician level, the denominator would be the total of all payments for Medicare Part B covered professional services provided to attribution-eligible beneficiaries by the eligible clinician. When determinations are made for episode payment models, payments used in the denominator would be those for Medicare Part B covered professional services provided eligible clinicians. In this case the denominator would include all such services to all attribution-eligible beneficiaries whether or not such services occurred during the episode under the Advanced APM. This denominator definition aligns with the way in which current APMs perform attribution. Including payment for services furnished only to attribution-eligible beneficiaries would standardize the denominator, ensuring fairness across eligible clinician types and across geographic regions.

d. *Medicare Option: Patient Count Method*

Under the Medicare incentive payment threshold option, QP status determination can be made using the Patient Count Method, rather than the Payment Method. Like the payment method, source data for this QP threshold calculation come from Medicare Part B FFS covered professional services claims. Like the payment method, any and all available Part B claims from the relevant QP reporting period will be used. The patient-count method calculation numerator would be the number of unique attributable beneficiaries to whom eligible clinicians in an Advanced APM Entity furnish Medicare Part B covered professional services during the relevant QP performance period. For episode payment models, the numerator would include the number

of attributed beneficiaries furnished Medicare Part B covered professional services by eligible clinicians in the Advanced Payment APM Entity during the episode under the Advanced APM.

CMS proposes that the patient-count method denominator would be the number of attribution-eligible beneficiaries to whom an Advanced APM Entity furnishes covered professional services during the relevant AP performance period. For episode payment models, the denominator would include the number of attribution-eligible beneficiaries furnished Medicare Part B covered professional services by eligible clinicians in the Advanced Payment APM Entity group, whether or not those services occurred during the episode under the Advanced APM.

Under the Patient Count Method, CMS may generally count a given beneficiary in the numerator and the denominator for multiple distinct Advanced APM Entities. Conversely, a beneficiary could not be counted more than once in the circumstance when QP status is determined by aggregation of all claims payments for an eligible single clinician who participates in multiple Advanced APMs but who does not achieve QP status in any single Advanced APM. In this special circumstance, the attributed beneficiary would be counted only once in the numerator while the denominator would encompass all unique attribution-eligible beneficiaries for whom claims were paid to the single clinician. CMS proposes that for each distinct Advanced APM Entity, each unique beneficiary will not be counted more than once in the numerator and once in the denominator.

CMS further proposes to base beneficiary counts on any beneficiary for whom eligible clinicians from an Advanced APM Entity receive payments for Part B services, even when an Advanced APM bases its attribution and/or financial risk on both Parts A and B.

Participating in Multiple Advanced APMs

CMS proposes to add the number of unique beneficiaries in the numerator of an episode payment model Advanced APM Entity to the numerator(s) for non-episode payment models when the same Advanced APM Entity participates in multiple Advanced APMs of which at least one is an episode payment model. When applying this provision, CMS considers APMs to be the same if CMS determines that the eligible clinician participant lists are the same or substantially similar.

Services Furnished Through CAHs, RHCs and FQHCs

Medicare proposes to count professional services billed by Critical Access Hospitals (CAHs) under the CAH Optional Payment Method (Method II)⁷ to count towards QP determination threshold calculation for both the Medicare payment and patient count methods. Under Method II CAH billing, the CAH bills Medicare for both facility services and professional services furnished to its outpatients by a physician or practitioner who has reassigned his/her billing rights to the CAH. Since Method II payments are linked directly to Medicare's Physician Fee Schedule, CMS considers them "covered professional services."

CMS also proposes to count towards the QP determination calculations professional services furnished at Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) that

⁷ Section 1834(g)(2) of the Act.

participate in ACOs and are reimbursed under the RHC AIR⁸ or FQHC PPS⁹ respectively. For the RHC/FQHC provision, CMS proposes to allow QP determination only through the patient-count method since services furnished at these sites do not qualify as “covered professional services.”¹⁰

6. Combination All-Payer and Medicare Payment Threshold Option

a. Overview

There are two avenues for eligible clinicians to become QPs—the Medicare Option and the All-Payer Combination Option. An eligible clinician need only meet the threshold under one of them to be a QP for the payment year.

Table 38 in the proposed rule and reproduced below demonstrates the QP threshold amounts that must be met in a given year for a clinician to qualify as a QP under the All-Payer Combination Option using the payment amount method. For example, in 2021 an eligible clinician must meet at least the 50% QP payment amount threshold – 50% or more of its payments must be from qualifying Advanced (Medicare) APMs or Other Payer Advanced APMs (non-Medicare) with at least 25% coming from Medicare sources. The 25% minimum QP payment amount threshold from Medicare Advanced APMs is constant from 2021 and beyond, whereas the total payment amount threshold increases to 75% in 2023 and beyond.

TABLE 38: QP Payment Amount Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method									
Payment Year	2019	2020	2021		2022		2023		2024 and later
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%
			Total		Total		Total		Medicare
			Medicare		Medicare		Medicare		Total

⁸ The Rural Health Clinic All Inclusive Rate is based upon reasonable costs up to a maximum payment per visit established by the Congress and updated annually based upon the percentage change in the Medicare economic Index and subject to annual payment reconciliation (section 1833(f) of the Act). Laboratory tests and technical components of RHC services are paid separately.

⁹ FQHCs are paid according to their own Prospective Payment System set out under Section 1834(o) of the Act. Medicare pays a national encounter based rate per beneficiary per day; some adjustments are made for where and by whom services are furnished.

¹⁰ Section 1848(k)(3)(A) of the Act.

Table 39 in the proposed rule and reproduced below demonstrates the threshold amounts that must be met in a given year to qualify as a QP under the Patient Count Method. For example, in 2021 an eligible clinician must meet at least the 35% QP patient count threshold – 35% or more of its patients must be from qualifying Advanced (Medicare) APMs or Other Payer Advanced APMs (non-Medicare) with at least 20% of these patients coming from Medicare sources.

TABLE 39: QP Patient Count Thresholds – All-Payer Combination Option

Payment Year	All-Payer Combination Option – Patient Count Method									
	2019	2020	2021		2022		2023		2024 and later	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	35%	50%	35%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	25%	35%	25%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

The QP determination process is shown in Figures J (2021-2022) and K (2023 and later). Figure J is reproduced below and shows the decision process which CMS would use to determine whether an eligible clinician would meet the payment amount threshold requirements.

