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October 21, 2016

Merit Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models – Executive Summary of Final Rule with Comment

On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) released its Final Rule with Comment Period implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The policies announced in this rule begin a process that will transform how clinicians (beyond just physicians) will get paid for their medical benefit professional services into a system of winners and losers. And the process begins January 1, 2017.

Clinicians must choose between two paths to get their annual "adjustments" (raises, bonuses, penalties). The first requires reporting on the quality measures they adhere to, the improvements they make to their practices, and the rate at which they adopt technology. CMS will also review claims data to see how much they spend on treating patients. All this will be measured and made public on the Physician Compare website. The second requires participation in an alternative payment model that bases payments on similar quality measures and other improvements, but also requires participants to take on financial risk. Low-volume (Medicare) clinicians do not have to participate.

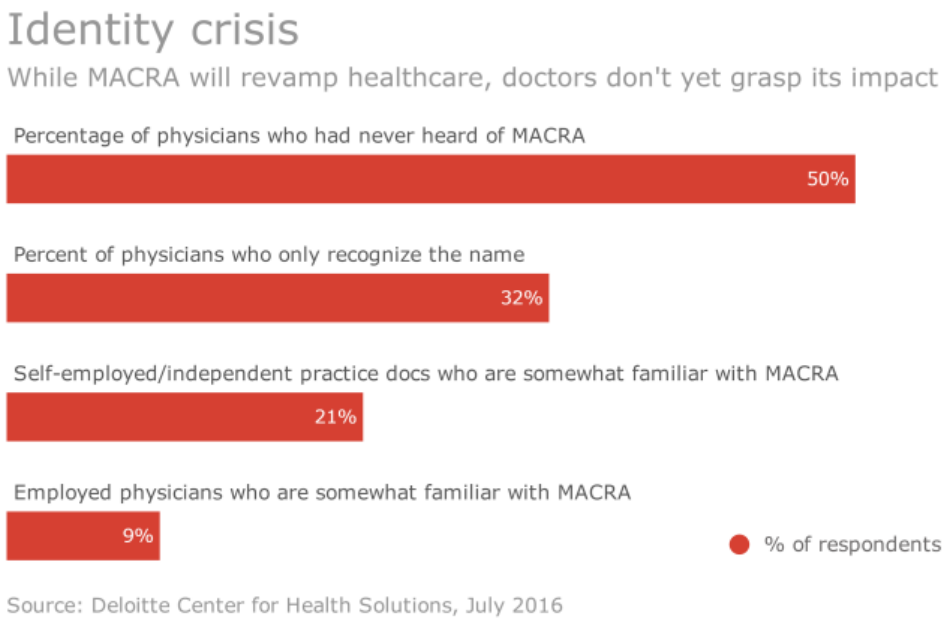
In order to get the program off the ground and incentivize participation, in the first year (2017) CMS provides options for different levels of engagement. CMS has also made it clear that this will be an iterative process, both from the clinician side as well as the CMS side, through further sub-regulatory outreach and guidance, as well as further rulemaking.

Although the rule has tremendous potential to impact clinicians' bottom line, there remains a prevailing lack of knowledge and understanding, particularly with respect to how to leverage this new program to optimize both Medicare payment adjustments and performance bonuses (see graphic below).

The release of the Final Rule with Comment on October 14th did little to alleviate the lack of understanding, given that the document is over 2200 pages long and written in such an opaque manner as to make deciphering difficult. The section headings in the attached summary outline the general contours of the changes and challenges ahead.

As January 1 fast approaches, there is approximately $1 billion in bonuses available for high performers in 2017 on the one hand, and a potential 4% cut in overall Medicare payments on the other. All stakeholders will need a working knowledge of MACRA and how its requirements will impact treatment decisions, clinician payment, and practice improvement priorities. Timely proactive engagement and clear, concise reporting protocols likely will separate the winners and losers among all stakeholder interests.

