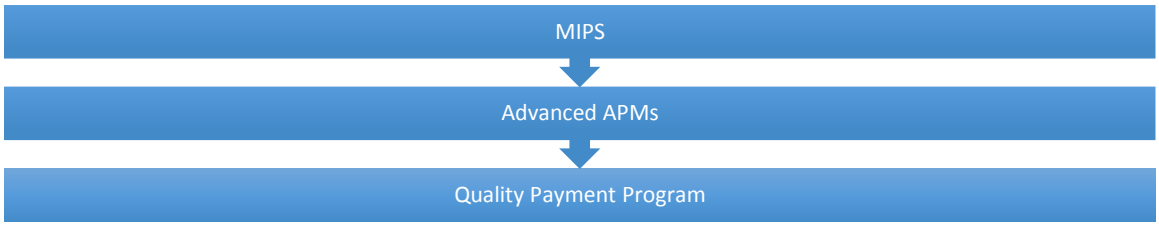
Proposed Rule: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

The Department of Health and Human Services issued a proposed rule to implement certain provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The proposed rule sets forth requirements for CMS' "Quality Payment Program," which provides two paths for tying PFS payments to quality, through the Merit-based Incentive Payment System (MIPS) or through Advanced Alternative Payment Models (APMs). Comments on this proposed rule are due June 27, 2016.

Quality Payment Program



Merit-Based Incentive Payment System

The MIPS streamlines the following quality programs into one: The Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program.

A MIPS eligible clinician would be assessed according to their performance under the following four categories:

1. **Quality Performance Category** — **50 Percent**
2. **Advancing Care Information Performance Category** — **25 Percent**
3. **Clinical Practice Improvement Activity (CPIA) Category** — **15 Percent**
4. **Resource Use Performance Category** — **10 Percent**

Proposed MIPS Timeline	
January 1, 2017	MIPS performance period begins
June 30, 2017	Registration for group practices electing to use the CMS web interface or to report the MIPS for CAHPS survey
July 1, 2017	CMS distributes 1st feedback report
December 31, 2017	MIPS performance period ends
March 31, 2018	Data submission deadline for qualified registry, QCDR, EHR, and attestation submission mechanisms. Deadline to submit claims to be processed.
July 2018	2nd feedback report Targeted review based on 2017 MIPS performance.
January 1, 2019	First MIPS adjustment in effect (based on performance in 2017)

Payment Adjustment Amounts. MIPS Composite Performance Scores (CPS) will be used to assess a positive, negative, or neutral payment adjustment to eligible clinicians' Part B payments. The maximum negative adjustment and generally the maximum positive adjustment a MIPS eligible clinician may receive under the MIPS is as follows:

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Who participates in the MIPS? Is anyone excluded from participating in the MIPS?
ALL Medicare Part B clinicians are subject to the MIPS. This includes:
- Physicians (MD/DO and DMD/DDS)
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

The Secretary may expand the definition of eligible clinicians to include physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians/nutritional professionals.

A MIPS eligible clinician may be excluded from the MIPS if any of the following apply:
- The MIPS eligible clinician is newly enrolled in Medicare (according to PECOS)
- The MIPS eligible clinician or group has less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients
- The MIPS eligible clinician is significantly participating in an Advanced Alternative Payment Model (APM)

Although these eligible clinicians are proposed to be excluded from MIPS, CMS proposes to allow these clinicians the option to voluntarily report measures and activities for MIPS.

Participation in the MIPS as an individual vs. Group Practice. For purposes of assessing a payment adjustment under MIPS, CMS proposes to use a single identifier, TIN/NPI, for applying the payment adjustment, regardless of how the clinician is assessed.

Group Practice. Under the MIPS, a group practice would be defined as a single Taxpayer Identification Number (TIN) with two or more MIPS eligible clinicians, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. If a group decides to report as a group practice, the eligible clinicians in the group practice MUST report across all four performance categories as a group. There is no requirement to register to participate in the MIPS as a group practice, unless the group chooses to use the CMS web interface or to report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Virtual Group Practice. CMS is not proposing to implement a virtual group practice option for the 2017 Performance Period. CMS plans to establish a web-based registration system for the 2018 Performance Period.