FIGURE J: QP Determination Tree, Payment Years 2021-2022

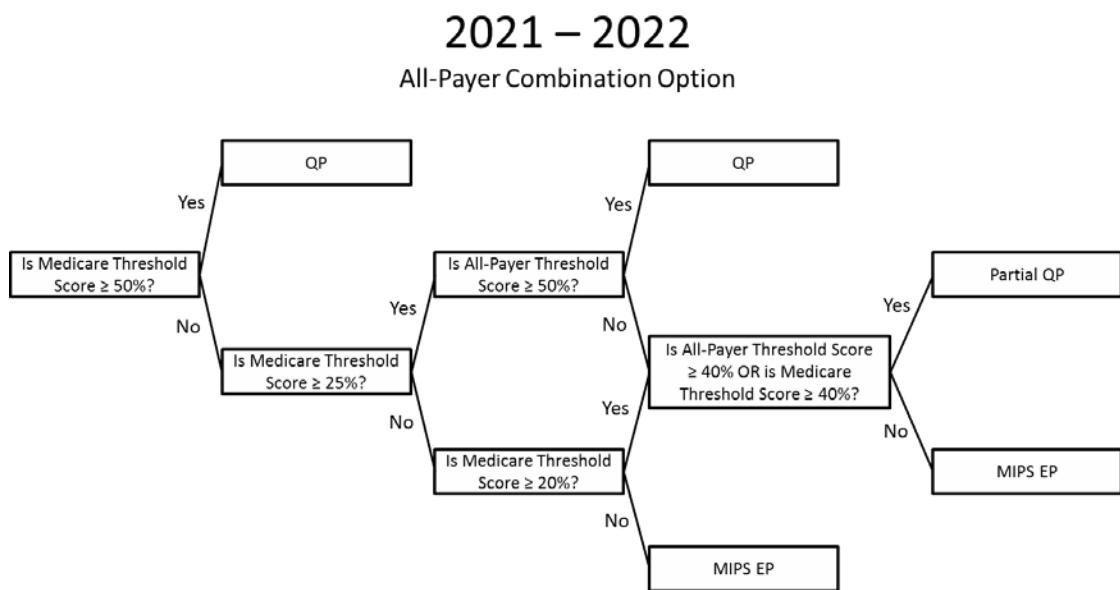
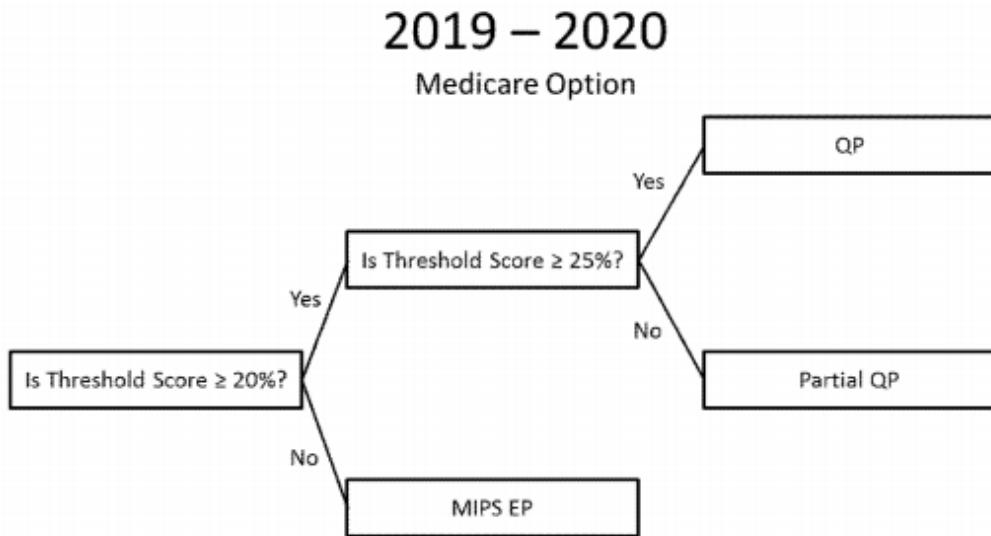


FIGURE E: QP Determination Tree, Payment Years 2019-2020



In summary, CMS notes that eligible clinicians may become QPs if the following steps occur: (1) the eligible clinician submits to CMS sufficient information on all relevant payment arrangements with other payers; (2) CMS determines that an Other Payer APM is an Other Payer Advanced APM; (3) the eligible clinician meets the relevant QP thresholds by having sufficient payments or patients attributed to a combination of participation in Advanced APMs and Other Payer Advanced APMs. These steps are discussed in more detail below.

1. Overview

CMS notes, in general that a payment arrangement with a non-Medicare payer (Other Payer APM) can become an Other Payer Advanced APM if the arrangement meets three criteria:

- Certified Electronic Health Record technology (CEHRT) is used;
- Quality measures comparable to measures under the MIPS quality performance category apply; and
- The APM Entity either: (1) bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or (2) for beneficiaries under title XIX, is a medical home in a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

Other Payer APMs include payment arrangements under any payer other than traditional Medicare FFS. Medicare Advantage and other Medicare-funded private plans are categorized as a payer other than traditional Medicare for these purposes.

2. Medicaid APMs

CMS proposes to define a Medicaid APM as a payment arrangement under title XIX that otherwise meets the criteria to be an Other Payer Advanced APM.

3. Medicaid Medical Home Model

CMS proposes that a Medicaid Medical Home Model is a Medical Home Model that is operated under a State title XIX program. CMS proposes that the definition of a Medicaid Medical Home Model must have the following two minimum elements: (1) model participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services, and (2) empanelment of each patient to a primary clinician.

In addition to these elements, CMS proposes that a Medicaid Medical Home Model must have at least four of the following elements:

- Planned chronic and preventive care.
- Patient access and continuity.
- 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).

CMS notes that this definition of Medicaid Medical Home Model applies only for the purposes of the Quality Payment Program.

CMS seeks comment on the definitions of Medicaid APMs and Medicaid Medical Homes Models.

