
MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: October 21, 2016

Re: Summary of the MACRA Final Rule

On October 14, 2016, CMS released the eagerly-awaited final rule implementing the new Medicare physician Quality Payment Program (“QPP”) as authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). The QPP incentivizes quality physician services through the Merit-based Incentive Payment System (“MIPS”) which adjusts Medicare reimbursement beginning in 2019 based on physician performance measured in 2017 and beyond. Physicians may be exempted from MIPS adjustments and may receive a bonus payment for participating in CMS-approved Advanced Alternative Payment Models (“Advanced APMs”). CMS made significant changes from the proposed rule.

This memorandum provides an overview of the major AAHKS comments on the MACRA proposed rule and summarizes CMS’ response in the final rule, as well as highlighting several other major changes from the proposed rule.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

I. Quality Performance Category

a. Decreasing Required Quality Measures – Sec. II.E.5.b.(1)(a)

AAHKS Comment: We support this proposed change to the number of quality measures required to be reported by physicians. As MIPS expands the factors that are reported and considered under the new Quality Payment Program (“QPP”), it is appropriate that reporting under some categories be reduced to account for the total time and effort necessary for physicians to comply with MACRA. Given the changes that will occur with implementation of MACRA, particularly in the first few years, we recommend that reporting obligations should be maintained at the minimum volume necessary . . . While AAHKS has been actively involved in measure development and maintains five of the 14 measures currently available in the Orthopedic Surgery Category under the Physician Quality Reporting System (“PQRS”), even these 14 measures are limited in scope across measure type and domain.

CMS Response: CMS has finalized its proposal to decrease the nine quality measures required under the 2016 PQRS requirement to six quality measures for 2017. At least one of the six quality measures must be an outcome measure. If an outcome measure is not available, then providers will be required to report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an outcome measure. If fewer than six measures apply to the provider, then the provider is only required to report on each measure that is “applicable” (which CMS defines as measures relevant to a particular provider’s services or care rendered). Alternatively, providers can elect to report one specialty-specific measure set, or the measure set defined at the subspecialty level, if applicable. CMS has declined to finalize its proposal that providers report a cross-cutting measure.

b. Increasing Requirements for Outcome Measures – Sec. II.E.5.b.(1)(a)

AAHKS Comment: We agree with the value to the Medicare program of increasing required reporting of outcome measures. Such an increase, however, is predicated on the existence of sufficient outcome measures for surgical procedures. While measures currently exist under the PQRS and electronic Clinical Quality Measures (“eCQMs”) (PQRS 376 and 376) that track the percentage of TJA patients who have completed baseline and follow-up functional status assessments, these are process measures. We note that all other measures available in the “Orthopedic Surgery” category of Table E are process measures. In fact, extensive work between CMS and the national orthopaedic specialty associations is needed to develop applicable outcome measures . . . AAHKS already has demonstrated experience in partnering with national orthopaedic specialty associations, CMS, other payers, and measure developers on the adoption of other consensus outcome measures, and we look forward to continuing such relationships as MACRA unfolds.

CMS Response: CMS acknowledged that some commenters “were concerned that a small number of orthopedic surgery outcomes measures currently exist and believed that more time is required to develop relevant outcomes measures before CMS emphasizes outcomes for specialty clinicians.” CMS noted that it has finalized the requirement for providers to report an outcome measure, but if an outcome measure is not available, another high priority measure may be selected. In addition, CMS agreed that “additional outcome measure development needs to occur.”

c. Risk Adjustment for Socioeconomic Status – Sec. II.E.5.b.(1)(a)

AAHKS Comment: We eagerly await CMS action to improve risk adjustment based on socioeconomic factors following completion of the ASPE and NQF analysis. Providers of all types have become more aware of the impact of socioeconomic factors on clinical outcomes. CMS considers the ASPE and NQF reports important enough to have indicated they will play a role in future rulemaking under the Inpatient Prospective Payment System and rate announcements for the Medicare Advantage program. We are grateful for CMS’ appropriate

focus on the importance of accurate risk adjustment. We hope that CMS will extend this risk adjustment emphasis into the one program most significantly missing it to date: the CJR model . . . Without properly adjusting for all of the factors that impact quality, physicians will be subject to payment adjustments that are reflective of the patient population and not reflective of the actual quality of care provided. We are concerned that MIPS will fail to incentivize better care if physicians find the measurement of quality dependent on factors outside the control of these physicians, and may in fact disincentivize care for those who are most in need.