Connect 4 Strategies has developed a general summary of the rule (next page), reducing over 2200 pages down to 10, and is engaged with stakeholders in identifying the specific provisions that offer the greatest opportunities and/or risk. We are working with client organizations to identify and execute strategies that best capture the opportunities offered in this rule, including developing responses to CMS' call for comments and increasing awareness of the rule's impact on providers, patients, and the treatment options available to them in specific specialties.



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Merit Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models – Summary of Final Rule with Comment

Background. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate (SGR) methodology for calculating updates to the physician fee schedule and replaced it with a new approach to payment updates called the Quality Payment Program (QPP). In its Final Rule with Comment Period, posted October 14, 2016, CMS finalizes two approaches for clinicians to receive annual positive/negative payment updates – the Merit Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APMs). The annual payment updates apply to the clinician's *Medicare Part B payments* for items and services furnished by the MIPS or Advanced APM eligible clinician. This program will begin, albeit slowly, on Jan 1, 2017, and is another step away from volume-based care and reimbursement and towards quality-driven, outcomes-focused care delivery.

Although the program will begin on time this January, it is clear that the incredibly short timeframe afforded CMS to review and respond to thousands of comments compelled the Agency to frame the program as an iterative process and to make several concessions just to get the program started. CMS punted on a number of suggestions, signaling revision and refinement opportunities in future rulemakings. Several comments were not even acknowledged in this final rule, leaving room to revisit issues next year.

Rollout of MIPS Approach. CMS expects over 640,000 clinicians will be participating in the MIPS approach to annual payment adjustments in 2017. These clinicians can "pick their pace" from among 4 participation options in 2017, at varying degrees of integration. There is a two year lag in payment, so 2017 reporting results in payment (or penalty) in 2019. Non-participators will face a 4% negative financial impact. CMS' first-year approach was intended to make it easy for MIPS eligible clinicians to avoid a negative payment adjustment.

Acting CMS Administrator Andy Slavitt noted that "[I]n 2017, we estimate that we will pay approximately $1 billion in bonuses for high quality care to clinicians in both advanced APMs and MIPS." CMS estimates about $200 million to $320 million in pay hikes will be awarded in 2019 to clinicians who participate in MIPS in 2017, plus $500 million in MIPS exceptional performance payments. The law authorizes the additional $500 million, which is a separate pool from that created by penalties. CMS also estimates that clinicians who qualify for APM bonuses will receive between $330 and $570 million in 2019. Connect 4 Strategies is working with organizations that wish to aid clinicians in their understanding of this program and their options for optimizing their bonus.

Four Options in 2017. Although some clinicians will choose the Advanced APM route, CMS believes most will begin with MIPS. The agency sets out four MIPS participation options for 2017:

1. Full MIPS participation may qualify for a 4% payment increase (based on clinician's Medicare Part B payments), and a possible bonus
   - ✓ Participate a minimum of 90 days or, ideally, a full year
   - ✓ Report at least six quality measures[1]
   - ✓ Report on five required measures in the advancing care category
   - ✓ Engage in up to four medium-weight **or** two high weight practice improvement activities[2]
   - ✓ Bonus score for improvements using CEHRT and for reporting to public health and clinical data registries
2. Partial MIPS participation – avoid a negative adjustment and possibly receive a positive one
   - ✓ Minimum of one continuous 90 day performance period
   - ✓ Report more than one quality measure, **or**
   - ✓ Report more than one improvement activity, **or**
   - ✓ Report more than the required measures in the advancing care information category
3. Minimum MIPS participation – avoid negative adjustment
   - ✓ Fewer than 90 days
   - ✓ Report one quality measure (more if submission is by a group practice through CMS Web Interface), **or**
   - ✓ Report one improvement activity **or**
   - ✓ Report the required measures in advancing care information
4. Advanced APM option – qualify for a 5% bonus incentive payment
   - ✓ practice in an Advanced APM, and see a sufficient number of their Medicare patients through that APM

Other 2017 Transition Year Adjustments.

- ✓ Cost category is zeroed out for composite score
- ✓ Quality category increased to 60% of composite score
  - ✓ Quality category -- Data completeness threshold set at 50% of patients qualifying for a quality measure.
  - ✓ Submitting data, even if it does not reach 50% will get EP three points for submitting the measure.[3]
- ✓ Advancing care information category – CMS makes participation by attestation an option if submission mechanisms are not yet set up by clinicians.[4]
- ✓ "Virtual groups" that bring together solo or small practices to report together will not be implemented in 2017.