4. Use of Certified Electronic Health Record Technology

Under section 1833(z)(2)(B)(iii)(II)(bb) and (z)(2)(C)(iii)(II)(bb) of the Act, to be an Other Payer Advanced APM, payments must be made under arrangements in which certified EHR technology is used. CMS states this is slightly different than the requirement for Advanced APMs that “requires participants in such model to use certified EHR technology (as defined in section 1848(o)(4) of the Act),” as specified in section 1833(z)(3)(D)(i)(I) of the Act. Although the statutory requirement is phrased slightly differently, CMS believes that there is value in keeping the two standards—for Advanced APMs and Other Payer Advanced APMs—as similar as possible.

CMS proposes that Other Payer APMs would meet this Other Payer Advanced APM criterion by **requiring participants to use CEHRT as defined for MIPS and APMs**. CMS notes that this approach is consistent with the approach for Advanced APMs. CMS proposes to adopt the

same specifications from within the current definition of CEHRT in its regulation at §414.1305 for eligible clinicians participating in MIPS or in APMs.¹¹ This definition is identical to the definition for use by eligible hospitals and CAHs and Medicaid eligible clinicians in the EHR Incentive Programs.

Consistent with section 1833(z)(2)(C)(iii)(II) of the Act, CMS proposes that an Other Payer Advanced APM must require at least 75 percent of eligible clinicians in each participating APM Entity to use the certified health information technology functions outlined in the proposed definition of CEHRT to document and communicate clinical care with patients and other health care professionals.

5. Application of Quality Measures Comparable to Those Under the MIPS Quality Performance Category

Quality measures comparable to those under the MIPS quality performance category apply under the Other Payer APM are required. CMS notes that as long as the Other Payer APM meets certain criteria, there is no additional prescription for how the Other Payer APM tests additional measures. CMS proposes that the quality measures on which the Other Payer Advanced APM bases payment must include at least one of the following types of measures, provided that they have an evidence-based focus and are reliable and valid:

- (1) Any of the quality measures included on the proposed annual list of MIPS quality measures;
- (2) Quality measures that are endorsed by a consensus-based entity;
- (3) Quality measures developed under section 1848(s) of the Act;
- (4) Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or
- (5) Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid.

CMS proposes that an Other Payer Advanced APM must include at least one outcome measure if an appropriate measure is available on the MIPS list of measures for that specific QP Performance Period.

6. Financial Risk for Monetary Losses

(a) Bearing Financial Risk for Monetary Losses

The third MACRA criterion that an Other Payer APM must meet to be an Other Payer Advanced APM is related to risk. The APM Entity either:

- (1) bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or

¹¹ In the 2015 EHR Incentive Programs final rule (80 FR 62872 through 62873), CMS established the definition of CEHRT for EHR technology that must be used by eligible clinicians to meet the meaningful use objectives and measures in specific years.

(2) for beneficiaries under title XIX, is a medical home in a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

CMS discusses in the proposed rule: (1) what it means for an Advanced APM Entity to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures under an Other Payer Advanced APM; and (2) what amounts of risk are considered to be more than nominal. CMS attempts to keep the standards consistent across different types of APMs, including Advanced APMs.

(i) **Generally Applicable Other Payer Advanced APM Standard**

CMS proposes that the generally applicable financial risk standard would apply for Other Payers Advanced APMs if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period. Under this payment arrangement standard, Other Payers Advanced APMs must (1) withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians; (2) reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians; or (3) require direct payments by the APM Entity to the payer.

(ii) ***Medicaid Medical Home Model Financial Risk Standard***

CMS proposes that the Medicaid Medical Home Model financial risk standard would apply for a Medicaid Medical Home Model if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period. Under this payment arrangement standard, the Medicaid Medical Home Model must:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians;
- Require direct payment by the APM Entity to the payer; or
- Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

CMS provides examples in the proposed rule of situations where a Medicaid Medical Home Model would meet its proposed financial risk standard. For example, a Medicaid Medical home Model would meet the criterion if it conditions the payment of some or all of a regular care management fee to medical home APM Entities upon expenditure performance in relation to a benchmark.

CMS believes that it would be appropriate to impose size and composition limits for Medicaid Medical Home Models to ensure that the focus is on organizations with a limited capacity for bearing the same magnitude of financial risk as larger APM Entities do. CMS proposes that this limits participation in Medicaid Medical Home Models as an advanced APM to medical homes that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated.

(b) Nominal Amount of Risk

CMS notes that when an Other Payer APM risk arrangement meets the proposed financial risk standard, CMS would then consider whether the risk is of a more than nominal amount such that it meets this nominal risk standard. Similar to the CMS approach to the financial risk portion of the assessment, CMS' general approach is to adopt a generally applicable nominal amount standard for Other Payer Advanced APMs and a unique nominal amount standard for Medicaid Medical Home Models. This would include measuring three dimensions of risk to determine whether a model meets the nominal amount standard: (a) marginal risk refers to the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under an Other Payer APM—a common component of risk arrangements, particularly those that involve shared savings; (b) minimum loss rate (MLR), which is a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk; and (c) total potential risk, which refers to the maximum potential payment for which an APM Entity could be liable under an Other Payer APM.

(i) Generally Applicable Other Payer Advanced APM Nominal Amount Standard

CMS proposes that for an Other Payer APM to meet the nominal amount standard, the specific level of marginal risk must be at least 30 percent of losses in excess of the expected expenditures and total potential risk must be at least four percent of the expected expenditures. Other Payer APM arrangements with less than 30 percent marginal risk would not meet the nominal amount standard. Table 40 in the proposed rule (reproduced below) summarizes the generally applicable nominal amount standard.

TABLE 40: Amounts of Risk Sufficient for Other Payer Advanced APMs to Meet the Nominal Amount Standard

Marginal Risk	Maximum Potential Risk Must At Least Be the Following
<30%	N/A
30-100% of spending in excess of expected expenditures	4% of Other Payer expected expenditures

(ii) Medicaid Medical Home Model Nominal Amount Standard

For Medicaid Medical Home Models, CMS proposes that the minimum total annual amount that an APM Entity must potentially owe or forego to be considered an Other Payer Advanced APM must be at least:

- In 2019, 4 percent of the APM Entity's total revenue under the payer.
- In 2020 and later, 5 percent of the APM Entity's total revenue under the payer.