CMS Response: CMS did not respond to this specific comment but reaffirmed that it will be closely examining the ASPE on studies on potential adjustments for socioeconomic status when completed and will incorporate findings as feasible and appropriate through future rulemaking. CMS also committed to monitor outcomes of beneficiaries with social risk factors, as well as the performance of the MIPS eligible clinicians who care for them to assess for potential unintended consequences such as penalties for factors outside the control of clinicians.

d. Use of All-Payer Data – Sec. II.E.5.b.(1)(c)

AAHKS Comment: We question the decision to include all-payer data in a quality program used specifically for measuring performance related to Medicare beneficiaries. While we acknowledge that all-payer data may be valuable in some respects, we believe that CMS is going beyond the boundaries necessary or appropriate for determining reimbursement under the QPP.

Different payers stress different approaches to care, and lumping private payer data in with Medicare data does not recognize the differences in approaches used by public and private payers. The initial performance periods for MIPS should focus on implementing only those provisions required by the law and should avoid using Congressional reforms as a back door for creating new reporting requirements. Eventually, all parties may come to agree on the utility of all-payer data, particularly through the ongoing work of the Health Care Payment Learning & Action Network (“HCP-LAN”). Until that point, CMS should not expand quality measure reporting populations beyond current requirements.

CMS Response: CMS finalized its use of all-payer data for various quality reporting requirements. CMS noted that section 1848(q)(5)(H) of the Social Security Act authorizes the Secretary to include, for purposes of the quality performance category, data submitted by MIPS eligible clinicians with respect to items and services furnished to individuals who are not Medicare beneficiaries. CMS did not agree with commenters who stated that using all-payer data would create an inequitable assessment of the MIPS eligible clinicians’ performance on quality, arguing instead that utilizing all-payer data will provide a more complete picture of the MIPS eligible clinicians’ performance.

II. Resource Use Performance Category

a. Value Modifier Cost Measures Proposed for the MIPS Resource Use Performance Category – Sec. II.E.5.e.(3)(a)

AAHKS Comment - CMS should clarify whether, under the proposed VM model, resource use by a particular physician or group is risk adjusted based on *all HCC codes attributed to the patient in the prior year*, or only those HCC codes entered by the particular physician subject to the resource use measure. In the case of a surgeon, many may not have had a patient-provider relationship in the prior year and therefore would not themselves have recorded HCC codes in the patient record in the prior year. The risk adjustment should be based on any and all HCC codes attributed to the patient in the prior year . . . Furthermore, development of risk adjustment methods must be done with close consideration of minimizing additional data collection steps for providers. Many important risk factors for adverse patient outcomes currently are either not measurable using available data (e.g., preoperative functional status) or are not consistently reported (e.g., obesity).

CMS Response: CMS did not address the specific comments raised by AAHKS. However, additional research suggests that risk adjustment occurs based on diagnoses from all FFS claims from the following settings: Hospital inpatient; Hospital outpatient; Physician; and Clinically-trained non-physician (e.g., clinical psychologist).

b. Episode-Based Measures Proposed for the MIPS Resource Use Performance Category – Sec. II.E.5.e.(3)(b)

AAHKS Comment: AAHKS opposes the use of the THA and TKA measure numbers 25 and 26 found in Table 4, known also as “Method A” at this time. While CMS and its contractors have evaluated measures under Method A, they have never before been calculated for physicians and certainly never applied for payment adjustments . . . The THA and TKA measures 6 and 7 found in Table 5, known also as “Method B,” would be preferable because practices have at least received assessments under these measures previously through the sQRUR.

