Saira Sultan, JD

6005 Gloster Road
Bethesda, MD 20816
(202) 360-9985
saira.sultan@connect4strategies.com

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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 – Executive Summary of Proposed Rule for Performance Year 2018

On July 20, 2017, the Centers for Medicare & Medicaid Services (CMS) released its Proposed Rule implementing the second full year of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The policies announced in this rule refine a process that began, albeit slowly, last year and will eventually transform how clinicians (beyond just physicians) will get paid for their medical-benefit professional services within a system of winners and losers. After reviewing comments (due in August 2017), CMS will issue a Final Rule that will be implemented January 1, 2018.

Clinicians continue to have a choice of two paths to get their annual "adjustments" (raises, bonuses, penalties). The first – the Medicare Incentive Payment System (MIPS) -- requires reporting on the quality measures clinicians 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 MIPS and MIPS APM option are set out in greater detail below. 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. The Advanced APM option is set out below as well. Low-volume (Medicare) clinicians do not have to participate, and this year, CMS proposed to raise the low-volume threshold, exempting more clinicians from this program for now.

CMS continues to roll out this program, officially called the Quality Payment Program (QPP), slowly and iteratively, both from the clinician side as well as the CMS side. There is an enormous amount of detail, with exceptions and alternatives at every turn, in this 1000+ page proposal. We have collapsed much of the detail into endnotes, to ensure the basic themes and structure are clear.

All eligible clinicians will have to take some action in 2018 to avoid a negative payment adjustment penalty (or receive a positive payment adjustment) in 2020. While the two-year lag between performance and payment impact may reduce clinician perceptions of urgency, the at-risk numbers – i.e., 4-5% of Medicare Part B billings – are significant.

We are excited to note CMS responded with action on many of our clients' comments last year, including recognizing the unique needs of complex patients and adopting measure language that underscores the importance of patient goals and priorities in care planning.

Patient groups should read carefully, and comment on the details of how and what clinicians are incented to provide in terms of practice improvements, adherence to quality measures, and health IT that better connects them to their care. Life science companies will likely want to review and comment with an eye towards appropriate quality measures and the new call for measures CMS proposes.

Treatment decisions will surely be impacted by this program, so timely proactive engagement and clear, concise reporting protocols 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 1000 pages down to 8, and is working with stakeholders on particular details and specific provisions that offer them greatest opportunities and/or risk as they prepare to weigh-in in response to CMS' call for comments.   We have reviewed the various tables in the proposed rule to ensure our clients are aware of specific quality measures, improvement activities, etc. that are of direct interest to their portfolios and patients.

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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 Proposed Rule for Performance Year 2018

BACKGROUND
On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) released a 1,058-page proposed rule (display version) that sets out proposals on implementing Year 2 of the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA) law. CMS proposes continuing its slow roll-out, letting doctors report a limited amount of quality data in order to avoid MACRA's "negative adjustment" penalties. It also proposes a "virtual group" option, raises the low-volume threshold so fewer clinicians would be subject to the program, increases flexibility for clinicians who do not see many patients face-to-face, and delays a requirement that clinicians use 2015 certified EHRs (although suggests a bonus for doing so). The agency also proposes to zero out for another year the cost/resource use category for measuring performance.

There remains a two-year lag between physician performance and physician payment updates. The first performance year under QPP was 2017, which kicked off a phased-in approach to the program. This proposed rule and comment period continues this gradual implementation for performance year 2 in 2018, and appears to respond to stakeholder comments on last year's proposed and final rules. Comments are due August 21, 2017 by 5pm EST.

INTRODUCTION
The overarching goal of the QPP is to calculate annual payment updates for clinicians based on their resource use, improvements in their practices, use of electronic health records (EHRs) and other health IT, and quality measures. The MACRA program continues to offer clinicians a choice between the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APM) paths for participation, the latter being more lucrative, earning clinicians a 5 percent bonus if they are willing to bear financial risk. The two MIPS options – MIPS (p. 3) and MIPS APM (see p. 7) – and the Advanced APM option (see p. 9) are detailed below.