Performance Period. The performance period for the 2019 MIPS adjustment, the first adjustment that will be assessed under the MIPS, is CY 2017: January 1, 2017 through December 31, 2017.

Data Submission. CMS proposes to allow MIPS eligible clinicians to use multiple mechanisms. However, they must use the same identifier for all performance categories and, generally, they may only use one submission mechanism within each category. For example, a clinician could submit quality measures via claims and CPIA data via attestation, but a MIPS eligible clinician could not use two submission mechanisms for a single category such as submitting three quality measures via claims and three quality measures via registry. 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 claims mechanism, the submission deadline would occur during the performance period with claims required to be processed no later than 90 days following the close of the performance period.

Proposed Data Submission Mechanisms

Performance Category	Data Submission Mechanisms (Individual)	Data Submission Mechanisms (Group Practice)
Quality	Claims QCDR Qualified Registry EHR ----- ----- Administrative Claims***	----- QCDR Qualified Registry EHR CMS Web Interface* CMS-approved survey vendor for CAHPS for MIPS** Administrative Claims***
Resource Use	Administrative Claims***	Administrative Claims ***
Advancing Care Information	Attestation QCDR Qualified Registry EHR -----	Attestation QCDR Qualified Registry EHR CMS Web Interface*
Clinical Practice Improvement Activity (CPIA)	Attestation QCDR Qualified Registry EHR Administrative Claims***	Attestation QCDR Qualified Registry EHR Administrative Claims***

** Only available for groups of 25 or more.*
*** Must be reported in conjunction with another data submission mechanism.*
**** No submission required; CMS will calculate automatically.*

Quality Performance Category

The quality performance category of the MIPS replaces the PQRS and the quality component of the VM.

Criteria and Measures. CMS has proposed over 200 measures available for reporting data under the quality performance category. In addition, CMS has proposed specialty-specific measure sets, such as the electrophysiology cardiac specialist measure set. For reporting options other than the Web Interface (where the group practice would be required to report on all the measures available under the Web Interface), clinicians and groups will have to select their measures from either the list of all MIPS measures or a set of specialty-specific measures. MIPS eligible clinicians will be scored on these measures based on benchmarks created based on a baseline period. For previously existing measures, the baseline period would be two years prior to the performance period.

If the MIPS eligible clinician opts to select measures from the broad measure set, CMS proposes that the clinician report six measures for either 80% of applicable Medicare patients (for claims) or 90% of ALL payer applicable patients (for QCDR, registry, and EHR). Of those 6 measures, the clinician must report on at least one cross cutting measure and at least one outcome measure or other high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination).

If a clinician opts to report on a specialty-specific measure set, the clinician would report on at least six measures within the set. In instances where a specialty set includes less than 6 measures, clinicians would report on all of the available measures, including an outcome measure or other high priority measure, within the set, as well as a cross-cutting measure. The electrophysiology cardiac specialist measure set only includes three measures, all of which are outcome measures. MIPS eligible clinicians and groups reporting on this set would report on all three measures, as well as a cross-cutting measure.

Measures that do not meet the required case minimum or do not have a benchmark are not used for scoring.

Electrophysiology Cardiac Specialist Measure Set

NQF/ PQRS	Data Submission Method	Measure Type	NQS Domain	Measure Title and Description	Measure Steward
N/A/ 348	Registry	Outcome	Patient Safety	HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD	The Heart Rhythm Society
2474 /392	Registry	Outcome	Patient Safety	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation This measure is reported as four rates stratified by age and gender: • Reporting Age Criteria 1: Females less than 65 years of age • Reporting Age Criteria 2: Males less than 65 years of age • Reporting Age Criteria 3: Females 65 years of age and older • Reporting Age Criteria 4: Males 65 years of age and older	The Heart Rhythm Society
N/A/ 393	Registry	Outcome	Patient Safety	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision Infection rate following CIED device implantation, replacement, or revision	The Heart Rhythm Society

Population Measures. For groups with 10 clinicians or more, CMS will automatically calculate the three population outcomes measures listed below. For individual clinicians and small groups of 2-9 clinicians, CMS will only calculate the two AHRQ composites. The measures would be each worth up to ten points for a total of 80 to 90 possible points depending on group size.