(c) Capitation

CMS proposes that full capitation risk arrangements would meet the same Other Payer Advanced APM financial risk criterion. CMS proposes defining a capitation risk arrangement, for purposes of this rulemaking, as a payment arrangement in which a per capita or otherwise predetermined payment is made to an APM Entity for services furnished to a population of beneficiaries, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity

(d) Criteria Comparable to Expanded Medical Home Model

CMS proposes to specify in subsequent rulemaking the criteria of any Medical Home Model that is expanded under section 1115A(c) of the Act that will be used for purposes of making this comparability assessment. In the absence of any expanded Medical Home Model to which CMS could draw comparisons, Medicaid Medical Home Models must meet the financial risk criterion through the other provisions (the financial risk and nominal amount standards) in order to be an Other Payer Advanced APM.

7. Medicare Advantage

CMS notes that under the All-Payer Combination Option for QP determinations, payment amounts or patient counts associated with Medicare Advantage plans can be counted, but do not count in the QP determination calculations under the Medicare Option.

CMS proposes to evaluate payment arrangements between eligible clinicians, APMs Entities and MA plans as Other Payer APMs and according to the proposed Other Payer Advanced APM criteria. CMS states that the APM Incentive Payments will be lump-sum payments made under Medicare Part B, but outside of the claims payment system, and that Medicare Advantage rates are set through a separate process.

a. Calculation of All-Payer Combination Option Threshold Score

(1) Submission of Information for Other Payer Advanced APM Determination and Threshold Score Calculation

CMS proposes that APM Entities and/or eligible clinicians must submit certain information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria and to calculate Threshold Scores for a QP determination under the All-Payer Combination Option. CMS notes that either the Advanced APM Entity or the eligible clinician may submit this information with respect to the individual eligible clinician. Without this information, CMS would not evaluate the eligible clinicians under the All-Payer Combination Option.

CMS states that it will ask each payer to attest to the accuracy of all submitted information including the reported payment and patient data. Contracts may be subject to audit by CMS. Without this payer attestation, CMS states these data will not be assessed under the All-Payer Combination Option.

For Advanced APM Entities and eligible clinicians participating in Medicaid, CMS will initiate a review and determine in advance of the QP determination period the existence of Medicaid Medical Home Models and Medicaid APMs. CMS states that this review will be based on information obtained from state Medicaid agencies and other authorities, such as professional organizations or research entities.

(2) Use of Methods

CMS proposes to calculate threshold scores for eligible clinicians in an Advanced APM Entity under both the payment amount and patient count methods for each QP Performance Period. CMS also proposes that it would assign QP status using the more advantageous of the Advanced APM Entity's two scores.

(3) Excluded Payments

CMS will exclude certain payments from the calculation under the All-Payer Combination Option. In addition, CMS also proposes to exclude patients associated with these excluded payments from the patient count method. Specifically, the statute excludes payments made for the costs of Department of Defense (DoD) health care programs, costs of Department of Veterans Affairs health care programs, and Medicaid in states in which no Medicaid Medical Home Model or APM is available under the state plan.

CMS proposes that Medicaid payments or patients would be excluded in the numerator and denominator for the QP determination under both the payment amount and patient count methods unless: (1) a state has at least one Medicaid Medical Home Model or Medicaid APM in operation that is determined to be an Other Payer Advanced APM; and (2) the relevant Advanced APM Entity is eligible to participate in at least one of such Other Payer Advanced APMs during the QP Performance Period, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs.

(4) Payment Amount Method

CMS proposes the score calculation method it plans to use to determine whether eligible clinicians meet the established QP threshold amounts in a given year to qualify as a QP under the All-Payer Combination Option using the payment amount method. The calculation is a ratio (numerator/denominator) converted into a percentage that results in a percent value threshold score.

CMS proposes that the numerator is payments made through an ACO (Advanced APM Entity) to an eligible clinician or clinicians that combine such payments from Medicare, commercial, and in certain cases Medicaid payers. Specifically, the numerator would be the aggregate of all payments from all other payers (except those excluded such as DOD, VA, and certain Medicaid payments as described above), made to the Advanced APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—under the terms of all Other Payer Advanced APMs during the QP performance period.

CMS proposes that the denominator is total payments made to eligible clinician or clinicians that combine payments from Medicare, commercial, and in certain cases Medicaid payers. Specifically, the denominator would be the aggregate of all payments from all other payers (except those excluded such as DOD, VA, and certain Medicaid payments) to the Advanced APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—during the QP Performance Period.

CMS notes that for both numerator and denominator Medicare Part B covered professional services will be calculated under the All-Payer Combination Option in the same manner as it is for the Medicare Option.

CMS provides two examples in its Table 41 and Table 42 that illustrate how the calculations work. Table 41 is reproduced below from the proposed rule for illustration. In this CMS example, an Advanced APM Entity participates in a Medicare ACO initiative, a commercial ACO arrangement, and a Medicaid APM. Each of the APMs is determined to be an Advanced APM. In the QP Performance Period for payment year 2021 (proposed in the proposed rule to be 2019), the Advanced APM Entity receives the following payments:

TABLE 41: All-Payer Combination Option Example 1

Payer	Payments through ACO	Total Payments from Applicable Payer	Threshold Score
Medicare*	\$300,000	\$1,000,000	30%
Commercial	\$300,000	\$500,000	60%
Medicaid	\$80,000	\$100,000	80%
Total	\$680,000	\$1,600,000	43%

*For Part B payments, the amount used for the All-Payer Combination Option will be the same as the amount tied to attribution-eligible beneficiaries used in the denominator of the calculation under the Medicare Option.

In the example, the Advanced APM Entity meets the minimum Medicare threshold (30% >25%). However, this entity does not meet QP Payment Amount Threshold (43% < 50%). In this case, the Advanced APM Entity would meet the Partial QP Payment Amount Threshold (43% >40%).

(5) Patient Count Method

Analogous to the approach CMS proposes under the payment amount method, CMS proposes a score calculation method using the patient count method to determine whether eligible clinicians meet the established QP threshold amounts in a given year to qualify as a QP under the All-Payer Combination Option. CMS notes that it will determine the QP status of an eligible clinician for the year based on the higher of the two values. The calculation is a ratio (numerator/denominator) converted into a percentage that results in a percent value threshold score.

CMS proposes the same approach to counting patients for the Other Payer Approach as the Medicare Option.