Finally we note that, at section II.E.5.e.(4), CMS intends to consider adding Medicare Part D drug costs to the resource use calculation in future rulemaking . . . if the capacity does exist, CMS must incorporate a means to ensure that Part D costs attribute to a physician are limited to the prescriptions and expenditures within the control of the physician. For instance, Part D costs included in an episode based resource measure for TJA should exclude costs unrelated to the TJA procedure.

CMS Response: CMS has modified its proposal and elected to finalize only 10 episode-based measures from the proposed rule for CY 2017 (Table 7), including the THA and TKA measures B/6 and B/7 that were listed under “Method B” of the proposed rule. All 10 of the finalized episode-based measures, including the THA and TKA measures, were included in the 2014

sQRUR and meet a reliability threshold of 0.4 for the majority of providers at a case minimum of 20. Note that these measures will be used to determine the cost performance category, which CMS has modified so that the cost category will have a weight of 0 percent for the 2019 MIPS payment year.

CMS also noted that it received comments in support of and in opposition to its consideration of adding Part D costs into the cost performance category. CMS stated that it will continue to investigate methods to incorporate Part D costs into future cost measures.

III. Clinical Practice Improvement Activity (“CPIA”) Category

a. CPIA Submission Criteria Sec. II.E.5.f.(3)(c)

AAHKS Comment: We endorse the proposal to grant an automatic score of 30 points for participating in an APM as we interpret that this would include participation in the CJR model. While we believe that CJR participation will ultimately be considered by CMS to be participation in an Advanced APM, it is appropriate that physicians be rewarded for participation in any of the many APMs that significantly advance value-based payments.

CMS Response: CMS clarified that it is required by statute to give MIPS eligible clinicians or groups participating in an APM a minimum of half of the highest score in a clinical practice improvement category. Eligible clinicians that are participating in an APM are considered to participate in a clinical practice improvement category unless they are participating in an Advanced APM or have met the Qualifying APM Participant (QP) thresholds or are Partial QPs that elect not to report information. In order to participate in a clinical practice improvement category through an APM the clinicians will be required to report that they are participating in an APM and the APM will submit the clinician’s improvement activities.

b. CPIA Inventory – Sec. II.E.5.f.(7)

AAHKS Comment: We thank CMS for proposing 14 CPIAs related to reporting to and use of a QCDR. We believe that QCDRs, such as the American Joint Replacement registry (“AJRR”), are an essential tool in care improvement. Many AAHKS members participate in the AJRR which leads to enhanced patient experience and benchmark performance; reduction in complications and revision rates; and post-market surveillance of implants. Because such registries are already performing all the activities intended to be advanced through MACRA, we believe that all CPIAs related to QCDR use should be granted a “high” weighting.

CMS Response: With the exception of the “Population Management” subcategory CMS gave all QCDR related activities a medium weighting. CMS addressed comments requesting that participation in a QCDR be granted a high weighting, explaining that because participation in a QCDR does not demonstrate the performance of multiple improvement activities it does not warrant a higher weighting. CMS further elaborated that while QCDR participation may not

confer improvement activities performance category credit, it likely places clinicians in a better position to report on improvement activities, including those activities that specifically reference QCDR participation.

IV. Advancing Care Information (“ACI”) Performance Category – Method Data Submission – Sec. II.E.5.g.(5)(b)

AAHKS Comment: We agree that many EHR vendors will be hard pressed to successfully update products to comply with final MIPS standards that will not be finalized by CMS until the Fall. By nevertheless assessing providers on the ACI category for performance year 2017 many providers will be penalized. Many clinicians and their groups and institutions have long-standing relationships with vendors who understand the needs of their practice. We prefer that providers not be forced to choose between having a reduced score in the ACI category and having to scramble in the final weeks of 2016 to determine which vendors have compliant and operational reporting systems. For the purposes of the ACI category, CMS should commence the 2017 performance period in the second half of the year to allow for vendors to complete and test fully compliant products in response to the final MACRA rule.

