Issue Brief

FEDERAL ISSUE BRIEF

October 19, 2016

KEY POINTS

- Revision to small practice definition
- Finalized definition of an advanced alternative payment model and other payer advanced APMs
- Finalized "pick your pace"
- Revisions to the MIPS performance category weighting

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HHS Finalizes MACRA

The Centers for Medicare & Medicaid Services has issued a final rule that establishes a Merit-based Incentive Payment System and Alternative Payment Models.

The Medicare Access and CHIP Reauthorization Act of 2015 repeals the Medicare sustainable growth rate methodology for updates to the physician fee schedule and replaces it with a new approach called the Quality Payment Program that is intended to reward the delivery of high-quality patient care through two avenues: Advanced Alternative Payment Models and MIPS. APMs are payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and costefficient care.

CMS notes that the Quality Payment Program policy will reform Medicare payments for more than 600,000 clinicians across the country.

MIPS will consolidate components of three existing programs, the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program for Eligible Professionals, and will continue the focus on quality, cost and use of certified EHR technology.

MACRA refers to the "four pillars" of the quality payment program as quality, clinical practice improvement activities (referred to as "improvement activities"), meaningful use of CEHRT (referred to as "advancing care information"), resource use (referred to as "cost").

The principal way MIPS measures quality of care, according to CMS, is through evidence-based clinical quality measures that MIPS eligible clinicians can select, the vast majority of which are created or supported by clinical leaders, and endorsed by a consensus-based process.

As of this date, the rule has not been scheduled for publication in the *Federal Register*. A copy of the nearly 2,400 page document, with a caveat of possible additional changes before final copy is sent to the *Federal Register* office for publication, is currently available at: https://qpp.cms.gov/education.

Comment

The release of this material has taken a remarkably different release approach. Normally, the public "sees" a proposed or final rule when it is placed on display at the Federal Register office. This final rule has not been posted at the Federal Register office.

It is a very long, complex, difficult and, to a certain degree, redundant rule to follow and digest especially if one is not involved in the quality arena. The rule's important appendix (Tables A-H) alone includes nearly 300 pages of tables reflecting the required quality measures for 2017.

It may be easier to comprehend many issues by referring to and by first reading parts of the regulation text itself. CMS has issued an extremely helpful 12-page fact sheet that provides a good basic explanation of what is in this massive rule.

A copy is at: https://qpp.cms.gov/docs/Quality Payment Program Overview-Fact_Sheet.pdf.

CMS talks about simplification issues. One good starting point would be for CMS to include page number references in its rulemaking. It is extremely challenging to locate cited references. At a minimum, including the entire reference point would be helpful. For example, the rule indicates material is in "section II.E.5.e." However, nothing in the rule has that explicit cite. One is lucky to find E.5. More likely all you will find is "5," and there are many items identified as a section "5."

There is still much unknown how the mechanisms of these changes will achieve desirable outcomes.

Finally, the material that follows is not all-inclusive. There are numerous aspects that have not been detailed. To do so would extend the length of the document extensively. Those involved with the various aspects of this program need to thoroughly digest the entire rule.

SUMMARY OF THE MAJOR PROVISIONS

1. Transition Year and Iterative Learning and Development Period

The initial development period of the Quality Payment Program implementation is intended to allow physicians to pick their pace of participation for the first performance period that begins Jan. 1, 2017. Eligible clinicians will have three flexible options to submit data and a fourth option to join Advanced APMs to become Qualifying APM Participants, which would ensure they do not receive a negative payment adjustment in 2019—the first payment year. The term eligible clinician is replacing eligible practitioners.

- "(1) Clinicians can choose to report for MIPS for a full 90-day period or, ideally, the full year, and maximize the MIPS eligible clinician's chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the first six years of the program.
- "(2) Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017, but for a full 90-day period at a minimum, and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.
- "(3) Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.
- "(4) MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019."



As noted above, "the 2017 performance period for the 2019 MIPS payment year [is] to be a transition year as part of the development period in the program. For this transition year, for MIPS the performance threshold will be lowered to a threshold of 3 points. Clinicians who achieve a final score of 70 or higher will be eligible for the exceptional performance adjustment, funded from a pool of \$500 million.

"For full participation in MIPS and in order to achieve the highest possible final scores, MIPS eligible clinicians are encouraged to submit measures and activities in all three integrated performance categories: quality, improvement activities and advancing care information. To address public comments on the cost performance category, the weighting of the cost performance category has been lowered to 0 percent for the transition year. For full participation in the quality performance category, clinicians will report on six quality measures, or one specialty-specific or subspecialtyspecific measure set. For full participation in the advancing care information performance category, MIPS eligible clinicians will report on five required measures. For full participation in the improvement activities performance category, clinicians can engage in up to four activities, rather than the proposed six activities, to earn the highest possible score of 40.

"For the transition year CY 2017, for quality, clinicians who submit one out of at least six quality measures will meet the MIPS performance threshold of 3; however, more measures are required for groups who submit measures using the CMS Web Interface. For the transition year CY 2017, for quality, higher measure points may be awarded based on achieving higher performance in the measure. For improvement activities, attesting to at least one improvement

activity will also be sufficient to meet the MIPS performance threshold in the transition year CY 2017. For advancing care information, clinicians reporting on the required measures in that category will meet the performance threshold in the transition year. These transition year policies for CY 2017 (according to CMS) will encourage participation by clinicians and will provide a ramp up period for clinicians to prepare for higher performance thresholds in the second year of the program."

2. Small Practices

For 2017, many small practices will be excluded from new requirements because of the low-volume threshold, which has been set at less than or equal to \$30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients, representing 32.5 percent of pre-exclusion Medicare clinicians but only 5 percent of Medicare Part B spending.

3. Advanced APMs

"This rule finalizes two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. To be considered an Advanced APM, an APM must meet all three of the following criteria: (1) The APM must require participants to use CEHRT; (2) The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS and; (3) The APM must either require that participating APM Entities bear risk for monetary losses of a more than nominal amount under the APM. or be a Medical Home Model expanded under section 1115A(c) of the Act.

"To be an Other Payer Advanced APM a payment arrangement with a payer (for example, Medicaid or a commercial payer) must meet all three of the



continued

following criteria: (1) The payment arrangement must require participants to use CEHRT; (2) The payment arrangement must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS and; (3) The payment arrangement must require participants to either bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act."