CMS provides two examples of patient count threshold score calculations in Tables 43 and 44 in the proposed rule. Table 44 is reproduced below to illustrate how CMS performs the calculation. In this example, the Advanced APM Entity meets the minimum Medicare threshold (40% >20%). It also exceeds the minimum QP Patient Count Threshold (61% > 35%). In this case, the eligible clinicians in the Advanced APM Entity would become QPs.

TABLE 44: All-Payer Combination Option Example 4

Payer	Patients through ACO	Total Patients from Payer	Threshold Score
Medicare*	2,000	5,000	40%
Commercial	4,000	5,000	80%
Medicaid	1,000	1,500	67%
Total	7,000	11,500	61%

*For Medicare Part B patients, the amount used for the All-Payer Combination Option will be the same as the number of attribution-eligible beneficiaries used in the denominator of the calculation under the Medicare Option.

b. Submission of Information for Assessment under the All-Payer Combination Threshold Option

CMS proposes that to be considered under the All-Payer Combination Option, APM Entities or individual eligible clinicians must submit by a date and in a manner determined by CMS:

- (1) Payment arrangement information necessary to assess whether each Other Payer APM is an Other Payer Advanced APM, including information on financial risk arrangements, use of certified EHR technology, and payment tied to quality measures; and
- (2) For each Other Payer APM, the amounts of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement (that is, patients for whom the eligible clinician is at risk if actual expenditures exceed projected expenditures), and the total number of patients furnished any service through the payer.

CMS would then make the determination and notify the APM Entities and/or eligible clinicians of the Other Payer Advanced APM determinations based on their submissions. CMS proposes further, that an Other Payer Advanced APM is required to have an outcome measure, or attest that there is no applicable outcome measure on the MIPs list.

With respect to timing, CMS proposes to make an early Other Payer Advanced APM determination on other payer arrangements if sufficient information is submitted at least 60 days before the beginning of a QP Performance Period.

To the extent permissible by federal law, CMS also proposes to maintain confidentiality of certain information (such as sensitive contractual information or trade secrets) provided by Advanced APM Entities and/or eligible clinicians. CMS proposes that the Other Payer Advanced APM determinations would be made available directly to participating APM Entities and eligible clinicians rather than through public notice.

CMS notes that information submitted as part of this determination is subject to audit and that eligible clinicians and Advanced APM Entities will be required to maintain copies of any supporting documentation.

7. APM Incentive Payment

a. Amount of the APM Incentive Payment

CMS will make an APM Incentive Payment to eligible clinicians that achieve QP status for the year during years 2019 through 2024. In accordance with the statute, CMS proposes that this APM Incentive Payment shall be equal to 5 percent of the estimated aggregate amounts paid for Medicare Part B covered professional services furnished by the eligible clinician from the preceding year across all billing TINs associated with the QP's NPI.

(1) Incentive Payment Base Period

CMS proposes to use the full calendar year prior to the payment year as the incentive payment base period from which to calculate the estimated aggregated payment amounts.

(2) Timeframe of Claims

CMS proposes to calculate the APM Incentive Payment based on data available 3 months after the end of the incentive payment base period in order to allow time for claims to be processed. For example, for the 2019 payment year, CMS would capture claims submitted with dates of service from January 1, 2018 through December 31, 2018 and processing dates of January 1, 2018 through March 31, 2019

Based on the proposed timeframe of claims, CMS estimates that incentive payments could be made approximately 6 months after the end of the incentive payment base period. CMS proposes that the APM Incentive Payment would be made no later than one year from the end of the incentive payment base period. CMS states that it did not set a specific deadline as doing so could pose operational risks in the event that 6 months is impracticable for unforeseen reasons.

(3) Treatment of Payment Adjustments in Calculating the APM Incentive Payment

CMS proposes to exclude the MIPS, VM, MU and PQRS payment adjustments when calculating the estimated aggregate payment amount for covered professional services upon which to base the APM Incentive Payment amount. For example, a QP who receives an upward or downward fee adjustment during 2018 in VM would not see that adjustment reflected in the estimated aggregate payment amount for covered professional services used to calculate his or her APM Incentive Payment in 2019.

(4) Treatment of Payments for Services Paid on a Basis Other than Fee-For-Service

CMS recognizes that many APMs use incentives and financial arrangements that differ from usual fee schedule payments. For the purposes of this proposed regulation, CMS places such

payments into three categories: financial risk payments, supplemental service payments, and cash flow mechanisms.

Financial Risk Payments

CMS defines financial risk payments as non-claims-based payments, based on performance in an APM when an APM Entity assumes responsibility for the cost of a beneficiary's care, whether it be for an entire performance year, or for a shorter duration of time, such as over the course of a defined episode of care. CMS would consider shared savings payments to ACOs in all tracks of the MSSP to be financial risk payments as well as net payment reconciliation amounts from CMS to an Awardee (or vice versa) under the BPCI Initiative, and reconciliation payments or repayment amounts under the CJR model to be examples of financial risk payments.

CMS proposes to exclude financial risk payments such as shared savings payments or net reconciliation payments, when calculating the estimated aggregate payment amount.

Supplemental Service Payments

CMS defines supplemental service payments as Medicare Part B payments for longitudinal management of a beneficiary's health, or for services that are within the scope of medical and other health services under Medicare Part B that are not separately reimbursed through the physician fee schedule. CMS cites per-beneficiary per-month (PBPM) payments that are made for care management services as an example.

CMS proposes to determine on a case-by-case basis whether certain supplemental service payments are in lieu of covered services that are reimbursed under the PFS. CMS proposes to include a supplemental service payment in calculation of the APM Incentive Payment amount if it meets all of the following 4 criteria:

1. Payment is for services that constitute physician services authorized under section 1832(a) of the Act and defined under section 1861(s) of the Act.
2. Payment is made for only Part B services under the first criterion above, that is, payment is not for a mix of Part A and Part B services.
3. Payment is directly attributable to services furnished to an individual beneficiary.
4. Payment is directly attributable to an eligible clinician.

For example, the supplemental service payments in the OCM MEOS Payment Model and the CPC Plus Care Management Fee (CMF) meet the four criteria and would be included in the APM incentive payment calculations. The Medicare Care Choices Model PBPM payment would not meet the first two criteria; that payment is for services defined as physician services and only for Part B services.