CMS Response: CMS did not specifically address the request that for the purposes of the EHR related ACI category it delay the performance period until the second half of 2017. CMS did however acknowledge concerns that EHR and QCDR vendors may face technical difficulties in submitting data in 2017 due to the time needed to develop the technology for data submission. However, CMS points out that clinicians have multiple reporting mechanisms that they can use as an alternative for 2017.

V. Additional MIPS Changes from the Proposed Rule

a. Transition Year and Iterative Learning and Development Period

CMS received many comments that many eligible clinicians face challenges in understanding the requirements and being prepared to participate in the QPP by 2017. As a result, CMS is implementing transitional policies to encourage participation and education of clinicians. The transition QPP implementation will allow the wide diversity of clinical practices to pick their pace of participation for the first performance period that begins January 1, 2017. Eligible clinicians will have three flexible options to submit data to MIPS and a fourth option to join Advanced APMs in order to become QPs, which would ensure they do not receive a negative payment adjustment in 2019.

- (1) Clinicians can choose to report to 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 6 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.

For the 2017 transition year, 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 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. 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 are intended by CMS to encourage and provide a ramp up period for clinicians to prepare for higher performance thresholds in the second year of the program. CMS anticipates that the iterative learning and development period will last longer than the 2017; therefore, MCS projects that 2018 to also be transitional in nature to provide a ramp-up of the program and of the performance thresholds. CMS anticipates making proposals on the parameters of this second transition year through rule-making in 2017.

ALTERNATIVE PAYMENT MODELS

Congress intended with the passage of MACRA to not only reduce the cost of care but revolutionize the way in which care is provided. Participation in APMs is a central element in ensuring that the latter goal is met. AAHKS commented to CMS that the agency should strive to ensure that physicians of all specialties, practice sizes, and geographic settings have access to APMs. Further, AAHKS stressed the importance of providing APM Entities and Qualifying APM Participants (“QPs”) with attainable goals that do not deter potential participants.

In the Final Rule, CMS establishes incentives for participation in Advanced APMs that can apply to a specific clinical condition, a care episode, or a population. CMS aims to encourage interested eligible clinicians in their successful transition into APMs, such as the Shared Savings Program, Medical Home Models, and innovative episode payment models for cardiac and joint care, while acknowledging that CMS must provide ongoing education, support, and technical assistance as well as increase opportunities for eligible clinicians to join Advanced APMs over time. CMS states that it has set ambitious yet achievable goals to allow eligible clinicians to move with greater certainty toward participation in APMs. Further, CMS includes the criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (“PTAC”) in making comments and recommendations on physician-focused payment models (“PFPMs”), which CMS sees as an important avenue for creating new APM opportunities.

I. Identification of Advanced APMs – Sec. II.F.4

AAHKS Comment: We urge CMS to designate the CJR model as an Advanced APM, and we appreciate that CMS specifically seeks comments on how the CJR model could be redesigned to make it an Advanced APM. We have a number of suggestions for redesigning the CJR model in a manner that would allow it to qualify as an Advanced APM.

CMS Comment: MACRA defines criteria for determining whether the design of an APM qualifies as an “Advanced APM” for purposes of a participating clinician’s eligibility for a 5 percent annual lump sum bonus payment and exclusion from the MIPS Program. Specifically, for an APM to qualify as an Advanced APM, it must require participants to use certified electronic health record technology (“CEHRT”), provide for payment for covered professional services based on quality measures that are comparable to those in the quality performance category under MIPS, and either require that the participating APM Entities bear more than nominal risk for financial losses under the APM or be a Medical Home Model.