MIPS PROGRAM PARTICIPATION

MIPS Eligible Clinicians include physicians, PAs, NPs, clinical nurse specialists, certified nurse anesthetists, and group practices who can participate in MIPS or a MIPS APM. <u>The MIPS payment adjustment only applies to the amount paid under Part B;[1] however, clinicians report on care provided to ALL patients.[2]</u>

There are some specific rules governing group practices,[3] small practices,[4] non-patient facing clinicians,[5] and rural area clinicians and health professional shortage areas.[6]

ACSs[7], HHAs, and HOPDs have their Part B items and services counted towards MIPS to the extent they are not billed by the facility. CMS proposes that if there is sufficient billing by the facility (instead of the clinician) to qualify the clinician under the low volume threshold, then MIPS updates will not apply.[8]

Virtual Groups**.** CMS proposes combination of solo practitioners and groups with 10 or fewer eligible clinicians (with at least one other MIPS eligible clinician/group) can, for a given performance period, be assessed and scored collectively. Only those in the group that meet the definition of a MIPS eligible clinicians would qualify for the payment adjustment. CMS solicits comment on its approach of not establishing any geographic or other classifications.[9]

Low Volume Threshold. CMS proposes to modify the threshold to exclude clinicians from QPP if Medicare Part B allowed charges are less than 90,000 (instead of $30,000 in 2017) or if they provide care to fewer than 200 Part B enrolled beneficiaries (instead of 100 in 2017).[10] This will reduce to 65 percent the Medicare payments captured under MIPS, compared to 72.2 percent for CY 2017.

MIPS PERFORMANCE CATEGORIES
Performance remains based on four categories: (a) quality measures, (b) cost, (c) practice improvement, and (d) advancing care information.

Generally -- Payment updates in 2020 are dependent on performance in 2018. CMS proposes allowing clinicians to report measures and activities via multiple data submission mechanisms so as not to artificially drive clinicians to the easily reportable ones.

The proposed rule states an additional amount in government outlays for exceptional performance payment adjustments under MIPS ($500 million), and incentive payments to QPs (approximately $590-$800 million, for APM clinicians).

Quality Measures

1. No changes proposed to the reporting of quality measures by individual clinicians or for groups reporting via the CMS Web Interface.[11]
2. CMS proposes requiring performing/reporting on quality measure data for a full calendar year (up from 90 days).
3. CMS proposes to maintain the 50% data completeness criteria for 2018, deferring the ramp-up to 60% to 2019.[12] No change proposed to the 2017 requirement that MIPS clinicians report at least one outcome measure, or if an outcome measure is not available, one high priority measure.
4. CMS also proposes an Annual Call for Measures, with a two-year implementation timeline to accommodate a pre-rulemaking process and NQF Measure Application Partnership review.

Cost/Resource Use
CMS proposes another performance year with weight of zero for this category.

Practice Improvement

CMS will continue to incentivize health IT, telehealth, and connection of patients to community based services, and will continue to allow for a bonus in this category when clinicians use functions included in the CEHRT to complete eligible activities from the Improvement Activities Inventory.

1. Maintain weight of 15 percent, with automatic full credit (40 points) for certified or recognized patient centered medical homes.[13]
2. Report two high weight or four medium weight activities for full credit;[14] for a minimum reporting period for one improvement activity of 90 days and maximum of 12 months.
3. CMS proposes to formalize an Annual Call for Activities,[15] with submissions due by March 1 before the following participation year.

Advancing Care Information

1. 25% weight to this category,[16] made up of a base score (no proposed changes), performance score, and potential bonus points.
2. Performance score based on reporting the Immunization Registry Reporting Measure, but if not available, then allows points for each public health agency or clinical data registry to which the clinician reports for several other measures.[17] Bonus points for reporting to another/different public health agency or clinical data registry.
3. CMS proposes to allow reporting through the 2014 Edition CEHRT (Certified EHR Technology) in 2018, but proposes a 10 point bonus for using only the 2015 Edition. This would increase the number of bonus points clinicians could earn from 15 to 25.
4. Minimum of 90 consecutive days of data, prefer a performance year of data for performance year 2018 and 19.
5. Example of measure -- Provide Patient Access Measure: The number of patients in the denominator (or patient authorized Representative) provided timely[18] access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.
6. Minimum reporting period for one improvement activity of 90 days and maximum of 12 mos.[19]
7. This category will be zeroed out for those that don't have control over their EHR systems, or where there aren't applicable measures.[20]
8. Group practices must aggregate their performance data across the TIN.[21]