4. QP determination

Qualifying APM Participants are eligible clinicians in an Advanced APM who have a certain percentage of their patients or payments through an Advanced APM. QPs are excluded from MIPS and receive a 5 percent incentive payment for a year beginning in 2019 through 2024.

CMS is finalizing the two methods by which it will calculate Threshold Scores to compare to the QP thresholds and make QP determinations for eligible clinicians. The payment amount method assesses the amount of payments for Part B covered professional services that are furnished through an Advanced APM. The patient count method assesses the amount of patients furnished Part B covered professional services through an Advanced APM.

CHANGES TO EXISTING PROGRAMS

Supporting Health Care Providers With the Performance of Certified EHR Technology, and Supporting Health Information Exchange and the Prevention of Health Information Blocking.

CMS is finalizing a two-part attestation that splits the SPPC activities. As it relates to ONC direct review, the attestation is required. As it relates to ONC-ACB surveillance, the attestation is optional. The attestations are as follows:

- Health care providers must attest that they engaged in good faith in SPPC activities related to ONC direct review by: (1) attesting their acknowledgment of the requirement to cooperate in good faith with ONC direct review of their health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) if a request is received, attesting that they cooperated in good faith in ONC direct review of health IT under the ONC Health IT Certification Program to the extent that such technology meets (or can be used to meet) the definition of certified EHR technology.
- Optionally, health care providers may attest that they engaged in good faith in SPPC activities related to ONC-ACB surveillance by: (1) attesting their acknowledgement of the option to cooperate in good faith with ONC-ACB surveillance of their health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and (2) if a request is received, attesting that they cooperated in good faith in ONC-ACB surveillance of health IT under the ONC Health IT Certification Program, to the extent that such technology meets (or can be used to meet) the definition of certified EHR technology.

Comment

CMS spends more than 60 pages discussing the EHR attestation issue. Again, a lot of discussion without a simple clear-cut analysis of what are the final actions. Yes, they're there, but you have read between all the



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continued

lines. For the most part, CMS continues its old ways of promulgating new rules. Too much time thanking commenters and not enough simple clear cut decision action sections. It's truly time for a new perspective and layout of the issues. CMS says it wants simplification. Perhaps it should start at home.

MIPS Program Details

1. MIPS Eligible Clinicians

a. Definition of a MIPS Eligible Clinician CMS is finalizing the definition at \$414.1305 of a MIPS eligible clinician, as identified by a unique billing TIN and NPI combination used to assess performance, as any of the following (excluding those identified at \$414.1310(b)): a physician (as defined in section 1861(r) of the Act), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act), a certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act), and a group that includes such clinicians.

CMS is finalizing its proposed policies at \$414.1310(b) and \$414.1310(c) that QPs, Partial QPs who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year, low-volume threshold eligible clinicians, and new Medicare enrolled eligible clinicians as defined at \$414.1305 are excluded from this definition per the statutory exclusions defined in section 1848(q)(1)(C)(ii) and (v) of the Act.

In accordance with section 1848(q)(1) (A) and (q)(1)(C)(vi) of the Act, CMS is finalizing its proposal at §414.1310(b) (2) to allow eligible clinicians (as defined at §414.1305) who are not MIPS eligible clinicians the option to voluntarily report measures and activities for MIPS. Additionally, CMS is finalizing its proposal at §414.1310(d) that in no case will a MIPS payment adjustment apply to

the items and services furnished during a year by individual eligible clinicians who are not MIPS eligible clinicians including eligible clinicians who are not MIPS eligible clinicians, but who voluntarily report on applicable measures and activities specified under MIPS.

b. Non-Patient Facing MIPS Eligible Clinicians

CMS is finalizing a modification to its proposal to define a non-patient facing MIPS eligible clinician as an individual MIPS eligible clinician that bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.

CMS says it believes that the use of patient-facing encounter codes is the most appropriate approach for determining whether or not MIPS eligible clinicians are non-patient facing. CMS intends to publish a list of patient-facing encounters on the CMS Website located at: QualityPaymentProgram.CMS.gov.

- c. MIPS Eligible Clinicians Who Practice in Critical Access Hospitals Billing Under Method II (Method II CAHs)

 CMS is adopting its proposal that the MIPS adjustment applies to Method II CAH payments under section 1834(g) (2)(B) of the Act when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights to the CAH.
- d. MIPS Eligible Clinicians Who Practice in Rural Health Clinics and/or Federally Qualified Health Centers CMS is finalizing its proposal that services rendered by an eligible clinician



under the RHC or FQHC methodology will not be subject to the MIPS payments adjustments. However, these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS, in which the data received will not be used to assess their performance for the purpose of the MIPS payment adjustment.

2. MIPS Eligible Clinician Identifier

CMS is finalizing the use of multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or collectively through a group's performance. Additionally, CMS is finalizing its proposal that the same identifier be used for all four performance categories.

CMS is finalizing a modification to its proposal regarding the use of a group's billing TIN to identify a group. CMS is codifying the definition of a group at \$414.1305 to mean a group that consists of a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the TIN.

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

3. Exclusions

a. New Medicare-Enrolled Eligible Clinician CMS is finalizing the definition of a new Medicare-enrolled eligible clinician at §414.1305 as a professional who first becomes a Medicare-enrolled eligible clinician within the Medicare Provider Enrollment, Chain, and Ownership System during the performance period for a year and had not previously submitted claims under Medicare such as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier.

CMS is finalizing its proposal at \$414.1310(c) that these eligible clinicians will not be treated as a MIPS eligible clinician until the subsequent year and the performance period for such subsequent year.

b. Qualifying APM Participant and Partial Qualifying APM Participant CMS is finalizing its proposal at §414.1305 that the definition of a MIPS eligible clinician does not include QPs (defined at §414.1305) and Partial QPs (defined at §414.1305) who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year. Also, CMS is finalizing its proposed policy at §414.1310(b) that for a year, QPs (defined at §414.1305) and Partial OPs (defined at §414.1305) who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year are excluded from MIPS. Partial QPs will have the option to elect whether or not to report under MIPS, which determines whether or not they will be subject to MIPS payment adjustments.

c. Low-Volume Threshold
At §414.1305, CMS is defining MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the low volume threshold determination period, has Medicare Part B billing charges less than or equal to \$30,000 or provides care for



100 or fewer Part B-enrolled Medicare beneficiaries

CMS is finalizing its proposed policy at §414.1310(b) that for a year, MIPS eligible clinicians who do not exceed the low-volume threshold (as defined at §414 1305) are excluded from MIPS for the performance period with respect to a year. The low-volume threshold also applies to MIPS eligible clinicians who practice in APMs under the APM scoring standard at the APM Entity level, in which APM Entities that do not exceed the low-volume threshold would be excluded from the MIPS requirements and not subject to a MIPS payment adjustment. Such an exclusion will not affect an APM Entity's QP determination if the APM Entity is an Advanced APM.