- 3 outcomes measures that CMS will automatically calculate based on claims:
  - **All-cause readmissions** *(minimum case size of 200 to apply)*
  - **AHRQ acute preventive quality indicator composite** (bacterial pneumonia, UTI, dehydration) *(minimum case size of 20 to apply)*
  - **AHRQ chronic preventive quality indicator composite** (COPD, HF, DM) *(minimum case size of 20 to apply)*

How do the proposed requirements for the quality performance category of MIPS differ from the requirements under the PQRS and quality component of the VM?

- CMS is proposing to drop the number of measures required to report from 9 to 6 measures.
- While the proposed measures are still classified with National Quality Strategy (NQS) domains, CMS does not propose to require the reporting of measures under the NQS domains.
- CMS is also proposing to raise the reporting threshold from requiring the reporting of measures data on 50% of his/her patients to 80%-90%, depending on the reporting mechanism used.
- CMS is eliminating measures groups
- Although it is still available for reporting, CMS is eliminating the requirement for large groups of 100+ to report CAHPS for MIPS.

SCORING FOR THE QUALITY PERFORMANCE CATEGORY:	
Quality Scoring Formula for Individual Eligible Clinicians and Groups of 10+ Eligible Clinicians:	
SELECTED MEASURES (up to 6 measures)	10 POINTS EACH MEASURE (60 points)
POPULATION MEASURES (up to 3 measures)	10 POINTS EACH MEASURE (30 points)
MAX QUALITY PERFORMANCE SCORE	**90 POINTS**
Quality Scoring Formula for Small Groups of 2-9 Eligible Clinicians:	
SELECTED MEASURES (up to 6 measures)	10 POINTS EACH MEASURE (60 points)
POPULATION MEASURES (up to 2 measures)	10 POINTS EACH MEASURE (20 points)
MAX QUALITY PERFORMANCE SCORE	**80 POINTS**
Quality Scoring Formula for Groups using the CMS Web Interface:	
SELECTED MEASURES (up to 17-18 measures) (170 points)	10 POINTS EACH MEASURE
POPULATION MEASURES (up to 3 measures)	10 POINTS EACH MEASURE (30 points)
MAX QUALITY PERFORMANCE SCORE	**200-210 POINTS**
BONUS POINTS (CAPPED at 5% of the MAX POSSIBLE POINTS):	
Outcome Measures	2 POINTS
Patient Experience	2 POINTS
High Priority Measures	1 POINT
CEHRT Submission	1 POINT FOR EACH MEASURE

Advancing Care Information Performance Category

The advancing care information performance category replaces the Medicare EHR Incentive Program (Meaningful Use) for physicians. A MIPS eligible clinician's score under the advancing care information performance category will be comprised of a base score + performance score.

Base Score. The base score accounts for 50 points of the total Advancing Care Information category score. To receive the base score, clinicians must provide the numerator/denominator or yes/no for each of the proposed six objectives and their corresponding measures.[1] **Clinicians MUST achieve the Protect Patient Health Information objective in order to receive any score in the Advancing Care Information performance category.** The objectives and proposed measures are as follows:

[1] Please note that CMS would no longer require reporting on the Clinical Decision Support and the Computerized Provider Order Entry objectives. However, CMS is proposing to include these objectives in its alternate proposal.