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[1] Must include at least one outcome measure, or report one (sub)specialty measure set *and* one outcome measure (if not available, then one high priority measure (i.e., appropriate use, patient safety, efficiency, patient experience, and care coordination measures)

[2] One high weight **or** two medium weight activities for non-patient facing EPs, for small or rural practices, or for geographic health professional shortage areas

[3] Group practices using the CMS Web Interface or a CMS approved vendor to report CAHPS for MIPS survey must meet the submission requirements on the sample of Medicare Part B patients provided by CMS. Group practices additionally responsible for the All Cause Readmissions (ACR) measure, although it will not, by itself, result in a negative or positive adjustment.

[4] CMS also allows both the 2014 or 2015 Edition of Certified HER Technology (CEHRT) to be used to report measures in 2017 (slightly different objectives/measures given different system capabilities under each).

Performance Year 2018. Also a transition year, with some reporting requirement adjustments.

- ✓ Full year reporting of at least six quality measures,[5] weighting resets to 50%, and data completeness threshold increases to 60%
- ✓ Minimum 90 day period for reporting improvement activities and advancing care measures[6]
- ✓ Cost category weighting increases from 0 to 10%

MIPS Eligible Clinicians (MIPS EP)

Qualifying clinicians (EP) – include physician, PA, NP, clinical nurse specialist, certified RN anesthetist, and such clinicians who bill under Part B (i.e., pathologists, chiropractors)

- CMS to add clinicians in future rulemaking
- Non-patient facing MIPS EP (i.e., pathologists, radiologists, nuclear medicine physicians)
  - ✓ Individual EPs w/ 100 or fewer patient facing encounters (including telehealth services)
  - ✓ 75% of the NPIs billing under the group practice meet the 100 or fewer encounters threshold[7]
  - ✓ CMS may re-weight performance categories if insufficient measures applicable/available for non-patient facing EPs; Also, advancing care category zeroed out for these EPs
- MIPS EPs Group practices – can report individually or as a group; if they don't qualify as an individual, they may report as a group;
- MIPS EPs Practicing in Critical Access Hospitals (CAHs), Hospitals, RHCs, or FQHCs
  - ✓ MIPS payment adjustment applies to the items and services billed by the EP under PFS, not to the facility payment to the CAH itself.
  - ✓ A hospital based clinician is a MIPS EP if he/she furnishes 75% or more of his/her covered professional services in inpatient hospitals or ED in the year preceding the performance year;[8]
  - ✓ If a clinician is paid by the RHC or FQHC, he/she is not a MIPS EP;[9]
- Low volume threshold exemption – Practices with $30,000 or less in Medicare Part B allowed charges or 100 Medicare patients[10] or fewer are exempt from MIPS (applies to individual eligible clinicians and group practices).[11]
  - ✓ New Medicare enrolled clinician exempt from MIPS the year of their enrollment
  - ✓ Threshold applies to Medicare Part B allowed charges
  - ✓ Unlike the Proposed Rule, the Final Rule low volume threshold exempts clinicians with EITHER fewer than 100 Medicare patients OR under $30,000 in allowed charges;

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[5] including at least one outcome measure, **or** report one (sub)specialty measure set *and* one outcome measure (if not available, then one high priority measure (i.e., appropriate use, patient safety, efficiency, patient experience, and care coordination measures).

[6] EPs required to use certified EHR technology certified to the 2015 Edition for 2018.

[7] CMS will inform EPs if they qualify for this status by the December preceding the new performance year; Face to face encounter codes to be published before a performance year (E&M services).

[8] CMS will determine which MIPS EPs qualify as "hospital based" for a payment year; if qualified, they must participate and if needed, CMS will assign a weight of zero for advancing care category if insufficient measures apply.

[9] If a clinician furnishes items and services in a RHC/FQHC and bills for them under the PFS, then a MIPS adjustment would apply just to those items and services (check low volume threshold).