CMS is finalizing a modification to its proposal to make eligibility determinations regarding low-volume status using historical data.

4. MIPS Performance Period

MIPS applies to payments for items and services furnished on or after Jan. 1, 2019. Section 1848(q)(4) of the Act requires the Secretary to establish a performance period (or periods) for a year (beginning with 2019).

(a). For purposes of the 2019 MIPS payment year, the performance period for all performance categories and submission mechanisms except for the cost performance category and data for the quality performance category reported through the CMS Web Interface, for the CAHPS for MIPS survey, and for the all-cause hospital readmission measure, is a minimum of a continuous 90-day period within CY 2017, up to and including the full CY 2017 (Jan. 1, 2017, through Dec. 31, 2017).

For purposes of the 2019 MIPS payment year, for data reported through the CMS Web Interface or the CAHPS for MIPS survey and administrative claims-based cost and quality measures, the performance period under MIPS is CY 2017 (Jan. 1, 2017, through Dec. 31, 2017).

- (b) For purposes of the 2020 MIPS payment year, the performance period for:
 - (1) The quality and cost performance categories is CY 2018 (Jan. 1, 2018, through Dec. 31, 2018).
 - (2) The advancing care information and improvement activities performance categories is a minimum of a continuous 90-day period within CY 2018, up to and including the full CY 2018 (Jan. 1, 2018, through Dec. 31, 2018).

5. MIPS Performance Category Measures and Activities

a. Performance Category Measures and Reporting

Section 1848(q)(2)(A) of the Act requires the Secretary to use four performance categories in determining each MIPS eligible clinician's Composite Performance Scoring under the MIPS: quality; resource use; Clinical Practice Improvement Activity; and advancing care information. Payment adjustments would be scaled for budget neutrality, as required by statute.



The final submission mechanisms in the tables below identify the available submission mechanisms for all MIPS eligible clinicians.

Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI			
Performance Category/Submission Individual Reporting Data submission Combinations Accepted Mechanisms			
Quality Claims QCDR Qualified registry EHR			
Cost Administrative claims (no submission required)			
Advancing Care Information	Attestation QCDR Qualified registry EHR		
Improvement Activities	Attestation QCDR Qualified registry EHR		

Data Submiss	Data Submission Mechanisms for Groups			
Performance Category/Submission Combinations Accepted	Group Reporting Data submission Mechanisms			
Quality	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) and Administrative claims (For all-cause hospital readmission measure – no submission required)			
Cost	Administrative claims (no submission required)			
Advancing Care Information	Attestation QCDR Qualified Registry EHR CMS Web Interface groups of 25 or more)			
Improvement Activities	Attestation QCDR Qualified registry EHR CMS Web Interface groups of 25 or more)			

CMS is finalizing the submission deadlines as proposed with one modification. Specifically, CMS is finalizing at §414.1325(f) the data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms as March 31 following the close of the performance period. The submission period will begin prior to January 2 following the close of the performance period, if technically feasible. For example, for the first MIPS performance period, the data submission period will occur prior to Jan. 2, 2018, through March 31, 2018, if technically feasible. If it is not technically feasible to allow the submission period to begin prior to Jan. 2 following the close of the performance period, the submission period will occur from Jan. 2 through March 31 following the close of the performance period. In any case, the final deadline will remain March 31, 2018.



b. Quality Performance Category
MACRA specified four performance
categories CMS is required to incorporate into the MIPS program – Quality,
Resource Use, Clinical Practice
Improvement Activity and Advancing
Information.

MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Appendix Table A or a set of specialty-specific measure set in Appendix Table F

The quality performance category will comprise:

- (1) 60 percent of a MIPS eligible clinician's final score for MIPS payment year 2019.
- (2) 50 percent of a MIPS eligible clinician's final score for MIPS payment year 2020.
- (3) 30 percent of a MIPS eligible clinician's final score for each MIPS payment year thereafter.

Data submission criteria for the quality performance category.

- (a) Criteria. A MIPS eligible clinician or group must submit data on MIPS quality measures in one of the following manners, as applicable:
- (1) Via claims, qualified registry, EHR or QCDR submission mechanism. For the performance period—
- (i) Submit data on at least six measures including at least one outcome measure. If an applicable outcome measure is not available, report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). If fewer than six measures apply to the MIPS eligible clinician or group, report on each measure that is applicable.

- (ii) MIPS eligible clinicians and groups can either select their measures from the complete MIPS final measure list or a subset of that list, MIPS specialty-specific measure sets, as designated by CMS.
- (2) Via the CMS Web interface for groups only. For the 12-month performance period-
- (i) For a group of 25 or more MIPS eligible clinicians, report on all measures included in the CMS Web interface. The group must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module.
- (ii) If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries. In some instances, the sampling methodology will not be able to assign at least 248 patients on which a group may report, particularly those groups on the smaller end of the range of 25–99 MIPS eligible clinicians.
- (iii) The group is required to report on at least one measure for which there is Medicare patient data.
- (iv) Groups reporting via the CMS Web interface are required to report on all of the 2016 measures in the set.
- (3) Via CMS-approved survey vendor for CAHPS for MIPS survey for groups only.
- (i) For the 12-month performance period, a group that wishes to voluntarily elect to participate in the CAHPS for MIPS survey measures must use a survey vendor that is approved by CMS for a particular performance period to transmit survey measures data to CMS.
- (A) The CAHPS for MIPS survey counts for one measure towards the MIPS



quality-performance category and, as a patient experience measure, also fulfills the requirement to report at least one high-priority measure in the absence of an applicable outcome measure.

(B) Groups that elect this data submission mechanism must select an additional group data submission mechanism in order to meet the data submission criteria for the MIPS quality-performance category.