Base Score Objective	Measures (Stage 3)
Protect Patient Health Information (yes/no)	Security Risk Analysis
Patient Electronic Access (numerator/denominator)	Patient Access Patient-Specific Education
Coordination of Care Through Patient Engagement (numerator/denominator)	View, Download, Transmit (VDT) Secure Messaging Patient-Generated Health Data
Electronic Prescribing (numerator/denominator)	ePrescribing
Health Information Exchange (numerator/denominator)	Patient Care Record Exchange Request/Accept Patient Care Record Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting (yes/no)	Immunization Registry Reporting

Performance Score. A MIPS eligible clinician may earn up to 80 points towards the Advancing Care Information category score. The objectives and proposed measures are as follows:

Performance Score Objective	Measures (Stage 3)
Patient Electronic Access	Patient Access Patient-Specific Education
Coordination of Care Through Patient Engagement	View, Download, Transmit (VDT) Secure Messaging Patient-Generated Health Data
Health Information Exchange	Patient Care Record Exchange Request/Accept Patient Care Record Clinical Information Reconciliation

Public Health Registry Bonus Point. MIPS eligible clinicians may earn one bonus point for reporting the following measures beyond the Immunization Registry Reporting measure: Syndromic Surveillance Reporting Measure, Electronic Case Reporting Measure, Public Health Registry Reporting Measure, and/or the Clinical Data Registry Reporting Measure.

Reweighting the Advancing Care Information Performance Category to Zero. CMS proposes to reweight the advancing care information performance category to zero for MIPS eligible clinicians without sufficient measures applicable and available, such as:

- Hospital-based MIPS eligible clinicians (i.e., 90 percent or more of services provided in inpatient or ED setting)
- MIPS eligible clinicians facing a significant hardship
    - Automatic Hardship: Non-patient facing MIPS eligible clinicians
    - Hardships Requiring a MIPS eligible clinician to apply for the hardship:
        - Insufficient Internet Connectivity
        - Lack of Control over the Availability of certified EHR technology
        - Lack of Face-to-Face Patient Interaction
- Clinicians previously not eligible to participate in the Medicare/Medicaid EHR Incentive Programs: Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists

How do the proposed requirements for the advancing care information performance category of MIPS differ from the requirements in the EHR Incentive Program?

- More eligible participants. The MIPS would allow the following eligible clinicians not previously eligible to participate in the EHR Incentive Program to be scored under the advancing care information performance category: nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists.
- Unlike the EHR Incentive Program, where EPs are required to meet a quality component for meaningful use, CMS is not proposing separate requirements for clinical quality measure reporting within the advancing care information performance category. The submission of quality data would fall strictly under the quality performance category of MIPS.
- CMS proposes a group reporting option where performance on the advancing care information performance category objectives and measures would be assessed and reported at the group level, as opposed to only the individual MIPS eligible clinician level.

SCORING FOR THE ADVANCING CARE INFORMATION PERFORMANCE CATEOGRY:		
BASE SCORE	50 POINTS	+
PERFORMANCE SCORE	80 POINTS	+
BONUS POINT FOR PUBLIC HEALTH REGISTRY	1 POINT	
MAX ADVANCING CARE INFORMATION SCORE	**131 POINTS (but the score would max at 100)**	

Clinical Practice Improvement Activity (CPIA) Performance Category

The clinical practice improvement activity (CPIA) performance category is a new category under the MIPS. CMS has proposed 94 activities that MIPS eligible clinicians and groups may perform to fulfill the CPIA performance category, designated as either high or medium-weighted activities. Of the 94 proposed CPIA activities, 11 are classified as high-weighted activities and 83 medium-weighted activities. CMS proposes that clinicians or groups must perform CPIAs for at least 90 days during the performance period for CPIA credit. The CPIAs are classified under the following categories:

CMS is also seeking comment on adding two CPIA subcategories: promoting health equity and continuity and social and community involvement.