Cash Flow Mechanisms

CMS defines cash flow mechanisms as changes in the method of payments for services furnished by providers and suppliers participating in an APM Entity. CMS cites the population-based payment (PBP) available in the Pioneer ACO Model and the Next Generation ACO Model as examples of a case flow mechanism. PBP provides ACOs with a monthly lump sum payment in exchange for a percentage reduction in Medicare fee-for-service payments to certain ACO providers and suppliers.

For expenditures affected by cash flow mechanisms, CMS proposes to calculate the estimated aggregate payment amount using the payment amounts that would have occurred for Part B covered professional services if the cash flow mechanism had not been in place. For example, for QPs in an ACO receiving PBP with a 50 percent reduction in fee-for-service payments, CMS would use the amount that would have been paid for Part B covered professional services in the absence of the 50 percent reduction.

(5) Treatment of Other Incentive Payments in Calculating the Amount of APM Incentive Payments

CMS notes that the statute specifies that CMS shall not include certain existing Medicare incentive payments in the calculation of the APM Incentive Payment. This includes payments related to the HPSA Physician Bonus Program.

(6) Treatment of the APM Incentive Payment in APM Calculations

The APM incentive payment will not be included in the benchmark (or rebased benchmark) for APMs. CMS anticipates that each APM will take steps to ensure that the payments are factored out of benchmarks moving forward.

b. Services Furnished Through CAHs, RHCs, and FQHCs

(1) Critical Access Hospitals (CAHs)

As proposed, the APM Incentive Payment would be based on the amounts paid for those services attributed to the eligible clinician, as identified using the attending NPI included on a submitted claim, in the same manner as all other covered professional services. For an eligible clinician who becomes a QP based on covered professional services furnished at a Method II CAH, CMS proposes that the APM Incentive Payment would be made to the CAH TIN that is affiliated with the Advanced APM Entity.

(2) Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS states payment for services furnished by eligible clinicians in RHCs and FQHCs is not reimbursed under or based on the PFS. Therefore, professional services furnished in those settings would not be considered part of the amount upon which the APM Incentive Payment is based. For eligible clinicians that practice in RHCs or FQHCs, this does not preclude the

inclusion of payment amounts for covered professional services furnished by those eligible clinicians in other settings. This only excludes payments made for RHC and FQHC services furnished by the eligible clinicians.

c. Payment of the APM Incentive Payment

(1) Payment to the QP

CMS proposes that for eligible clinicians that are QPs, CMS would make the APM Incentive Payment to the TIN that is affiliated with the Advanced APM Entity through which the eligible clinician met the threshold during the QP performance period.

CMS states that it recognizes that there may be scenarios in which an individual eligible clinician may change his or her affiliation between the QP Performance Period and the payment year such that the eligible clinician no longer practices at the TIN affiliated with the Advanced APM Entity. In this instance, CMS proposes to make the APM Incentive Payment to the TIN provided on the eligible clinician's CMS-588 EFT Application.

(2) Exceptions

As discussed earlier, CMS recognizes that there may be instances where none of the Advanced APM Entities with which an individual eligible clinician participates meets the QP threshold. In this instance, CMS proposes to assess the eligible clinician individually, using services furnished through all Advanced APM Entities during the QP Performance Period.

For purposes of making the QP determination at the individual eligible clinician level, CMS proposes to split the APM Incentive Payment amount proportionally across all of the QP's TINs associated with Advanced APM Entities. For example, if an eligible clinician is a QP who participates in two APMs (APM 1 and APM 2), and has 75 percent of his or her payments (or patients) used to make the QP determination through APM 1 and 25 percent of his or her payments (or patients) used to make the QP determination APM 2, CMS would make 75 percent of the APM Incentive Payment to the TIN affiliated with APM 1, and 25 percent of the APM Incentive Payment to the TIN affiliated with APM 2. CMS believes this approach is most consistent with the statute and encourages participation in APMs.

(3) Notification of APM Incentive Payment Amount

CMS anticipates that notification of the APM Incentive Payment amount will likely not occur at the same time as the notification of QP status; CMS anticipates that notification will occur later in the year to allow for accurate calculation and validation of the incentive payment amount. CMS proposes to send notification to both Advanced APM Entities and their individual participating QPs of their APM Incentive Payment amount as soon as CMS has calculated and performed the necessary validation of results.

In addition, CMS proposes that the APM Incentive Payment amount notification would be made directly to QPs along with a general public notice that such calculations have been

completed for the year. For the direct QP notification, CMS intends to include the amount of APM Incentive Payment and the TIN to which the incentive payments will be made. If the incentive payment is split across multiple TINS, CMS intends to identify which TINs CMS will make the incentive payment to, and include the amount of APM Incentive Payment that will be made to each TIN. For the notification to Advanced APM Entities, CMS intends to include the total amount of APM Incentive Payments that will be made to each participating TIN within the Advanced APM Entity, as well as QP specific payment amounts.

8. Monitoring and Program Integrity

CMS proposes to monitor Advanced APM Entities and eligible clinicians on an ongoing basis for non-compliance with the conditions of participation for Medicare and the terms of the relevant Advanced APMs in which they participate during the QP Performance Period. CMS states that this will include vetting of applicants to Advanced APMs and their compliance with the conditions of participation of Medicare and ongoing, periodic assessments of Advanced APM Entities and eligible clinicians by APMs in conjunction with the CMS Center for Program Integrity and other relevant federal government departments and agencies.

CMS proposes that if an Advanced APM Entity or eligible clinician is terminated from the program during the QP Performance Period for program integrity reasons, or if the Advanced APM Entity or eligible clinician is out of compliance with program requirements, CMS may reduce or deny the APM Incentive Payment to such eligible clinicians. In addition, CMS states that if an eligible clinician is later terminated due to a program integrity matter arising during the QP Performance Period, CMS may recoup all or a portion of the amount of the payment from the entity to which CMS made the payment. Furthermore, CMS proposes that CMS will reopen and recoup any payments that were made in error in accordance with procedures similar to those set forth at §§405.980 and 405.370 et seq. or established under the relevant APM.

CMS also proposes that Advanced APM Entities and eligible clinicians must maintain copies of all records related to the All-Payer Combination Option for at least ten years and must provide the government with access to these records for auditing and inspection purposes.