For the transition year of MIPS, CMS is modifying its proposal and will finalize a 50 percent data completeness threshold for claims, registry, QCDR and EHR submission mechanisms. For the transition year, MIPS eligible clinicians whose measures fall below the data completeness threshold of 50 percent would receive 3 points for submitting the measure.

It is important to note that CMS is also finalizing to ramp up the data completeness threshold to 60 percent for MIPS, for performance periods occurring in 2018, for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims.

Summary of Final Quality Data Submission Criteria for MIPS Payment Year 2019 via Part B Claims, QCDR, Qualified Registry, EHR, CMS Web Interface and CAHPS for MIPS Survey				
Performance Period	Measure Type	Submission Mechanism	Submission Criteria	Data Completeness
A minimum of one continuous 90-day period during CY2017	Individual MIPS eligible clinicians	Part B Claims	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty-specific measures in Table E.	50 percent of MIPS eligible clinician's Medicare Part B patients for the performance period



Summary of Final Quality Data Submission Criteria for MIPS Payment Year 2019 via Part B Claims, QCDR, Qualified Registry, EHR, CMS Web Interface and CAHPS for MIPS Survey

Performance Period	Measure Type	Submission Mechanism	Submission Criteria	Data Completeness
A minimum of one continuous 90-day period during CY 2017	Individual MIPS eligible clinicians	QCDR Qualified Registry EHR	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS Measures in Table A or a set of specialty-specific measures in Table E.	50 percent of MIPS eligible clinician's or groups patients across all payers for the performance period
Jan. 1 – Dec. 31	Groups	CMS Web Interface	Report on all measures included in the CMS Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure. I the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries.	Sampling requirements for their Medicare Part B patients
Jan. 1 – Dec. 31	Groups	CAHPS for MIPS Survey	CMS-approved survey vendor would have to be paired with another reporting mechanism to ensure the minimum number of measures are reported. CAHPS for MIPS Survey would fulfill the requirement for one patient experience measure towards the MIPS quality data submission criteria. CAHPS for MIPS Survey will only count for one measure.	Sampling requirements for their Medicare Part B patients

c. Selection of Quality Measures for Individual MIPS Eligible Clinicians and Groups
The Final Individual Quality Measures Available for MIPS Reporting in 2017 are
located in Table A of the appendix. Included in Table B of the Appendix is a final list
of quality measures that do not require data submission. Newly proposed measures
are listed in Table D of the Appendix.



The final specialty-specific measure sets are listed in Table E of the Appendix. Measures for removal can be found in Table F of the Appendix and measures that will have substantive changes for the 2017 performance period can be found in Table G of the Appendix.

d. Miscellaneous Comments (not addressed in this analysis)

e. Cost Performance Category

CMS proposed that all measures used under the cost performance category would be derived from Medicare administrative claims data and as a result, participation would not require use of a data submission mechanism.

CMS has finalized its proposal to include the total per capita cost measure and the MSPB measure within the MIPS cost performance category for the CY 2017 performance period.

CMS is lowering the weight of the cost performance category in the MIPS final score from 10 percent in the proposed rule to 0 percent for the transition year (MIPS payment year 2019). Finalizing a weight of 10 percent for MIPS payment year 2020, and for MIPS payment year 2021 and beyond, the cost performance category will have a weight of 30 percent of the final score as required by section 1848(q)(5)(E)(i) of the Act.

CMS is finalizing its proposal to use modified attribution methods from the VM for the total per capita cost measure and the MSPB. CMS is also finalizing the removal of skilled nursing facility codes (CPT Codes 99304-99318) from and addition of transitional care management (CPT codes 99495-99496) and chronic care management codes (CPT code 99490) to the list of primary care services used to attribute the total per capita cost measure.

CMS will use the 0.4 reliability threshold currently applied to measures under the VM to evaluate their reliability. A MIPS eligible clinician must have a minimum of 20 cases to be scored on the total per-capita cost measure.

CMS is finalizing a minimum case volume of 35 for the MSPB. CMS is also adopting its proposals to not adjust the MSPB measure by specialty and to calculate observed to expected ratio at an episode level.

The measures listed in the table below will be used (along with the total per capita cost measure and the MSPB measure finalized in this rule) to determine the cost performance category score.



Episode-E	Based Measures Finalized for the CY	2017 Perfc	ormance Po	eriod
Method Type/ Measure Number from Table 4 and Table 5 (Method B) from Proposed Rule*	Episode Name and Description	Included in 2014 sQRUR	% TINs Meeting 0.4 Reliability Threshold	% TIN/NPIs Meeting 0.4 Reliability Threshold
A/1	Mastectomy (formerly titled "Mastectomy for Breast Cancer") Mastectomy is triggered by a patient's claim with any of the interventions assigned as Mastectomy trigger codes. Mastectomy can triggered by either an ICD procedure code, or CPT codes in any setting (e.g. hospital, surgical center).	Yes	99.6%	100.0%
A/5	Aortic/Mitral Valve Surgery Open heart valve surgery (Valve) episode is triggered by a patient claim with any of Valve trigger codes.	Yes	93.9%	92.0%
A/8	Coronary Artery Bypass Graft (CABG) Coronary Artery Bypass Grafting (CABG) episode is triggered by an inpatient hospital claim with any of CABG trigger codes for coronary bypass. CABG generally is limited to facilities with a Cardiac Care Unit (CCU); hence there are no episodes or comparisons in other settings	Yes	96.9%	94.8%
A/24	Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based Fracture/ dislocation of hip/femur (HipFxTx) episode is triggered by a patient claim with any of the interventions assigned as HipFxTx trigger codes. HipFxTx can be triggered by either an ICD procedure code or CPT codes in any setting.	Yes	88.9%	76.1%
B/1	Cholecystectomy and Common Duct Exploration Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs.	Yes	89.6%	81.8%
B/2	Colonoscopy and Biopsy Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs.	Yes	100.0%	99.9%
B/3	Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia For procedural episodes, treatment services are defined as the services attributable to the MIPS eligible clinician or group managing the patient's care for the episode's health condition.	Yes	95.2%	95.5%



Episode-Based Measures Finalized for the CY 2017 Performance Period					
Method Type/ Measure Number from Table 4 and Table 5 (Method B) from Proposed Rule*	Episode Name and Description	Included in 2014 sQRUR	% TINs Meeting 0.4 Reliability Threshold	% TIN/NPIs Meeting 0.4 Reliability Threshold	
B/5	Lens and Cataract Procedures Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day.	Yes	99.7%	99.5%	
B/6	Hip Replacement or Repair Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day	Yes	97.8%	97.7%	
B/7	Knee Arthroplasty (Replacement) Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day	Yes	99.9%	99.8%	

CMS will finalize the attribution methodology for episode-based measures as proposed.