In the proposed rule, CMS identified six current models and demonstration programs being tested through the Center for Medicare and Medicaid Innovation (“CMMI”) that would be considered Advanced APMs under the established criteria. However, CMS did not include the CJR model in the list of Advanced APMs. AAHKS provided a number of comments on how the CJR model could be redesigned to allow it to qualify as an Advanced APM, including allowing physicians to be CJR episode “initiators” and “conveners” so that the two-sided financial risk that currently only applies to hospitals (starting in the second year of the CJR model) could also be applied to such physicians who participate in CJR as episode initiators and conveners. Further, physicians who serve as collaborators with hospitals in the CJR model should be identified as CJR model participants and the two-sided risk arrangements between such hospitals and physicians should be deemed as the acceptance of “more than nominal” financial risk.

AAHKS also recommended limiting the episodes of care included in the CJR model to elective TJA due to osteoarthritis, expanding the quality measures reported under the CJR model to

include physician-reported measures and developing TJA outcome measures with a longer timeframe than 3-6 months, requiring a risk and severity adjustment method to be incorporated into the CJR model, adding a requirement that CJR model participants do “end-to-end” reporting of quality metrics through the use of an EHR that exports data to a QCDR, and making the CJR model voluntary so that all hospitals and surgeons who would like to participate are able to do so.

In the final rule, CMS acknowledges that public comments on the proposed rule were considered in developing the proposed amendments to the CJR model that were included in the Advancing Care Coordination Through Episode Payment Models proposed rule (81 Fed. Reg. 50,794 (Aug. 2, 2016)). Changes to the CJR model that would allow for it to qualify as an Advanced APM will be addressed in the final rule under that separate rulemaking process expected in the next few weeks.

II. Use of CEHRT Requirements – Sec. II.F.4.b.(1)

AAHKS Comment: We do not believe that it is appropriate or necessary to increase minimum CEHRT levels sharply between the first and second performance years. The increase of the threshold from 50 to 75 percent should be gradually phased in over a period of years to allow greater transition time and the opportunity for upgrades.

CMS Response: For the 2017 performance year, CMS proposed to require that at least 50 percent of eligible clinicians participating in an Advanced APM must use CEHRT to document care and communicate with patients and other health care professionals, and that this threshold would increase to 75 percent in the 2018 performance year and beyond. AAHKS supported the 50 percent threshold for the first performance period, but encouraged CMS to either phase in the 75 percent threshold more gradually to allow greater transition time and the opportunity for upgrades or make an exception for new Advanced APMs that begin after the first performance period.

In the final rule, CMS agreed with commenters that raising the threshold to 75 percent in 2018 may create an overly rigorous standard for Advanced APMs and that it would be prudent to wait until more information is available on how the threshold would impact specific APMs, such as specialty APMs, before increasing the threshold, if at all. As a result, CMS is finalizing the proposal to require that at least 50 percent of eligible clinicians participating in an Advanced APM must use CEHRT in the first performance period; however CMS is not finalizing the proposal to increase the threshold for CEHRT use to 75 percent after the first performance period. CMS states that it will maintain the 50 percent CEHRT use requirement for the second performance year and beyond and consider making any potential changes through future rulemaking.

III. Financial Risk Requirements – Sec. II.F.4.b.(3)

AAHKS Comment: We urge CMS . . . to include the true variety of financial risks faced by physicians when establishing alternative payment innovations: initially establishing infrastructure for data analysis and procedures for coordinating care and sharing information; participating in a clinical data registry; jointly developing treatment plans; ongoing costs for new employees such as care managers; and foregone revenue from billable services that are reduced under an APM due to the use of appropriateness guidelines and efforts to reduce emergency department visits and hospitalizations.