[10] Medicare Advantage beneficiaries and charges are excluded.

[11] CMS will provide a low volume threshold lookup by NPI number per a determination period, again available Dec before a new performance year, based on closest Sept-Aug 12 month data (including a 60 day claims run out period).

- ✓ Qualifying APM Participant (QP) or Partial APM Participant (Partial QP) Qualifying APM QPs who choose not report under MIPS are exempt from MIPS.

The MIPS pathway to earning an increase and avoiding a penalty requires clinicians to report on three categories (quality, practice improvements, and advancing care information) and CMS mines claims data to report on a clinician's resource use, or cost. CMS will make data across all four categories publicly available on the Physician Compare website. Below are some details on each category.

Quality Measures – Contributes 50% to the composite score after 2017

- Starting in 2018, EPs must report 6 quality measures;[12]
- Data completeness threshold is 60%.[13] CMS notes this will likely increase in future rulemaking;
- CMS is postponing implementation of cross-cutting measures for future rulemaking;
- CMS punted to future rulemaking re: inclusion of inpatient measures;
- CMS included one global and population based measure, the 30-day All Cause Readmission (ACR) measure;[14]
- CMS will continue to add Medicaid measures, and seeks input on a Medicaid measure set;
- CMS included measures developed in collaboration with AHIP and will continue to do so;
- CMS will select quality measures annually and publish them by November 1 before a new performance year; they must be peer reviewed.[15]
    - ✓ Annual call for measures through pre-rulemaking; adoption of measures, changes, etc. through rulemaking;
    - ✓ For adoption of new measures, CMS will consider extent to which they have been tested for feasibility, reliability and validity and have an evidence-based focused (see Quality Measure Development Plan on CMS website); and
    - ✓ CMS asks measure recommendations focus on patient safety and adverse events, appropriate use of diagnosis, care coordination, patient and caregiver experience, efficiency, cost, and utilization of healthcare resources, and performance gaps.[16]

Cost (Resource Use) – Contributes 0% in 2017, 10% in 2018, and 30% thereafter

- CMS provided no real insight into how they will include Part D costs; only that they continue to evaluate how best to do so.

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[12] Six *or* one (sub)specialty specific measure set *and* an outcomes measure (if unavailable, then a high priority measure). The appendix has several tables listing final individual measures available for reporting in 2017, measures that don't require data submission, newly proposed measures CMS is finalizing, the final specialty specific measure sets, the final list of removed measures, and substantively changed measures for 2017.

[13] This is the percent of patients meeting a measure being reported; Group practices reporting via CMS Web Interface (group practices of 25+), must report on all measures therein for all the CMS-assigned Medicare beneficiaries in the sample.

[14] The ACR measure comes from the Value Based Modifier program, it will apply to group practices with 15+ EPs with a case volume of 200+ and will be calculated by CMS using claims and administrative data;

[15] To meet statutory requirement of peer reviewed measures, CMS will have to collect data, draft and submit for publication to peer reviewed journals articles on quality measures before including those measures in the final annual list of quality measures. Publication not required.

[16] CMS and ONC will work with IT vendors to support identification/capture of data elements and test/improve calculations and functionality of measures to ease reporting. Measure specifications at CMS' website.

- An EP's cost performance = the total per capita cost measure[17] + the Medicare Spending Per Beneficiary (MSPB) measure + 10 episode based measures;[18]
- Measures will come from Medicare administrative claims, and will not be reported by Eps;
- All measures attributed to clinicians will be weighted equally and there are no minimum number of measures required to receive a score; and
- As there is no national data source to accurately capture cost data for all payers, cost is limited to Medicare cost data for the total per capita cost measure.

Practice Improvements -- Contributes 15% to the composite score

- Report 6 medium weight **or** 3 high weight activities;[19]
- Certain Medical Home models automatically get a 100% score in the practice improvement category;
- A subset of improvement activities that are completed using CEHRT enable clinicians to achieve a bonus score;
- CMS will undertake a study on the activities in this category to see if/how clinical quality workflows and data capture are improving quality measure use – study participants to receive full credit (40 pts) for this category;
- New activities will be added in future rulemakings; parameters include improved outcomes, patient engagement and safety based on evidence, improvements in patient care or improvement in performance on quality/cost measures; and
- Nomination/call for activities will try to parallel call for quality measures.