For those groups that participate in group reporting in other MIPS performance categories, their cost performance category scores will be determined by aggregating the scores of the individual clinicians within the TIN.

f. Improvement Activities Performance Category

CMS is finalizing at §414.1305 the definition of improvement activities, as proposed, to mean an activity that relevant MIPS eligible clinician, organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

CMS is reducing the number of required activities it proposed from a maximum of six medium-weighted or three high-weighted or some combination thereof for full credit to a requirement of no more than four medium-weighted activities, two high-weighted activities, or a combination of medium and high-weighted activities where each selected high weighted activity reduces the number of medium-weighted activities required.

CMS is reducing the number of activities for small practices, practices located in rural areas, and geographic HSPAs and non-patient facing MIPS eligible clinicians to no more than one high-weighted activity or two medium-weighted activities, where each activity counts for doubled weighting to also achieve a total of 40 points.



CMS is finalizing at \$414.1355, that the improvement activities performance category would account for 15 percent of the final score. CMS is not finalizing the policy on recognizing only practices that have received nationally recognized accredited or certified-patient centered medical home certifications. Rather, CMS is finalizing at \$414.1380 an expanded definition of what is acceptable for recognition as a certified-patient centered medical home or comparable specialty practice.

CMS is finalizing at \$414.1360 that MIPS eligible clinicians or groups must perform improvement activities for at least 90 consecutive days during the performance period for improvement activities performance category credit.

CMS is finalizing at \$414.1380 that for non-patient facing MIPS eligible clinicians or groups, to achieve the highest score one high-weighted or two medium-weighted improvement activities are required.

CMS is finalizing at §414.1365 that the improvement activities performance category will include the subcategories of activities provided at section 1848(q)(2)(B)(iii) of the Act. In addition, CMS is finalizing at §414.1365 the following additional subcategories: "Achieving Health Equity," "Integrated Behavioral and Mental Health," and "Emergency Preparedness and Response."

g. Advancing Care Information Performance Category

MIPS eligible clinicians will be evaluated under all four of the MIPS performance categories, including the advancing care information performance category. This includes MIPS eligible clinicians who were not previously eligible for the EHR Incentive Program incentive payments under section 1848(o) of the Act or subject to the EHR Incentive Program payment adjustments under section 1848(a)(7) of the Act, such as physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and hospital-based EPs (as defined in section 1848(o)(1) (C)(ii) of the Act).

CMS' Table 8 identifies a set of improvement activities from the improvement activities performance category that can be tied to the objectives, measures, and CEHRT functions of the advancing care information performance category and would thus qualify for the bonus in the advancing care information performance category.

CMS is adopting for MIPS the 2017 Advancing Care Information Transition objectives and measures (referred to in the proposed rule as Modified Stage 2 objectives and measures) and Advancing Care Information objectives and measures (referred to in the proposed rule as adapted from the Stage 3 objectives and measures) and allowing MIPS eligible clinicians and groups to use technology certified to either the 2014 Edition or the 2015 Edition or a combination of the two editions to support their selection of objectives and measures for 2017. In 2018, MIPS eligible clinicians must use EHR technology certified to the 2015 Edition.

For the first performance period of MIPS (CY 2017), CMS will accept a minimum of 90 consecutive days of data in CY 2017, however, CMS encourages MIPS eligible clinicians to report data for the full year performance period.

CMS proposed at §414.1375 that performance in the advancing care information



performance category would comprise 25 percent of a MIPS eligible clinician's MIPS final score for payment year 2019 and each year thereafter.

CMS has reduced the total number of required measures from 11 in the base score as proposed to only five in the final policy, which addresses some of the concerns raised by commenters while meeting statutory requirements.

		Required/ Not		
Advancing Care Inform Objective	Advancing Care Information Measure*	Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing	Required	0	Numerator/ Denominator
Patient Electronic	Provide Patient Access	Required	Up to 10%	Numerator/ Denominator
Access	Patient-Specific Education	Not Required	Up to 10%	Numerator/ Denominator
Coordination of Care	View, Download or Transmit	Not Required	Up to 10%	Numerator/ Denominator
Through Patient	Secure Messaging	Not Required	Up to 10%	Numerator/ Denominator
Engagement	Patient-Generated Health Data	Not Required	Up to 10%	Numerator/ Denominator
Health Information	Send a Summary of Care	Required	Up to 10%	Numerator/ Denominator
Exchange	Request/Accept Summary of Care	Required	Up to 10%	Numerator/ Denominator
	Clinical Information Reconciliation	Not Required	Up to 10%	Numerator/ Denominator
Public Health and Clinical	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
Data Registry Reporting	Syndromic Surveillance Reporting	Not Required	Bonus	Yes/No Statement
	Electronic Case Reporting	Not Required	Bonus	Yes/No Statement
	Public Health Registry Reporting	Not Required	Bonus	Yes/No Statement
	Clinical Data Registry Reporting	Not Required	Bonus	Yes/No Statement
Bonus up to 15	%			
health and clin	or more additional public ical data registries beyond on Registry Reporting	5% bonus	Yes/No Stateme	ent
Report improvement activities using CEHRT 10% bonus Yes/No Statement			ent	

^{*} Several measure names have been changed since the proposed rule. This table reflects those changes.