Finalized and Proposed Weights for Performance Category Score Calculation

Performance Category	**Performance Yr. 2017[22]**	**Performance Yr. 2018**	**Perf. Yr. '19 & Beyond**
Quality	60%	60%	30%
Cost	0%	0%	30%
Practice Improvement	15%	15%	15%
Advancing Care Info	25%	25%	25%

MIPS SCORING

Proposed modifications for the 2020 MIPS payment year include -- adjusting scoring for measures that do not meet the data completeness criteria, and adding methods for scoring (i) measures submitted via multiple mechanisms, (ii) selected topped out measures, and (iii) improvement.

Quality Performance Category Criteria

CMS proposes to retain the policy to assign zero points for failing to submit a measure that is required.[23]

Note: To receive a quality performance category improvement percent score greater than zero, CMS proposes that

clinicians must fully participate in MIPS, i.e., submitting 6 measures, including 1 outcome measure (if an outcome measure is available) or 1 high priority measure (if an outcome measure is not available), and meet the 50 percent data completeness criteria for each of the 6 measures. Improvement score focuses on measures, not on bonus points. Improvement scores cannot be negative.

Topped Out Measures
Based on 2015 benchmark data, approx. 45 percent of the quality measures benchmarks currently meet the definition of topped out.[24] CMS proposes that after a measure benchmark is identified as topped out for 2 years, it will be considered for removal through notice-and-comment rulemaking or the QCDR approval process, and it may be removed in the fourth year.[25]

Benchmarks
CMS seeks comment on whether to broaden the criteria for creating MIPS benchmarks to include PQRS and any data from MIPS, including voluntary reporters, that meet criteria, and whether to stratify benchmarks by practice characteristics such as specialty or practice setting.

Cost Performance Category
The Agency proposes to weight the cost performance category at zero percent for the 2018 performance year,[26] but will calculate clinician scores and provide feedback for informational purposes. CMS proposes to not calculate a cost performance category score if a MIPS eligible clinician or group does not have cost measures or has not met the case minimum requirements. Improvement would be assessed at the measure level.

CMS proposes facility-based scoring options for Quality and Cost categories,[27] as well as some bonus point options.[28]

MIPS PERFORMANCE THRESHOLDS
CMS proposes to increase the threshold from 3 points to 15 points (out of 100) in Performance Year 2018. CMS seeks comment on whether this strikes the balance between continuing to encourage participation while maintaining flexibility. Also proposed is a 70 point exceptional performance threshold, requiring clinicians to report in more than one category.[29]

> Examples: Eligible clinicians (individual, group, or virtual group) that submit the maximum number of practice improvement activities could qualify for a score of 15 points.[30] Similarly, submitting all required quality measures with the necessary data completeness would earn a quality category score of 30%.[31]

MIPS PERFORMANCE FEEDBACK
CMS proposes to provide feedback at least annually to participating clinicians on quality and cost categories for the 2017 performance year, and if technically feasible, on all four categories.[32]

CMS proposes to loosen restrictions on third party intermediaries submitting data on behalf of clinicians,[33] so long as they certify the information. CMS proposes no changes to definitions, capabilities, criteria, self-nomination, and renewal of Qualified Clinical Data Registries (QCDRs).[34] Of note, QCDRs can report on each other's' measures with permission and can report on MIPS measures as well.

PUBLIC REPORTING ON CLINICIANS on PHYSICIAN COMPARE WEBSITE

CMS proposes to extend indefinitely the reporting of MIPS clinicians' final score, as well as scores for each performance category (along with aggregate information for comparison).[35]

1. Specific **quality** measures will not be public in the first year and will only be posted as a list.
2. CMS seeks comment on publicly reporting on five open-ended questions related to patient experience in patients' own words.[36]
3. CMS proposes to post only a subset of **cost** measures, recognizing that it is statutorily mandated but difficult for patients to understand/interpret.
4. All **improvement** activities are proposed to be reported, including for the first time, all first year activities;
5. CMS will again list an indicator for successfully meeting the **advancing care** information category, as well as indicators such as high performance in patient access, care coordination and patient engagement, or health information exchange. CMS proposes to include reporting on first year activities.
6. CMS proposes use of a **benchmark** methodology already validated and finalized for use in assigning stars for the Physician Compare 5-star rating to determine a five star rating for each MIPS measure where feasible/appropriate.
7. Finally, CMS seeks comment on accounting for social risk factors of patients and board certification information of clinicians on the site.[37]