Advancing Care Information – Contributes 25% to the composite score

- Comprised of a "base score," a "performance score," and a "bonus score"
  - ✓ Base Score requires reporting on five measures,[20] performance score requires choosing from three objectives and eight measures, including reporting on the Immunization Registry,[21] and bonus score allows for reporting to one or more public health/clinical data registries
- Mandatory attestation of good faith cooperation with ONC "direct review" of certified health IT
- Optional attestation of good faith cooperation with ONC-ACB "surveillance"[22]
- Mandatory attestation regarding compatibility and interoperability[23]

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[17] Total per capita costs for all attributed beneficiaries measure

[18] Only applied to EPs with a minimum case volume of 35 cases; The ten include (i) hip replacement/repair, (ii) knee replacement, and (iii) hip/femur fracture or dislocation treatment (inpatient based).

[19] Appendix Table H lists the activities and weighting for 2017 – little change from proposed rule; addition of Million Hearts model and clearer requirements related to PDMP consultation, and some weighting changes; Using

[20] This score is geared to e-prescribing, sending summary of care, requesting/accepting patient care record, and protecting patient privacy. Ten percent bonus score in this category for attesting to completing even one practice improvement activities using CEHRT functionality (i.e., meet 24/7 access practice improvement through CEHRT's secure messaging functionality), regardless of weight of the practice improvement measure. Group practices will need to aggregate data for all the individual EPs within the group for whom they have data in CEHRT. CMS will work with ONC in coming rulemakings to refine CEHRT capabilities to support group reporting.

[21] Geared to patient electronic access, coordination of care with patient engagement, and health information exchange;

[22] ONC-ACB (authorized certification bodies) "surveillance" = real world check on if certified health IT meets certification requirements in the real world (reactive and randomized)

[23] Mandatory attestation re (i) no knowing and willful action to limit or restrict compatibility or interoperability of certified EHR technology; (ii) implementing technologies, standards, policies and practices reasonably calculated to ensure certified EHR technology is connected, compliant with all standards related to exchange of information, implemented to allow timely access by patients and (iii) EP is engaging in secure trusted bi-directional exchange of

- CMS will zero out this category if there are not sufficient measures applicable and available for hospital based or non-patient facing clinicians; and[24]
- Clinicians using certified EHR technology (CEHRT) to complete certain practice improvement activities will get the EP a bonus in the advancing care category.

Alternative Payment Model (APM) Participating MIPS EPs (Group & Individual)
Not to be confused with advanced APMs (which starts below on the next page), CMS separately focuses on APMs that, while not meeting Advanced APM requirements, enable APM participation for their clinicians. In order not to duplicate or contradict reporting already required in these MIPS' APMs, CMS will give participants a score based on their participation that will translate to a MIPS payment adjustment. As long as APM participation is conditioned on payment incentives based on performance on cost/utilization and quality measures, CMS will align the performance periods and may assign different weights to the four performance categories as needed. MIPS' APM Entities will receive one score for their payment adjustment.

- If a Shared Savings ACO doesn't report quality measures, each ACO in the program can report their own directly to the MIPS program.
- The Shared Savings Program score will trump if EP is in more than one APM; the performance categories will be adjusted as follows:[25]
  - ✓ Cost zeroed out and weight is redistributed to advancing care and improvements categories. This will remain in effect until further rulemaking (not just for 2017);
  - ✓ Quality score will be zeroed out for 2017;
  - ✓ Improvements score will be based on each APM's own requirements and be published in advance for use by all APM Entities. If it is less than full credit, APM participants can submit through MIPS mechanisms for additional credit.[26]
  - ✓ Advancing care score will be based on APM participants' submissions into MIPS, and CMS will aggregate and weight each participant's submission and provide one APM Entity score for the category. Non submission will mean a zero score.
- APM Data Submission – submit quality data through APM processes; use MIPS submission mechanism if additional improvements data is needed and for advancing care data.