Advancing Care Information Performance Category Scoring Methodology for 2017 Advancing Care Information Transition — Objectives and Measures Care Information Required/ Not Required for **Transition** 2017 Advancing Care **Objective Information Transition** Base Score **Performance Score** Reporting (50%) (Up to 90%) (2017 only) Measure* (2017 only) Requirement Required 0 Yes/No Patient Health Security Risk Analysis Statement Information Electronic E-Prescribing 0 Numerator/ Required Prescribing Denominator **Patient Provide Patient Access** Required Up to 20% Numerator/ Electronic Denominator Access View, Download, or Not Required **Up to 10%** Numerator/ Denominator Transmit (VDT) Patient-Specific **Patient-Specific Education** Numerator/ Not Required Up to 10% Education Denominator Numerator/ Secure Secure Messaging Not Required **Up to 10%** Denominator Messaging **Health Information** Health Required **Up to 20%** Numerator/ Information Denominator Exchange Exchange Medication Medication Reconciliation Not Required **Up to 10%** Numerator/ Reconciliation Denominator **Public Health** 0 or 10% Yes/No Immunization Registry Not Required Reporting Statement Reporting Syndromic Surveillance Not Required **Bonus** Yes/No Reporting Statement Specialized Registry Not Required Bonus Yes/No Reporting Statement Bonus up to 15% Report to one or more additional public health and clinical data 5% bonus Yes/No registries beyond the Immunization Registry Reporting measure Statement Report improvement activities using CEHRT Yes/No 10% bonus Statement

CMS is finalizing its proposal for the Advancing Care Information objectives and measures and the 2017 Advancing Care Information Transition objectives and measures as proposed with modifications to correct language in certain measures as noted as follows:

For the 2017 Advancing Care Information Transition Medication Reconciliation measure: CMS is maintaining the Modified Stage 2 numerator as follows: "Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.

For the Advancing Care Information View, Download Transmit measure: During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician. An MIPS eligible clinician may meet the measure by a patient either— (1) viewing, downloading. or transmitting to a third party their health information; or (2) accessing their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's CEHRT; or (3) a combination of (1) and (2).



For the Advancing Care Information Syndromic Surveillance Reporting measure: The MIPS eligible clinician is in active engagement with a public health agency to submit surveillance data from an urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.

Section 1848(a)(7)(D) of the Act exempts hospital-based EPs from the application of the meaningful use payment adjustment under section 1848(a)(7)(A) of the Act. CMS defined a hospital-based EP for the EHR Incentive Program under §495.4 as an EP who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the payment year, or in the case of a payment adjustment year, in either of the 2 years before the year preceding such payment adjustment year.

CMS is finalizing that a hospital-based MIPS eligible clinicians is defined as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by CMS.

Comment

There is much material in this section, too. It is more than 160 pages long.

h. APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs Under section 1848(q)(1)(C)(ii) of the Act, as added by section 101(c)(1) of MACRA, Qualifying APM Participants are not MIPS eligible clinicians and are thus excluded from MIPS payment adjustments. Partial Qualifying APM Participants are also not MIPS eligible clinicians unless they opt to report and be scored under MIPS. All other eligible clinicians participating in APMs who are MIPS eligible clinicians are subject to MIPS requirements, including reporting requirements and payment adjustments.

CMS is finalizing an APM scoring standard that is different from the generally applicable standard. MIPS APMs will be scored using the APM scoring standard instead of the generally applicable MIPS scoring standard.

MIPS APMs are APMs that meet the following criteria: (1) APM Entities participate in the APM under an agreement with CMS or by law or regulation; (2) the APM requires that APM Entities include at least one MIPS eligible clinician on a Participation List; and (3) the APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

CMS is finalizing its proposal to score MIPS eligible clinicians in the MIPS APM at the APM Entity level. The final score calculated at the APM Entity level will be applied to each MIPS eligible clinician in the APM Entity group.

The three performance category scores (quality, improvement activities, and advancing care information) will be aggregated into a final score. The final score will be compared against a MIPS performance threshold of 3 points. The final score will be used to determine whether a MIPS eligible clinician receives an upward MIPS payment adjustment, no MIPS payment adjustment, or a downward MIPS payment adjustment



continued

as appropriate. Upward MIPS payment adjustments may be scaled for budget neutrality, as required by MACRA. The final score will also be used to determine whether a MIPS eligible clinician qualifies for an additional positive adjustment factor for exceptional performance. The performance threshold will be set at 3 points for the transition year, such that clinicians engaged in the program who successfully report one quality measure can avoid a downward adjustment. MIPS eligible clinicians submitting additional data for one or more of the three performance categories for at least a full 90-day period may quality for varying levels of positive adjustments.

For the Shared Savings Program CMS is finalizing the weights assigned to each of the MIPS performance categories as proposed for Shared Savings Program ACOs: quality 50 percent; cost 0 percent; improvement activities 20 percent; and advancing care information 30 percent for purposes of the APM scoring standard. CMS is finalizing the proposal that for the advancing care information performance category, ACO participant TINs will report the category to MIPS, and the TIN scores will be aggregated and weighted in order to calculate one APM Entity score for the category. In the event a Shared Savings Program ACO fails to satisfy quality reporting requirements for measures reported through the CMS Web Interface, advancing care information group TIN scores will not be aggregated to the APM Entity level. Instead, each ACO participant TIN will be scored separately based on its TIN-level group reporting for the advancing care information performance category.

The following table summarizes the finalized APM scoring standard rules for the Shared Savings Program.

APM Entity Su	APM Entity Submission Method for Each MIPS Performance Category				
MIPS Performance Category	APM Entity Eligible Clinician Submission Method				
Quality	The APM Entity group submits quality measure data to CMS as required under the APM.				
Cost	No data submitted by APM Entity group to MIPS.				
Improvement Activities	No data submitted by APM Entity group to MIPS unless the assigned score at the MIPS APM level does not represent the maximum improvement activities score, in which case the APM Entity may report additional improvement activities using a MIPS data submission mechanism.				
Advancing Care Information	Shared Savings Program ACO participant TINs submit data using a MIPS data submission mechanism. Next Generation ACO Model and other MIPS APM eligible clinicians submit data at either the individual level or at the TIN level using a MIPS data submission mechanism.				

Comment

Again, this is a long section — over 100 pages — that needs a concerted review by those clinicians in APMs



6. MIPS Final Score Methodology

"By incentivizing quality and value for all MIPS eligible clinicians, MIPS creates a new mechanism for calculating MIPS eligible clinician payments.

Section 1848(q) of the Act requires the Secretary to: (1) Develop a methodology for assessing the total performance of each MIPS eligible clinician according to performance standards for a performance period for a year; (2) using the methodology, provide a final score for each MIPS eligible clinician for each performance period; and (3) use the final score of the MIPS eligible clinician for a performance period to determine and apply a MIPS payment adjustment factor (and, as applicable, an additional MIPS payment adjustment factor) to the MIPS eligible clinician for the MIPS payment year.

CMS' rationale for its scoring methodology is grounded in the understanding that the MIPS scoring system has many components and numerous moving parts.