SCORING FOR THE CPIA PERFORMANCE CATEGORY:	
For most MIPS eligible clinicians and groups:	
MEDIUM-WEIGHTED ACTIVITY	10 POINTS EACH
HIGH-WEIGHTED ACTIVITY	20 POINTS EACH
MAX CPIA SCORE	**60 POINTS**
For small groups of 2-15 MIPS eligible clinicians, clinicians in rural areas or geographic HPSAs, or non-patient-facing clinicians or groups:	
MEDIUM-WEIGHTED ACTIVITY	30 POINTS EACH

HIGH-WEIGHTED ACTIVITY	30 POINTS EACH
MAX CPIA SCORE	**60 POINTS (COMBINATION OF ANY 2 CPIA ACTIVITIES)**

For MIPS eligible clinicians or groups participating in an APM:

APM PARTICIPATION (NOT AN ADVANCED APM)	30 POINTS
MEDIUM-WEIGHTED ACTIVITY	10 POINTS EACH
HIGH-WEIGHTED ACTIVITY	20 POINTS EACH
MAX CPIA SCORE	**60 POINTS**

Full CPIA Credit: A MIPS eligible clinician or group who is either (1) practicing in a patient-centered medical home or (2) participating in a CMS study on CPIAs will earn the MIPS eligible clinician or group the full 60 CPIA score.

Resource Use Performance Category

The resource use category replaces the cost (resource use) component of the Value-based Payment Modifier. Performance in the resource use performance category would be assessed using measures based on administrative Medicare claims data and would not require data submission by clinicians. As such, MIPS eligible clinicians and groups would be assessed based on resource use for Medicare patients only and only for patients that are attributed to them. CMS proposes to use the following measures for the MIPS resource use performance category:

- The VM Total per Capita Cost measure
- The VM Medicare Spending Per Beneficiary (MSPB); and
- Several new episode-based measures

CMS proposes to establish a 20 case minimum for each resource use measure, including the Medicare Spending Per Beneficiary (MSPB) measure. If the 20 case minimum is not met for a particular measure, the MIPS eligible clinician will not be assessed under that particular measure.

Episode-based Measures. With respect to the new episode-based measures, CMS is proposing to calculate several episode-based measures for inclusion in the resource use performance category. Previously, groups have received feedback on their performance on episode-based measures through the Supplemental Quality and Resource Use Report (sQRUR) but not assessed payment adjustments based on their performance on these episode-based measures. CMS is proposing to assess performance on 41 clinical condition and treatment episode-based measures, 34 of which were previously included in the sQRURs and 7 new clinical condition and treatment episode measures. While all 41 clinical condition and treatment episode-based measures were proposed under the resource use performance category, CMS is unsure which and how many of these measures will be finalized for the 2017 performance period.

One such proposed episode-based measure is **Pacemaker: Cardiac pacemaker insertion (Pacemaker) episode is triggered by claim with any of the interventions assigned as Pacemaker trigger codes**.

How do the proposed requirements for resource use performance category of MIPS differ from the requirements in the cost component of the Value-based Payment Modifier?

- Whereas all resource use measures were previously attributed at the group/TIN level under the VM, the proposed resource use measures under the MIPS will be attributed at the group and individual level.
- Performance on episode-based measures may now be used to assess performance and therefore to calculate payment adjustments under the MIPS
- Whereas the case minimum for the MSPB measure is 125 cases under the Value Modifier, CMS proposes the case minimum to be 20 cases for the resource use performance category under MIPS

SCORING FOR THE RESOURCE USE PERFORMANCE CATEGORY:	
COST MEASURES	AVERAGE OF 10 POINTS EACH/NUMBER OF MEASURES ASSESSED
MAX RESOURCE USE SC0RE	**10 POINTS**