Rollout of the *Advanced* APM Approach. MACRA's alternative to a MIPS pathway to annual payment increases and penalties is the Advanced APM pathway. CMS outlines several principles related to this approach to earning annual payment adjustments. CMS will continue to build a portfolio of APMs designed to encourage participation by those entities "truly engaged in care transformation," i.e., those that will take financial risk for potential losses, are accountable for "meaningful quality metrics and use

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structured health information with other health care providers, including unaffiliated health care providers and with disparate certified EHR technology and vendors.

[24] Hardship exceptions also could support reweighting if (i) internet access is insufficient, (ii) extreme or uncontrollable situations like natural disaster cause access problem, (iii) 50% or more of EPs outpatient encounters occur in locations where they have no control over the health IT decisions of the facility (applications due annually by March 31 after the performance year.) They will be similarly zeroed out for non-physician practitioners (NPs, PAs, etc) for 2017, unless they choose to report such measures, in which case, they will be graded the same as other EPs.

[25] The same adjustments apply to Next Generation ACOs, except advancing care, where CMS will review all data submissions by APM entities (both individual and group EPs) and use the highest reported score and assign it to all participants/APM entities.

[26] Eligible clinicians participating in an APM Entity will receive a minimum of a 50% score in the clinical improvement category.

certified EHR technology." CMS will support multi-payer models, including Medicaid, minimize burden, and aim for seamless transition from MIPS participation to Advanced APMs. The agency specifically notes that Advanced APM participation will measure participants on their "relative degree of participation," not their performance within the APM.

Two Options for Qualifying as an Advanced APM Eligible Participant (QP)

- Medicare Advanced APM Option: For payment years 2019 and 2020, CMS will see if the clinician has a certain percentage of their Medicare patients or Part B payments flow through the Advanced APM;
- Other-Payer Advanced APMs – For payment year 2021, CMS can also qualify a QP that has a lower percentage of their Medicare patients or Part B payments flow through an Advanced APM, but has a greater percentage flow through an other-payer advanced APM.

In payment years 2019 to 2024, an advanced APM QP receives a bonus 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. The incentive payment base period is the preceding full calendar year. The APM Incentive Payment is made one year after the end of the incentive payment base period.[27]

Other Advanced APM Specifics. CMS will release an initial list of Advanced APMs before Jan 1, 2017.[28] Ad hoc notifications of advanced APM status will be provided as new APMs are rolled out, so CMS expects to see an increase in QPs (70-120,000 in 2017, increasing to 125-250,000 in 2018).

- A performance period/year will run from Jan 1-Aug 31 and CMS will make QP determinations three times during this period (March 31, June 30, and August 31).
- QPs include more than physicians[29] but cannot be MIPS EPs.
- If QPs miss their Advanced APM targets, they can, as Partial QPs, make an election to report MIPS, making the clinician or the entire practice (Advanced APM Entity group) subject to MIPS payment adjustments.
- Advanced APMs must require at least 50% of QPs in each APM entity to use Certified EHR Technology (CEHRT), must base payment for covered professional services on quality measures comparable to those in MIPS,[30] and must either require participants to bear more than nominal risk for monetary losses or meet certain Medical Home criteria.[31]

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[27] Financial risk payments are excluded from the calculation of incentive payment. CMS will calculate the incentive payment without consideration of any cash flow mechanisms.

[28] It expects the list will include the Comprehensive ESRD Care (CEC)—2-Sided Risk, Comprehensive Primary Care Plus (CPC+), Next Generation ACO Model, Shared Savings Program—Track 2, and the Shared Savings Program—Track 3.

[29] Non physicians can include PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dieticians or nutritional professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists, and a group that includes these professionals.

[30] Quality measures in advanced APMs must evidence based, reliable, valid, and at least one measure must be an outcomes measure, unless there is not an applicable outcome measure on the MIPS measures list at the time the APM is developed.