CMS has created a transition year scoring methodology that does the following:

- Provides a negative 4 percent payment adjustment to MIPS eligible clinicians who do not submit any data to MIPS;
- Ensures that MIPS eligible clinicians who submit data and meet program requirements under any of the three performance categories for which data must be submitted (quality, improvement activities, and advancing care information) for at least a 90-day period and have low overall performance in the performance category or categories on which they choose to report may receive a final score at or slightly above the performance threshold and thus a neutral to small positive adjustment, and
- Ensures that MIPS eligible clinicians who submit data and meet program requirements under each of the three performance categories for which data must be submitted (quality, improvement activities, and advancing care information) for at least a 90-day period, and have average to high overall performance across the three categories may receive a final score above the performance threshold and thus a higher positive adjustment, and, for those MIPS eligible clinicians who receive a final score at or above the additional performance threshold, an additional positive adjustment.

A summary of the performance standards per performance category is provided in the table below.

Performance Category Performance Standards for the 2017 Performance Period				
Performance Proposed Performance Category Standard Final Performance Standard				
Quality	Measure benchmarks to assign points, plus bonus points.	Measure benchmarks to assign points, plus bonus points with a minimum floor for all measures.		
Cost	Measure benchmarks to assign points.	Measure benchmarks to assign points.		



Performan	Performance Category Performance Standards for the 2017 Performance Period			
Performance Category	Proposed Performance Standard	Final Performance Standard		
Improvement Activities	Based on participation in activities that align with the patient-centered medical home.	Based on participation in activities listed in Table H of the Appendix final rule with comment period.		
	Number of points from reported activities compared against a highest potential	Based on participation as a patient- centered medical home or comparable specialty practice		
	score of 60 points.	Based on participation as an APM		
		Based on participation in the CMS study on improvement activities and measurement		
		Number of points from reported activities or credit from participation in an APM compared against a highest potential score of 40 points.		
Advancing Care Information	Based on participation (base score) and performance (performance score).	Based on participation (base score) and performance (performance score).		
	Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure.	Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure. Performance score: Between zero and 10 or 20 percent per measure (as designated by CMS) based upon measure reporting rate, plus up to 15 percent bonus score.		
	Performance score: decile scale for additional achievement on measures above the base score requirements, plus 1 bonus point.			

CMS list the following policies it is finalizing related to the proposed unified scoring system.

For the quality and cost performance categories, all measures will be converted to a 10-point scoring system which provides a framework to universally compare different types of measures across different types of MIPS eligible clinicians.

The measure and activity performance standards will be published, where feasible, before the performance period begins, so that MIPS eligible clinicians can track their performance during the performance period.

MIPS eligible clinicians who fail to report specific measures or activities would receive zero points for each required measure or activity that they do not submit to MIPS.



The scoring policies provide incentives for MIPS eligible clinicians to invest and focus on certain measures and activities that meet high priority policy goals such as improving beneficiary health, improving care coordination through health information exchange, or encouraging APM Entity participation.

Performance at any level would receive points towards the performance category scores.

CMS is finalizing that the baseline period will be the 12-month calendar year that is two years prior to the performance period for the MIPS payment year.

CMS is finalizing the alternative approach for the scoring of new measures, or measures without a comparable historical benchmark, to have a floor of 3 points until baseline data can be utilized.

Example of Using Benchmarks for a Single Measure to Assign Points With a Floor of 3 Points				
Benchmark Decile	Sample Quality Measure Benchmarks	Possible Points With 3-Point Floor	Possible Points Without 3-Point Floor	
Benchmark Decile 1	0.0-9.5%	3.0	1.0-1.9	
Benchmark Decile 2	9.6-15.7%	3.0	2.0-2.9	
Benchmark Decile 3	15.8-22.9%	3.0-3.9	3.0-3.9	
Benchmark Decile 4	23.0-35.9%	4.0-4.9	4.0-4.9	
Benchmark Decile 5	36.0-40.9%	5.0-5.9	5.0-5.9	
Benchmark Decile 6	41.0-61.9%	6.0-6.9	6.0-6.9	
Benchmark Decile 7	62.0-68.9%	7.0-7.9	7.0-7.9	
Benchmark Decile 8	69.0-78.9%	8.0-8.9	8.0-8.9	
Benchmark Decile 9	79.0-84.9%	9.0-9.9	9.0-9.9	
Benchmark Decile 10	85.0%-100%	10	10	

After consideration of the comments on quality measure benchmarks, CMS is finalizing many policies as proposed. Specifically:

- For quality measures for which baseline period data is available, CMS is establishing at §414.1380(b)(1)(i) measure benchmarks based on historical performance for the measure based on a baseline period. Each benchmark must have a minimum of 20 individual clinicians or groups who reported the measure meeting the data completeness requirement and minimum case size criteria and performance greater than zero. CMS will restrict the benchmarks to data from MIPS eligible clinicians, and comparable APM data, including data from QPs and Partial QPs.
- For quality measures for which there is no comparable data from the baseline period, CMS is establishing at §414.1380(b)(1)(ii) that CMS will use information from the performance period to create measure benchmarks. CMS will publish the numerical performance period benchmarks after the end of the performance period. CMS is finalizing that for the transition year, the performance period will be a minimum of any continuous 90-day period within CY 2017. Therefore, for MIPS payment year 2019, CMS will use data submitted for performance in CY 2017, during which MIPS eligible clinicians may report for a minimum of any continuous 90-day period.



- CMS is establishing at \$414.1380(b)

 (1)(iii) separate benchmarks used for the following submission mechanisms: EHR submission options; QCDR and qualified registry submission options; claims submission options; CMS Web Interface submission options; CMS approved survey vendor for CAHPS for MIPS submission options, and administrative claims submission options.
- CMS is establishing at §414.1380(b) (1)(ii)(A) that the CMS Web Interface submission will use benchmarks from the corresponding reporting year of the Shared Savings Program. CMS will post the MIPS CMS Web Interface benchmarks in the same manner as the other MIPS benchmarks. CMS is not building CMS Web Interface-specific benchmarks for the MIPS. CMS will apply the MIPS scoring methodology to each measure. Measures below the 30th percentile will be assigned a value of 3 points during the transition year to be consistent with the global floor established in this rule for other measures.

MIPS eligible clinicians that report measures with fewer than 20 cases (and the measure meets the data completeness criteria) would receive recognition for submitting the measure, but the measure would not be included for MIPS quality performance category scoring.