III. Collection of Information Requirements

Table 60, reproduced here, summarizes the estimated annual recordkeeping and reporting requirements under the proposed rule, and compares them to requirements under the PQRS and the Medicare EHR Incentive Program. On net, CMS estimates that the proposed rule requirements would increase the aggregate annual reporting and recordkeeping hourly burden by about 25 percent and the annual total cost by about 11 percent.

TABLE 60: Proposed Annual Recordkeeping and Reporting Requirements

Section(s) in title 42 of the CFR and Section of Rule	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Annual Burden Cost (\$)
§414.1330 and §414.1335	299,169	299,169	17.8	5,325,208	Varies (see	387,252,730

TABLE 60: Proposed Annual Recordkeeping and Reporting Requirements

Section(s) in title 42 of the CFR and Section of Rule	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Annual Burden Cost (\$)
(Quality Performance Category) - Claims Submission Mechanism					Table 47)	
§414.1330 and §414.1335 (Quality Performance Category) - Qualified Registry or QCDR Submission Mechanisms	214,590	214,590	10	2,163,711	Varies (see Table 48)	138,734,298
§414.1330 and §414.1335 (Quality Performance Category) - EHR Submission Mechanism	77,241	77,241	11	849,651	Varies (See Table 49)	55,883,864
§414.1330 and §414.1335 (Quality Performance Category) - CMS Web Interface Submission	300	300	81	24,300	Varies (See Table 50)	2,054,850
§414.1400 (Quality Performance Category) - CAHPS for MIPS	86,100	986,100	.337	29,016	23.06	669,102
§414.1400 QCDR and Registries self-nomination	150	10	1500	1,500	83.96	125,940
§414.1390 (Data Validation and Auditing)	430	430	1.5	645	34.20	22,059
§414.1375 (Advancing Care Information Performance Category)	517,425	517,425	4	2,069,700	182.46	377,637,462
§414.1360 (CPIA)	676,325	676,325	3	2,028,975	182.46	370,206,779
§414.1430 (Partial Qualifying APM Participant (QP) election)	543	543	.5	272	83.96	22,795
Total Gross Burden		1,872,273		12,492,977		1,327,162,070
Total Burden Under Previous Programs		1,339,050		9,969,514		1,199,257,029
Total Net Burden		535,233		2,523,464		127,905,041

IV. Regulatory Impact Analysis

In the aggregate, CMS estimates that for 2019, the proposed rule would distribute about \$833 million in payment adjustments on a budget neutral basis. An additional \$500 million is available for exceptional performance payments. The 5 percent incentive payment to clinicians qualifying as APM participants (QPs) is estimated to total from \$146 million to \$429 million.

Tables 63 and 64 (reproduced at the end of this document) summarize the average CMS estimated dollar impact of the proposed rule on physicians by specialty and by practice size, respectively.

Overall, CMS estimates that 54 percent of MIPS eligible clinicians would receive a positive adjustment, and 46 percent would receive a negative adjustment. These proportions vary by specialty. Eleven specialties show a net negative adjustment even when the \$500 million in additional adjustments are taken into account: podiatry, chiropractic, psychiatry, optometry, nurse anesthetist, physical medicine, infectious disease, plastic surgery, general practice, allergy/immunology, and dentist. All practice sizes except solo practitioners show a net positive adjustment, and this increases by size. It may be worth noting that a specialty or practice size with low participation in PQRS in 2014 would not fare well in this impact analysis.

**TABLE 63: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY:
MID-POINT ESTIMATE***

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with negative payment adjustment	Percent with positive payment adjustment	Aggregate Impact Negative Payment Adjustment (mil)*	Aggregate Impact Positive Adjustment (mil)	Aggregate Positive Adjustment, Excluding Exceptional Performance Payment (mil)	Aggregate Positive Adjustment, Exceptional Performance Payment Only (mil)
ALL**	761,342	\$72,606	45.5%	54.1%	-\$833	\$1,333	\$833	\$500
Allergy/Immunology	3,031	\$199	57.1%	42.6%	-\$4	\$3	\$2	\$1
Anesthesiology	34,233	\$1,904	47.4%	52.2%	-\$25	\$29	\$18	\$11
Cardiology	29,176	\$5,791	37.5%	62.1%	-\$35	\$127	\$80	\$47
Chiropractic	20,572	\$585	98.4%	1.5%	-\$22	\$0	\$0	\$0
Clinical Nurse Specialists	1,681	\$57	54.7%	44.9%	-\$1	\$1	\$0	\$0
Colon/Rectal Surgery	1,244	\$136	40.0%	59.7%	-\$1	\$3	\$2	\$1
Critical Care	2,550	\$265	46.3%	53.5%	-\$4	\$4	\$2	\$1
Dentist	915	\$26	68.9%	30.1%	-\$1	\$0	\$0	\$0
Dermatology	10,317	\$2,824	42.2%	57.6%	-\$21	\$92	\$55	\$37
Emergency Medicine	41,728	\$2,626	35.4%	64.0%	-\$19	\$53	\$33	\$20
Endocrinology	5,401	\$445	32.6%	67.3%	-\$3	\$10	\$6	\$4
Family Practice	79,541	\$5,666	40.2%	59.5%	-\$60	\$103	\$65	\$38
Gastroenterology	12,608	\$1,639	38.3%	61.5%	-\$16	\$34	\$21	\$13

**TABLE 63: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY:
MID-POINT ESTIMATE***

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with negative payment adjustment	Percent with positive payment adjustment	Aggregate Impact Negative Payment Adjustment (mil)*	Aggregate Impact Positive Adjustment (mil)	Aggregate Positive Adjustment, Excluding Exceptional Performance Payment (mil)	Aggregate Positive Adjustment, Exceptional Performance Payment Only (mil)
General Practice	3,598	\$273	69.4%	30.3%	-\$5	\$2	\$1	\$1
General Surgery	20,387	\$1,926	45.5%	54.2%	-\$24	\$35	\$22	\$13
Geriatrics	3,790	\$447	48.3%	51.6%	-\$7	\$7	\$4	\$3
Hand Surgery	1,779	\$230	48.7%	51.1%	-\$3	\$4	\$3	\$2
Infectious Disease	5,544	\$644	42.9%	56.9%	-\$12	\$9	\$5	\$3
Internal Medicine	89,257	\$9,327	40.3%	59.4%	-\$101	\$176	\$110	\$66
Interventional Radiology	1,780	\$337	40.4%	59.2%	-\$4	\$6	\$4	\$2
Nephrology	8,497	\$2,065	41.6%	58.0%	-\$19	\$37	\$23	\$14
Neurology	13,000	\$1,248	40.6%	59.2%	-\$15	\$24	\$15	\$9
Neurosurgery	4,489	\$689	43.8%	55.6%	-\$8	\$12	\$8	\$5
Nuclear Medicine	626	\$100	44.2%	55.0%	-\$2	\$2	\$1	\$1
Nurse Anesthetist	31,737	\$826	51.1%	48.4%	-\$14	\$9	\$6	\$3
Nurse Practitioner	50,764	\$1,626	37.7%	62.0%	-\$25	\$27	\$17	\$10
Obstetrics/Gynecology	21,650	\$538	38.8%	61.1%	-\$8	\$10	\$6	\$4