[31] CMS will include payments for Method II Critical Access Hospitals' (CAHs) professional services furnished by eligible clinicians in an Advanced APM Entity in the calculation of the payment amount method. Beneficiaries will be included in the patient count method if they receive Method II CAH

- CMS will establish an Innovation Center to review quality measures that are not NQF-endorsed and not on the MIPS measures list.
- The financial risk criteria is met when CMS can withhold or reduce payment to Entities or their eligible clinicians if actual expenditures for which an APM Entity is responsible exceed expected expenditures during a specific performance period.[32]
- Nominal risk means the APM Entity potentially owes or foregoes, in performance years 2017 and 2018, at least 8% of the average estimated total Medicare Parts A and B revenues of the participating Entities (revenue based standard) or owes or foregoes, in all performance periods, 3% of expected expenditures for which an APM Entity is responsible under the APM (benchmark based standard).[33]

Alternative Other-Payer Advanced APM Option Begins 2021

Starting in 2021, eligible clinicians may become QPs through the All-Payer Combination Option if: (1) the eligible clinician submits sufficient information on all relevant payment arrangements with other payers; (2) CMS determines that at least one of those payment arrangements is an Other-Payer Advanced APM; (3) clinician has sufficient payments or patients attributed to a combination of participation in Other-Payer Advanced APMs and Advanced APMs.[34]

Entities seeking approval as Other Payer Combination Option Advanced APMs must use CEHRT, payment must be based on quality measures comparable to those in MIPS, and the payment arrangement must either require (i) the entity to bear more than nominal financial risk if actual aggregate expenditures exceed expected expenditures, or (ii) the entity is a Medicaid Medical Home[35]

- Quality. Payments to Other-Payer Advanced APM Entities must be evidence-based focused, reliable, and valid quality measures, (including at least one outcome measure) that are MIPS quality measures or endorsed by a consensus-based entity.[36]
- Financial Risk. If the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period, payments for services to the APM entity or its' eligible clinicians are structured to be withheld, reduced, or returned to the to the payer.[37]

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professional services furnished by eligible clinicians in an Advanced APM Entity at Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs).

[32] For a Medical Home to be an advanced APM, the same criteria apply, although CMS has the additional option to deny the APM Entity all or part of an otherwise guaranteed payment. Starting in 2018, financial risk for Medical Home APM Entities that are owned and operated by more than 50 eligible clinicians would be the same as all other Advanced APMs.

[33] Nominal risk for Medical Home Advanced APMs is 2.5% of the APM Entity's total Medicare Part A and B revenue in 2017, increasing to 3, 4, and then 5% in 2018, 2019, and 2020 and later.

[34] CMS seeks comment on the possibility of establishing a process to prospectively engage in the design and review of payment arrangements to determine if they meet the criteria for being Other-Payer Advanced APMs, particularly regarding the assessment of Medicaid APMs.

[35] Medicaid Medical home for beneficiaries under title XIX and meeting criteria comparable to Medical Home models under Section 1115A.

[36] These measures can also have been developed under section 1848(s) of the Act, have been submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or be any other quality measures that CMS determines to have an evidence-based focus, reliable and valid.

[37] The same options must exist for a Medicaid Medical Home, as well as the ability to require the APM Entity to lose the right to all or part of an otherwise guaranteed payment(s).

- ✓ The payment arrangement must require APM Entities to bear financial risk for at least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.
- ✓ For episode payment models, expected expenditures are equal to the target price for an episode.
- ✓ Full capitation other payer advanced APMs automatically meet the risk standards.

- Nominal Risk. The payment arrangement's level of marginal risk must be at least 30 percent of losses in excess of the expected expenditures, and the maximum allowable MLR must be 4 percent.

Medicaid Medical Home Model

Medicaid Medical Home Models must include primary care practices or multispecialty practices that include a primary care physician and offer primary care services, enroll each patient with a primary care clinician, and have payment arrangements where at least 50 percent of participating eligible clinicians in each APM Entity use CEHRT to document and communicate clinical care. In addition, they must have at least four of the following: (i) planned chronic and preventive care, (ii) patient access and continuity, (iii) risk-stratified care management, (iv) coordination of care across the medical neighborhood, (v) patient and caregiver engagement, (vi) shared decision-making, or (vii) payment arrangements in addition to, or substituting for, FFS payments (e.g., shared savings).