MIPS APMs

APM Eligibility. A MIPS APM must have APM Entities that (i) participate under an agreement with CMS or by law/regulation, (ii) include at least one MIPS eligible clinician, and (iii) base payment incentives on cost/utilization and quality measures.

CMS proposes adding the Comprehensive ESRD Care Model, the Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model (OCM) to "Other MIPS APMs."

Quality Measures in MIPS APMs -- Weighted at 50%

1. CMS proposes to begin collecting MIPS APM quality measure performance data beginning in 2018. The Proposed Rule lists the complete set of proposed quality measures that the various MIPS APMS might include in their reporting.
2. Shared Savings Program and Next Generation ACO Model are MIPS APMs that use the CMS Web Interface to submit data on quality measures (which are also MIPS measures for 2017). CMS proposes to add reporting/scoring of the CAHPS for ACOs survey for these two ACOs.
3. Incentives to Report High Priority Measures -- CMS proposes adding two bonus points for reporting two or more outcome or patient experience measures, and one bonus point for reporting any other high priority measure (beyond the first high priority measure).

Calculating the Quality Performance Category Percent Score for MIPS APMs

1. For 2018, CMS proposes APM-specific quality measures with scoring only on measures that: (1) are tied to payment as described under the terms of the APM, (2) are available for scoring near the close of the MIPS submission period, (3) have a minimum of 20 cases available for reporting, and (4) have an available benchmark.[38]
2. <u>A MIPS APM Entity's total quality performance category score would be: [(achievement points + bonus points)/ total available achievement points] + quality improvement score.</u>
3. If a MIPS APM does not have to report on quality measures, CMS proposes to weight the category at zero – and reweight the improvement activities to 25 percent and advancing care information to 75 percent.[39]
4. CMS proposes adding a Quality Improvement Score[40] equal to (Absolute Improvement/Previous Year Quality Performance Category Percent Score Prior to Bonus Points)/10.

CMS proposes scoring improvement from year to year so that (i) quality score is based on measure improvement at the performance category level and (ii) cost score is based on measure improvement at measure level.[41] CMS offers no details on how to calculate improvements for practice improvement activities or advancing care information in this rule, but may address later.

Cost Category – Weighted to 0%

Improvement Activities – Weighted to 20%

CMS proposes assigning the same improvement activities score to each APM Entity (based on the activities of each participating clinician).

Advancing Care Information – Weighted to 30%

CMS proposes to simplify and attribute the same score to each clinician in the APM Entity group. Scores attributed to each MIPS eligible clinician will be averaged for a single APM Entity score.

Complex Patient Bonus

CMS seeks to implement a short-term strategy to address the impact patient complexity may have on final scores to (a) protect access to quality care for complex patients and (b) avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage. CMS proposes the bonus only for the 2018 MIPS performance period and will assess each year whether or not to continue it. The Agency identified two potential indicators for complexity: medical complexity (as measured through Hierarchical Condition Category (HCC) risk scores), and social risk as measured through the proportion of patients with dual eligible status.

A mean HCC risk score for a MIPS eligible clinician can be calculated by averaging the HCC risk scores for the beneficiaries cared for by the clinician. In addition to medical complexity, patient complexity includes social risk factors – a ratio of beneficiaries seen by a MIPS eligible clinician who are dual eligible can be calculated using claims data. CMS proposes to add a complex patient bonus to the final score for the 2020 MIPS payment year for MIPS eligible clinicians that submit data (as explained below) for at least one performance category. CMS would calculate an average HCC risk score for each MIPS eligible clinician or group, and use that average HCC risk score as the complex patient bonus. HCC risk scores for beneficiaries would be calculated based on the calendar year immediately prior to the performance period, and the bonus would not exceed 3%. The bonus would range from 1.16 points in the first quartile based on HCC risk scores to 2.49 points in the fourth quartile for individual reporters.