**TABLE 63: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY:
MID-POINT ESTIMATE***

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with negative payment adjustment	Percent with positive payment adjustment	Aggregate Impact Negative Payment Adjustment (mil)*	Aggregate Impact Positive Adjustment (mil)	Aggregate Positive Adjustment, Excluding Exceptional Performance Payment (mil)	Aggregate Positive Adjustment, Exceptional Performance Payment Only (mil)
Oncology/Hematology	11,705	\$1,706	37.5%	62.1%	-\$13	\$24	\$15	\$9
Ophthalmology	17,259	\$5,060	44.8%	54.7%	-\$43	\$114	\$71	\$43
Optometry	18,394	\$945	79.7%	20.2%	-\$21	\$10	\$6	\$4
Oral/Maxillofacial Surgery	200	\$7	55.0%	44.5%	\$0	\$0	\$0	\$0
Orthopedic Surgery	20,277	\$3,254	46.4%	53.3%	-\$33	\$63	\$40	\$24
Other MD/DO	10,674	\$1,117	42.9%	56.7%	-\$15	\$20	\$12	\$7
Otolaryngology	8,211	\$1,015	47.4%	52.3%	-\$13	\$18	\$11	\$7
Pathology	7,302	\$593	43.3%	56.7%	-\$9	\$10	\$6	\$4
Pediatrics	4,589	\$55	20.6%	79.3%	-\$1	\$1	\$1	\$0
Physical Medicine	7,295	\$918	57.9%	41.9%	-\$17	\$12	\$8	\$5
Physician Assistant	43,994	\$1,212	32.5%	67.1%	-\$13	\$26	\$16	\$10
Plastic Surgery	3,691	\$287	65.4%	34.5%	-\$7	\$4	\$2	\$1
Podiatry	15,310	\$1,882	78.0%	21.8%	-\$46	\$14	\$9	\$5
Psychiatry	20,854	\$1,143	68.8%	31.1%	-\$29	\$8	\$5	\$3

**TABLE 63: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY:
MID-POINT ESTIMATE***

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with negative payment adjustment	Percent with positive payment adjustment	Aggregate Impact Negative Payment Adjustment (mil)*	Aggregate Impact Positive Adjustment (mil)	Aggregate Positive Adjustment, Excluding Exceptional Performance Payment (mil)	Aggregate Positive Adjustment, Exceptional Performance Payment Only (mil)
Pulmonary Disease	10,493	\$1,655	41.9%	57.8%	-\$20	\$26	\$17	\$10
Radiation Oncology	4,239	\$1,513	44.2%	55.4%	-\$16	\$27	\$17	\$10
Radiology	34,998	\$4,165	49.2%	50.4%	-\$49	\$65	\$41	\$24
Registered Nurse	1,942	\$58	49.3%	50.4%	-\$1	\$1	\$0	\$0
Rheumatology	4,274	\$495	32.2%	67.6%	-\$3	\$13	\$8	\$5
Thoracic/Cardiac Surgery	3,688	\$596	37.7%	61.8%	-\$5	\$11	\$7	\$4
Urology	8,814	\$1,586	40.5%	59.2%	-\$13	\$31	\$19	\$11
Vascular Surgery	3,244	\$906	42.4%	57.2%	-\$10	\$18	\$11	\$7

*2014 data used to estimate 2017 performance. Payments estimated using 2014 dollars.

**Due to limitations in scoring model data, the number of clinicians in the sample for Table 63 (761,342) exceeds our upper bound estimate of the number of eligible clinicians that will receive composite performance scores for MIPS Year 1 (746,000). The upper bound estimate of the number of eligible clinicians that would receive composite performance scores excludes clinicians that participated in the two APMs that were in effect in 2014 and met the criteria for Advanced APMs. In its scoring model data, CMS could not identify and exclude eligible clinicians that would begin participating in existing or new Advanced APMs after 2014.

TABLE 64: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY PRACTICE SIZE*

Practice Size - Eligible Clinicians	Eligible Clinicians	Physician Fee Schedule Allowed Charges (\$ Mil)	Percent Eligible Clinicians with Negative Adjustment	Eligible Clinicians with Negative Adjustment	Percent Eligible Clinicians with Positive Adjustment	Eligible Clinicians with Positive Adjustment	Eligible Clinicians with no Adjustment	Aggregate impact Negative Payment Adjustment (\$ Mil)	Aggregate Impact Positive Adjustment (\$ Mil)	Aggregate Positive Adjustment, excluding exceptional Performance Payment (\$ Mil)	Aggregate Positive Adjustment, exceptional Performance Payment only (\$ Mil)
Solo	102,788	\$12,458	87.0%	89,383	12.9%	13,302	103	-\$300	\$105	\$65	\$40
2-9	123,695	\$18,697	69.9%	86,519	29.8%	36,887	289	-\$279	\$295	\$182	\$113
10-24	81,207	\$9,934	59.4%	48,213	40.3%	32,737	257	-\$101	\$164	\$103	\$61
25-99	147,976	\$12,868	44.9%	66,515	54.5%	80,588	873	-\$95	\$230	\$147	\$84
100+	305,676	\$18,648	18.3%	56,045	81.3%	248,626	1,005	-\$57	\$539	\$336	\$203
Overall	761,342	\$72,606	45.5%	346,675	54.1%	412,140	2,527	-\$833	\$1,333	\$833	\$500

*2014 data used to estimate 2017 performance. Payments estimated using 2014 dollars.