- Nominal Risk. The minimum total annual amount that a Medicaid Medical Home APM Entity must potentially owe or forego to be considered an Other Payer Advanced APM must be at least 4 percent of the APM Entity's total revenue from the payer in 2019 and 5 percent in 2020 and beyond.

Physician-Focused Payment Models (PPFMs)

Definition of PFPM. PFPM require that (1) Medicare be included, but inclusion of other payers (i.e., Medicaid, commercial, etc.) is not precluded (2) MIPS EPs are participants and play a core role in implementing the APM's payment methodology, and (3) it target the quality and costs of services that eligible clinicians participating in the APM provide, order, or can significantly influence.

Criteria for PFPMs. PFPM criteria are organized into three categories that are consistent with the Administration's strategic goals for "achieving better care, smarter spending and healthier people:" (1) payment incentives; (2) care delivery; and (3) information availability. CMS finalized the following criteria from the proposed rule:

- Payment incentives:
  - ✓ Value over volume: provide incentives to deliver high-quality health care.
  - ✓ Flexibility: provide the flexibility needed for practitioners to deliver high-quality health care.
  - ✓ Quality and Cost: improve quality at no additional cost, maintain quality while decreasing cost, or both.
  - ✓ Payment methodology: use a payment methodology designed to meet PFPM criteria.
  - ✓ Scope: broaden and expand the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
  - ✓ Evaluation: have evaluable goals for quality, cost, and any other goals of the PFPM.\\
- Care delivery improvements:
  - ✓ Integration and Care Coordination: encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

- ✓ Patient Choice: encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- ✓ Patient Safety: aim to maintain or improve standards of patient safety.

- Information Enhancements:
  - ✓ Health Information Technology: encourage use of health information technology to inform care and guide decision-making.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
An 11-member federal advisory committee will provide independent advice PFPMs. Stakeholders can submit proposals to the PTAC on an on-going basis for PFPMs that meet the criteria above. CMS retains final decision making authority on which models to test and when, based on multiple factors that it would consider separately from the PTAC's comments and recommendations. CMS would, however, make its evaluation using the proposal submitted to the PTAC.

Regulatory Impact Statement – Payers and Providers Outside the Medicare Program
CMS noted that its Rule would have impact beyond health care services delivered to Medicare beneficiaries, but characterized these as "beneficial effects on a far broader range of patients in the health care system than simply Medicare patients, and we believe those effects would include improved health care quality and lower costs over time." The Agency acknowledged that it had "no basis at this time for quantifying such effects." CMS did not address the impact of its quality measures on health care decisions for non-Medicare patients. This is a significant opportunity for comment.

CMS Finalization of 2017 Quality Measures
There are many opportunities to comment in this "Final Rule with Comment Period." However, we want to make specific note of the agency's handling of quality measures for use in 2017. It appears that CMS' tight timeframe for publishing a Final Rule for January 2017 implementation precluded any meaningful consideration of comments on proposed quality measures. Stakeholders that submitted comments that were either not acknowledged or acknowledged without satisfactory resolution should consider this Final Rule with Comment Period an opportunity to reiterate any concerns so that issues can be appropriately resolved for the 2018 reporting year. The vast majority of quality measures were finalized as proposed, including:

- Measures with requests for modification that were finalized as proposed because CMS does not "own" the measure. CMS punted by stating that it will share the measure modification requests with the measure owner, while finalizing for now and noting changes could be made in the future.
- CMS-owned measures with recommendations for modification. CMS again punted by stating that it would finalize the measure as proposed and that comments have been "shared w/ our technical expert" and may be tested later;
- Measures that commenters urged CMS to remove from the quality measure set were uniformly finalized as proposed.

There are over 200 pages of tables in the Final Rule with Comment dedicated to quality measures. Connect 4 Strategies is evaluating measures for individual organizations specific to their areas of focus, and related opportunities to comment and develop measures that meet CMS outlined criteria.