CMS seeks comment on an alternative complex patient bonus methodology of utilizing dual eligible status.

Small Practice Bonus

CMS noted that MIPS eligible clinicians in small practices consistently have a lower combined impact performance than larger practices based on actual historical data. They proposed that small practice clinicians submitting data on at least one performance category in the 2018 MIPS performance period would be eligible for a bonus of 5 points added to the final score. The bonus is intended to be a short-term strategy to help small practices transition to MIPS, and would apply to 2018 performance year and be re-evaluated in future years.

CMS also seeks comment on the need for a rural area practice bonus in future years.

Physician-Focused Payment Models (PFPMs)

CMS seeks comment on whether to broaden the definition of PFPM to include payment arrangements involving Medicaid or the Children's Health Insurance Program (CHIP) as a payer, even if Medicare is not a payer.

Virtual Groups

CMS solicits comment on virtual group election through a separate Federal Register Notice (82 FR 27257) published on June 14, 2017. Comments on the Virtual Group Notice are due on or before August 14,

2017.

ADVANCED ALTERNATIVE PAYMENT MODELS (Advanced APMs)

Financial Risk -- Perhaps the most significant way in which Advanced APMs differ from MIPS APMs is that the former requires clinicians to bear more than nominal financial risk. CMS proposes to set this nominal risk as a percent of Medicare Parts A and B revenue – 2% in 2018, increasing annually in one percent increments until it reaches 5% in 2020. The Medical Model Home Advanced APM can only participate if it has fewer than 50 eligible clinicians in its parent organization.

Qualifying APM Participant (QP) and Partial QP Determination -- CMS proposes that QPs participate for a minimum of 60 days,[xlii] but for QPs participating in multiple Advanced APMs, use the full Medicare QP Performance Period.[xliii]

Other Payer APMs

- The same risk sharing requirements exist with Other Payer APMs.
- Other Payer arrangements meet risk sharing requirement if, in the 2019 and 2020 All Payer QP Performance Periods, the APM Entity potentially owes the payer (or foregoes) at least 8 percent of the total combined revenues from the payer;
- To be an Other Payer Advanced APM, a Medicaid Medical Home Model must require the total annual amount owed/foregone must be at least 3 percent of the APM Entity's total revenue from the payer for the All-Payer QP Performance Period in 2019.[xliv]
- Payer attestation of accuracy to be replaced with clinicians/APMs certification that information submitted is, to the best of its knowledge, true, accurate, and complete. Replace record retention requirement with requirement to maintain auditable records. QP determinations must be requested under the All-Payer Combination Option[xlv] and made at the individual eligible clinician level only.[xlvi]