CMS is finalizing at \$414.1380(b)(1)(vi) that MIPS eligible clinicians who fail to report a measure that is required to satisfy the quality performance category submission criteria will receive zero points for that measure.

CMS is finalizing at §414.1380(b)(1)(xiii) its proposal to award 2 bonus points for each outcome or patient experience measure and 1 bonus point for each other high priority measure that is reported in

addition to the 1 high priority measure that is already required to be reported under the quality performance category submission criteria.

CMS is increasing the cap for high priority measures from 5 percent to 10 percent of the denominator (total possible points the MIPS eligible clinician could receive in the quality performance category) of the quality performance category for the first two years.

CMS is finalizing its proposed policy that the CEHRT bonus would be available for groups using CMS Web Interface for measures submitted in a manner that meets the end-to-end reporting requirements. CMS Web Interface users may receive one bonus point for each reported measure with a cap of 10 percent of the denominator of the quality performance category.

Section II.E.6 f contains the detailed description and examples of how the quality performance category score would be calculated under the finalized policies.

CMS is not finalizing any policies related to improvement in this rule, but will consider comments for future rulemaking.

CMS is finalizing its proposal at \$414.1380(b)(2)(i) to establish cost measure benchmarks based on the performance period. CMS is finalizing the methodology proposed at \$414.1380(b) (2) to assign one to ten points to each cost measure attributed to the MIPS eligible clinician based on the MIPS eligible clinician's performance compared to the measure benchmark.

CMS has finalized a higher case minimum of 35 for a MIPS eligible clinician or group to be attributed to the MSPB cost measure. CMS has finalized a case



minimum of 20 for all other cost measures.

CMS is finalizing its proposal at \$414.1380(b)(2)(iii) that a MIPS eligible clinician's cost performance category score is the equally-weighted average of all scored costs measures.

The rule's Table 26 (section II.E.6.a(4)(a) lists all of the improvement activities that are high-weighted. All other activities not listed as high-weighted activities are considered medium activities. Table H in the Appendix provides the Improvement Activities Inventory of all activities, both medium-weighted and high-weighted.

CMS is modifying its proposal to reduce the number of activities so that no more than four medium-weighted activities, or no more than two high-weighted activities, or an equivalent combination (that is, 1 high and 2 medium) are required in order to achieve the highest possible improvement activities performance category score. Each medium-weighted activity is worth 10 points toward the total category score, and each high-weighted activity is worth 20 points toward the total category score of 40 points. These points are doubled for small practices, rural practices, or practices located in geographic health professional shortage areas, and non-patient facing MIPS eligible clinicians.

The table below summarizes the weights specified for each performance category under section 1848(q)(5)(E)(i) of the Act and in accordance with CMS' final policies which are summarized at \$414.1380(c)(1) and detailed at \$\$414.1330(b), 414.1350(b), 414.1355(b), and 414.1375(a).

	Final Weights by Performance Category					
Performance Category	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year and Beyond			
Quality	60%	50%	30%			
Cost	0%	10%	30%			
Improvement Activities	15%	15%	15%			
Advancing Care Information*	25%	25%	25%			

^{*}The weight for advancing care information could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.

7. MIPS Payment Adjustments

Section 1848(q)(6)(A)(iii) of the Act provides that MIPS eligible clinicians with a final score at or above the performance threshold receive a zero or positive MIPS adjustment factor on a linear sliding scale such that a MIPS adjustment factor of 0 percent is assigned for a final score at the performance threshold and a MIPS adjustment factor of the applicable percent is assigned for a final score of 100. Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure the budget neutrality requirement is met.

Section 1848(q)(6)(A)(iv) of the Act provides that MIPS eligible clinicians with a final score below the performance threshold receive a negative MIPS adjustment factor on a



linear sliding scale such that a MIPS adjustment factor of 0 percent is assigned for a final score at the performance threshold and a MIPS adjustment factor of the negative of the applicable percent is assigned for a final score of 0; further, MIPS eligible clinicians with final scores that are equal to or greater than zero, but not greater than one-fourth of the performance threshold, receive a negative MIPS adjustment factor that is equal to the negative of the applicable percent.

Section 1848(q)(6)(B) of the Act defines the applicable percent for each year as follows: (i) for 2019, 4 percent; (ii) for 2020, 5 percent; (iii) for 2021, 7 percent; and (iv) for 2022 and subsequent years, 9 percent.

Rule section II.E.7.g [beginning on page 1282 of the pre-published copy] contains a number of examples of how various final scores would be converted to an adjustment factor and potentially an additional adjustment factor, using the statutory formula.

PERFORMANCE FEEDBACK

CMS is finalizing a process for providing performance feedback to MIPS eligible clinicians. Initially, CMS will provide performance feedback on an annual basis. In future years, CMS aims to provide performance feedback on a more frequent basis, as well as providing feedback on the performance categories of improvement activities and advancing care information in line with clinician requests for timely, actionable feedback that they can use to improve care. CMS is finalizing its proposal to make performance feedback available using a web-based application. Further, CMS is finalizing its proposal to leverage additional mechanisms such as health IT vendors and registries to help disseminate data contained in the performance feedback to MIPS eligible clinicians where applicable.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting



THIRD PARTY INTERMEDIARIES

CMS is finalizing requirements for third party data submission to MIPS that are intended to decrease burden to individual clinicians. Specifically, qualified registries, QCDRs, health IT vendors, and CMS-approved survey vendors will have the ability to act as intermediaries on behalf of MIPS eligible clinicians and groups for submission of data to CMS across the quality, improvement activities, and advancing care information performance categories.

PUBLIC REPORTING

CMS is finalizing a process for public reporting of MIPS information through the Physician Compare Web site, with the intention of promoting fairness and transparency. CMS is finalizing public reporting of a MIPS eligible clinician's data; for each program year, CMS will post on a public Web site, in an easily understandable format, information regarding the performance of MIPS eligible clinicians or groups under MIPS.

Final Comment

As noted earlier, this analysis is not all inclusive. A number of items have not been addressed. Again, this rule is long and complex requiring in-depth review by those being affected.

The early sections are not as well written as later provisions. Many areas lack clear and final actions. In many instances the actions appear redundant. The sheer number of comments does, in fact, demonstrate the confusion and concern of moving to a new physician payment system.

Many of CMS' responses to comments and actions reveals a degree of uncertainty on the part of CMS in moving forward on the legislative mandate.