CMS Response: In the proposed rule, CMS considered, but rejected, the concept that the required assumption of financial risk by Advanced APMs can arise from an APM’s “business risks” associated with the size of the financial investments made by an APM, in terms of time and money, to meet the conditions to be an Advanced APM. AAHKS urged CMS to include the true variety of financial risks faced by physicians when establishing alternative payment innovations: initially establishing infrastructure for data analysis and procedures for coordinating care and sharing information; participating in a clinical data registry; jointly developing treatment plans; ongoing costs for new employees such as care managers; and foregone revenue from billable services that are reduced under an APM due to the use of appropriateness guidelines and efforts to reduce emergency department visits and hospitalizations.

In the final rule, CMS acknowledges that APM Entities must invest substantial time and money to become successful APM participants. However, CMS does not agree that costs not encompassed by an APM’s financial risk arrangements (i.e., costs associated with investments in IT acquisition, hiring of care coordination and case management personnel, business and clinical process development, population management analytics, and other administrative costs) should be considered when assessing financial risk under the APM. CMS does not believe that it can objectively and accurately assess business risk without exceptional administrative burden on both CMS and APM Entities to quantify such expenditures and verify that they were made solely for participation in a particular APM. CMS states that business risk is generally a sunk cost that is unrelated to performance-based payment under an APM and that the placement of any objective monetary standard for how much investment could be considered more than “nominal” would inherently offer an incentive for excessive or wasteful investment that might be unrelated to performance by the APM Entity.

Accordingly, CMS is finalizing the Advanced APM financial risk standard as proposed. Specifically, to be an Advanced APM, an APM must provide that, if actual expenditures for which an APM Entity is responsible under the APM exceed expected expenditures during a specified performance period, CMS can: (1) withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians; (2) reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians; or (3) require the APM Entity to owe payment(s) to CMS. This financial risk standard does not include reductions in otherwise guaranteed payments

made under the terms of the APM, such as care management fees that vary based on quality performance. However, the Medical Home Model financial risk standard does take into consideration reductions in otherwise guaranteed payments under certain circumstances.

IV. Definition of Medical Home Model – Sec. II.F.3

AAHKS Comment: The definition for a medical home cited by CMS appears to largely preclude specialty medical homes . . . CMS further states a principle that medical homes are intended to focus on primary care, which seems to preclude any medical home that includes primary care but is focused on specialty care. We believe that this definition could eliminate future innovative Medical Home Models that focus on specialty care for complex patients with chronic needs, many of whom rely on their specialty physician as a de facto provider of primary care.

CMS Response: The proposed rule established unique criteria for Medical Home Models to ensure that primary care physicians would have opportunities to participate in Advanced APMs. However, the definition for a medical home proposed by CMS largely precludes specialty medical homes. AAHKS encouraged CMS to revise the definition of Medical Home Models to allow for future models that focus on specialty care for complex patients with chronic needs, many of whom rely on their specialty physician as a de facto provider of primary care.

In the final rule, CMS acknowledges commenters recommendations to broaden the definition of a Medical Home Model to include APMs that focus on specialty care. CMS specifically references AAHKS' comment that elements of the definition, such as continuity of care, coordination of chronic and preventive care, and coordination across the medical neighborhood, will assist multispecialty practices when seeking to participate in an Advanced APM, but that the proposed definition for a Medical Home Model would largely exclude specialty-focused models. CMS states that it will consider the suggestions for future rulemaking applicable to performance periods after 2017, but that the proposed definition is sufficient to identify Medical Home Models with a primary care focus that might be in place for the 2017 performance period.

V. Determination of Qualifying APM Participants – Sec. II.F.5

AAHKS Comment: There are concerns . . . surrounding the requirement that an eligible clinician be listed as a participant on December 31 of the QP performance period in order to qualify. This requirement essentially eliminates the ability of any eligible clinician to participate in an Advanced APM – or potentially a collection of Advanced APMs – on a partial year basis.