ENDNOTES

[1] No changes proposed to scaling, budget neutrality, or other adjustment factors. Also, CMS clarifies items or services provided by suppliers cannot be traced back to the clinician, and may be excluded in making eligibility determinations or payment adjustments.
[2] For example, if a clinician applies relevant quality measures or uses health IT in caring for Medicare, Medicaid, or commercial patient, it counts towards the work they report for their payment update; however, the update amount – i.e., 5% increase – is calculated off that clinician's Part B payments.
[3] CMS clarifies that a group practice is an entire single TIN or portion of a TIN that participates in MIPS, while any remaining portion of the TIN is participating in a MIPS APM or Advanced APM, and chooses to participate as a group.
[4] This categorization is relevant to access to technical support, different criteria for improvement activities, hardship exception under the advancing care information category, and the small practice bonus for the final score. Examples – quality measure achievement points for each quality measure even if the measure doesn't meet data completeness standards; significant hardship exception would transfer advancing care category weight to quality category, raising that category's weight to 85% of the final score; special scoring for practice improvement activities, small practice bonus; CMS proposes to replace the 2017 attestation test with using claims data for a four month period ("small practice determination period") far enough out to let practices know before each performance year if they qualify for the next performance year. CMS seeks comment on the determination period methodology. Qualifying as a small practice kicks in several special scoring rules.
[5] CMS will once again provide a list of patient facing encounter codes to determine non-patient facing status (and proposes using a 24-month non-patient facing determination period during which to reviews claims). The Advancing Care Information category is weighted at zero for non-patient facing status EPs and group practices.
[6] They receive full credit for the Practice Improvement activities if they report one high-weighted and two medium weighted activities. CMS proposes defining rural areas as those with zip codes categorized by HRSA's resource file. Where clinicians have multiple office locations, CMS proposes the threshold is met if 75 percent of the NPIs billing under the individual MIPS clinician/group's TIN or virtual group are in the HRSA designated rural zip codes.
[7] CMS proposes to define an ASC-based MIPS eligible clinician as one who furnishes 75 percent or more covered professional services in Place of Service (POS) code 24 based on claims for a period prior to the performance period. ASC-based determination will be made independent of the hospital-based determination. ASC-based MIPS eligible clinicians would get zero percent weighting to the advancing care information performance category, but can report on measures and have standard weighting if they choose to do so.
[8] ASC=Ambulatory Surgery Centers; HHA=home health agencies; HOPD=hospital outpatient department; No changes proposed for clinicians practicing in Method I or II Critical Access Hospitals. MIPS program also does not apply to rural health clinics or federally qualified health centers, but they can voluntarily report.
[9] CMS proposes to identify each eligible clinician participating in a virtual group have a unique participant identifier. And to generally apply finalized and proposed group policies to virtual groups. In addition, virtual groups must declare their intention to participate in this way by the Dec. 1 prior to the participation period and cannot change that election for one year. CMS proposes details for technical assistance for electing, forming, implementing and reporting as a virtual group.
[10] This proposal will exempt approximately 134,000 additional clinicians from MIPS from the approximately 700,000 that would have been eligible under the CY2017 threshold. Almost half of the additionally exempt are small practices and about 17 percent are in designated rural areas.
[11] However for groups electing to report Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey, CMS proposes to shift the survey administration period to eight weeks ending no later than Feb 28th after the performance year. Further, CMS proposes removing measures related to taking medication as directed (due to low reliability) and between-visit communications.

[12] CMS does seek comment on a methodology and timeline for removing topped out measures and outcome and non-outcome measures that cannot be reliably scored.
[13] At least 50% of the practice sites within the TIN must be recognized as patient centered medical home (this is a proposed increase over just one site in 2017); The Comprehensive Primary Care Plus (CPC+) APM design qualifies as a medical home (and also an Advanced APM).
[14] Small practices, rural area or geographic HPSAs or non-patient facing clinicians/groups to report one high-weighted or two medium weighted activities, or a 50% score for reporting one-half of a high weighted or one medium weighted improvement activity.
[15] Criteria for nominations include relevance to existing activities, importance of an activity toward achieving improved outcome, reduce disparities, align with patient centered homes, etc.
[16] CMS has authority to reduce this to 15%, and invites comment on using 2017 performance period data to estimate the proportion of physicians who are meaningful EHR users for purposes of reweighting this category for the 2021 payment year (a four year lag).
[17] Syndromic Surveillance Reporting, Electronic Case Reporting, Public Health Registry Reporting, and Clinical Data Registry Reporting;
[18] Beginning with the 2018 performance period, "timely" means w/in 4 business days.
[19] There are numerous exclusions and exceptions for reach measure that account for circumstances like patients being transferred to other clinicians, patients not having internet access, etc. For practices of 15 or fewer clinicians, CMS proposes a 'significant hardship' exception so that the category reweights to zero; CMS asks what other categories of clinicians may need such an exception.
[20] Clinicians like those in an off-campus outpatient hospital likely have no control over EHR systems; NPs, PAs, etc. may not have relevant measures to choose from;
[21] Clinicians eligible for 0% weighting would lose that exception if reporting within a group practice.
[22] Performance Year 2017 (PeY17) impact payment update on Part B items and services in Payment Year 2019 (PaY19). Two year lag. CMS outlines the rare circumstances in which a clinician is unable to find a relevant quality measure or there are extreme and uncontrollable circumstances. Although CMS believes this will be rare, they propose and seek comment on how to redistributing weight of any one category across the others.
[23] In extremely rare cases, where there are not sufficient measures for the clinician, CMS may reweight their score.
[24] Approximately 70 percent of claims measures, 10 percent of EHR measures, and 45 percent of registry/QCDR measures are topped out.
[25] CMS plans to phase in special scoring starting with the 2018 MIPS performance period so that in the 2nd year, topped out measures would have a 6-point cap. Six measures would have the 6-point cap in the 2018 performance year.
[26] Although CMS will calculate a cost improvement score, it will be informational only/not contribute points for the 2020 payment year.
[27] CMS proposes facility-based measures would all the measures adopted for the FY 2019 Hospital Value Based Purchasing (VBP) Program on the MIPS list of quality measures and cost measures., and seeks comments on what other programs it should consider in future program years.
A clinician would be eligible for facility-based measurement if they furnished 75 percent or more of their covered professional services in an inpatient hospital or an emergency room or if they are part of a group w/ 75 percent or more clinicians eligible as facility-based. The value based purchasing score of the hospital in which the clinician saw the most Medicare patients would be used.
CMS seeks comment on whether it should automatically calculate facility-based scores for eligible clinicians, or have a voluntary application process.
[28] MIPS eligible clinicians that report on quality measures are eligible for bonus points for reporting additional outcome and high priority measures beyond the one that is required. 2 bonus points are awarded for each additional outcome or patient experience measure, and 1 bonus point is awarded for each additional other high priority measure.