SUMMARY OF MIPS SCORING PROPOSALS

Performance Categories	Quality	Advancing Care Information	Clinical Practice Improvement Activity (CPIA)	Resource Use
General Weights	50 Percent	25 Percent	15 Percent	10 Percent
Reweighting **Can the performance category be reweighted to a reduced percentage or 0?**	Yes If there are no applicable measures available, this category will be reweighted to 0. Reduced Weight: If a MIPS eligible clinician reports on two measures, CMS would reduce the weight by one-fifth. If a MIPS eligible clinician has only one scored quality measure, then CMS would reduce the weight by two-fifths.	Yes Reweighted to 0 for the following: • Hospital-based Eligible Clinicians • MIPS Eligible Clinicians Facing a Significant Hardship • Clinicians previously not eligible to participate in the Medicare/Medicaid EHR Incentive Programs: NPs, Pas, Clinical Nurse Specialists, and CRNAs	No If there are no applicable measures available, this category will be reweighted to 0.	Yes If there are no applicable measures available, this category will be reweighted to 0.
Potential Maximum Points Earned	90 Points: Individual MIPS Eligible Clinicians and Groups of 10+ 80 Points: Small Groups of 2-9 MIPS Eligible Clinicians 200 Points: Web Interface	100 Points Base Score: 50 Points Performance Score: 80 Points	60 Points 20 Points: High-Weighted Activities 10 Points: Medium-Weighted Activities	10 Points

	Users			
Bonus Points	Outcomes Measures (beyond the one required to report) High Priority Measures Submission using CEHRT **BONUS CAPPED at 5%**.	Public Health Registry	Full 60 points given for: - Practicing in a patient-centered medical home - Participating in a CMS study on CPIAs.	None

Reweighting and Redistribution of Weights:

If the advancing care information and/or resource use performance category is reweighted to 0, the weight for that performance category would be distributed to the quality performance category. Exception: If the MIPS eligible clinician does not report on at least three measures in the quality performance category, then the weight would be reassigned proportionately to each of the other performance categories for which the MIPS eligible clinician has received a performance category score.

If the quality performance category is reweighted to 0 (if no measures apply) or reduced (if only 1 or 2 measures apply), the weight would be redistributed proportionately to the other performance categories.

Composite Performance Score (CPS) Formula =

[(quality performance category score x quality performance category weight) + (resource use performance category score x resource use performance category weight) + (CPIA performance category score x CPIA performance category weight) + (advancing care information performance category score x advancing care information performance category weight)] x 100

A MIPS eligible clinician's payment adjustment rate is based on the relationship between their CPS and the CPS performance threshold. A CPS below the performance threshold will result in a negative payment adjustment. A CPS above the performance threshold will result in a neutral or positive payment adjustment.

A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.

An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians where their CPS is equal to or greater than an "exceptional performance threshold," defined as the 25th quartile of possible values above the CPS performance threshold.

Advanced Alternative Payment Models (APM)

Identifying APM Participants. CMS proposes that each eligible clinician who is a participant of an APM Entity would be identified by a unique APM participant identifier. The unique APM participant identifier would be a combination of four identifiers: (1) APM Identifier (established by CMS; for example, XXXXXX); (2) APM Entity identifier (established under the APM by CMS; for example, AA00001111); (3) TIN(s) (9 numeric characters; for example, XXXXXXXXX); (4) EP NPI (10 numeric characters; for example, 1111111111).

From 2019 through 2024, qualifying participants (QPs) will receive the APM Inventive Payment ("a lump sum payment equal to 5 percent of the QP's estimated aggregated payments for Medicare Part B covered professional services (services paid under or based on the Medicare PFS) for the prior year." To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. CMS proposes to collectively assess eligible clinicians on the participant list of an Advanced APM entity as to whether they meet the revenue or patient count thresholds rather than require that each individual eligible clinician meet this threshold on her or his own. If CMS determines through this collective assessment that the organization meets the revenue or patient count thresholds, every eligible clinician on the Advanced APM's participant list will become a QP.

For 2017, CMS proposes to identify the following six models as Advanced APMs. CMS proposes to update this list annually.

ADVANCED APMs
1. **Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization (LDO) arrangement)**
2. **Comprehensive Primary Care (CPS) Plus**
3. **Medicare Shared Savings Program – Track 2**
4. **Medicare Shared Savings Program – Track 3**
5. **Next Generation ACO Model**
6. **Oncology Care Model Two-Sided Risk Arrangement (available in 2018)**

Physician-focused Payment Technical Advisory Committee (PTAC). The PTAC, comprised of 11 Committee members, was established to identify future opportunities for APM participation. The rule proposes criteria for the Committee to use in making comments and recommendations on proposed Physician-focused Payment Models.