[29] The quality category maximum is 60 points; submitting full data for the other two categories would not be enough for this higher threshold without also submitting some quality category data.
[30] 40 out of 40 possible points, which is worth 15% of the final score.
[31] A quality performance category score of 30% is three measure achievement points out of 10 measure points for each required measure. Weighted at the proposed 60%, the 30% earned x 60% weight x 100 = 18 points and exceeds the proposed performance threshold of 15 points. Another example using the advancing care category, a score of 15 points could be earned by achieving a 60% category score x 25% weight x 100.
[32]Feedback for MIPS APMs as technically feasible. Similar feedback to those voluntarily submitting data although not qualified for MIPS; Also CMS seeks input on IT and third party intermediaries as mechanisms for feedback, receipt of information, types of information, data validation and auditing, recoupment of incorrect payments.
[33] Third party intermediaries are qualified registry, qualified clinical data registry (QCDR), health IT vendor or other third party that obtains data from clinician's CEHRT, or a CMS approved survey vendor. In response to comments, CMS proposes to make a list of approved vendors available to MIPS participants earlier. CMS also proposes rules for disqualifying and auditing third party intermediaries.
[34] CMS proposes no changes to definition, capabilities, qualifications, self-nomination of other qualified registries, although it proposes to simplify renewal of their status.
[35] Once determined to meet reliability threshold and public reporting standards;
[36] AHRQ is beta testing the questions; they would be for CAHPS for MIPS survey on the site, and not for 2018 but future rulemakings
[37] This request includes information on which boards, a process for consideration.
[38]CMS proposes if an APM Entity submits some, but not all measures required by the MIPS APM, the APM Entity would receive points for the measures submitted, but would receive a score of zero for each remaining measure. If an APM Entity reports on more than the minimum number of measures, only the measures with the highest scores (up to the number of measures required) would be counted, but additional measure reporting could earn bonus points.
[39] If the advancing care information performance category is reweighted to zero, the quality performance category weight would be increased to 80 percent.
[40] Quality Improvement Score equal to (Absolute Improvement/Previous Year Quality Performance Category Percent Score Prior to Bonus Points)/10.
[41] Since cost category weighting is zero for 2018 performance year, the improvement score would be informational.
[xlii] Using only the dates that APM Entities were able to participate in the Advanced APM per the terms of the Advanced APM, not the full Medicare QP Performance Period; To establish the Al -Payer QP Performance Period, beginning on January 1 and ending on June 30 of the calendar year that is 2 years prior to the payment year.

[xliii] Clarify that if eligible clinician is determined to be a QP based on participation in multiple Advanced APMs, and any APM in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP.
[xliv] 4 percent in 2020 and 5% in 2021.
[xlv] Eligible clinicians must submit payer payment amount and patient count data from other payers to support the determination;
[xlvi] Eligible clinicians who are Partial QPs under the All-Payer Combination Option would make the election whether to report to MIPS and be subject to MIPS reporting requirements and payment adjustments.