CMS Response: CMS proposed that a clinician's eligibility as a QP is determined at the group level and based on all eligible clinicians participating in an Advanced APM. AAHKS supported

this approach to ensure that APM requirements are met without instituting a burdensome new reporting requirement.

In the final rule, CMS is revising the proposal to use December 31 as the date to identify the Advanced APM Entity group for QP determinations and, if applicable, MIPS reporting and scoring under the APM scoring standard. Instead, CMS will use several snapshots throughout the year that better represent eligible clinician participation in Advanced APMs over the course of the year. Specifically, CMS will review the APM Entity's Participation Lists on March 31, June 30 and August 31. All eligible clinicians who appear on an APM Entity's Participation List on at least one of those three dates will be included in the APM Entity group for the applicable performance period. If a clinician is determined to be a participant in an APM Entity at any of those three snapshots, that clinician will be considered by CMS for QP determinations as part of an APM Entity group, or as an individual, as appropriate, regardless of whether they are included on a Participation List or Affiliated Practitioner List in later snapshots.

In the event that the APM Entity participates in a MIPS APM and is not excluded from MIPS, the final APM Entity group after the third snapshot also will be the APM Entity group used for purposes of MIPS group reporting and scoring under the APM scoring standard. CMS intends for this policy to allow for substantially greater certainty at an earlier point in time of an eligible clinician's status, first as a participant or affiliated practitioner in an Advanced APM or MIPS APM, and then as a QP or MIPS eligible clinician. CMS will monitor whether APM Entities systematically construct their lists in a manner that inappropriately affects the assessment of participation in Advanced APMs and may modify this policy through future rulemaking to address any such issues.

CMS also proposed to apply QP status to an eligible clinician's National Provider Identifier ("NPI") rather than limiting status to the Taxpayer Identification Number ("TIN") affiliated with the Advanced APM. AAHKS supported this proposal to use TIN/NPI combinations as a way to ensure that participation in an Advanced APM satisfies all requirements to be excluded from MIPS. In the final rule, CMS is finalizing the proposal to identify individual eligible clinicians by a unique APM participant identifier using the individuals' APM, APM Entity, and TIN/NPI combinations, and to assess as an APM Entity group all individual eligible clinicians listed as participating in an Advanced APM Entity to determine their QP status for a year.

VI. Combination All-Payer and Medicare Payment Threshold Option – Sec. II.F.7

***AAHKS Comment:* Allowing for participation in Other Payer Advanced APMs to count towards QP status is likely to encourage broader participation in APMs. More and more payers are committing to moving their medical spending to value-based contracts, including payers who are committed to APM adoption through implementation of the recommendations developed by the HCP-LAN.**

CMS Response: For 2021 and later, eligible clinicians may become QPs through a combination of participation in Advanced APMs and APMs with other payers (“Other Payer Advanced APMs”), such as private insurers, state Medicaid programs, and Medicare Advantage plans. An Other Payer Advanced APM must meet criteria similar to those for Advanced APMs. AAHKS urged CMS to clearly define the process for determining if another payer’s APM qualifies as an Other Payer APM, which could include the adoption of deeming standards for such APMs (e.g., for APMs that have been developed through HCP-LAN recommendations).

In the final rule, CMS is adopting the same overall approach to the All-Payer Combination Option as proposed (i.e., that a payment arrangement is an Other Payer Advanced APM if CEHRT is used, quality measures comparable to measures under the MIPS quality performance category apply, and the payment arrangement either requires entities to bear more than nominal financial risk or is a Medicaid Medical Home Model). CMS acknowledges commenters suggestions that CMS have a streamlined process for assessing Other Payer Advanced APMs (e.g., by allowing payers to submit models to CMS for basic approval of the specifications as Other Payer Advanced APMs in advance of parties finalizing contracts) and that CMS work with the HCP-LAN to support this process.

Instead of adopting any such processes in the final rule, CMS is seeking public comment on the overall process for reviewing payment arrangements in order to determine whether they are Other Payer Advanced APMs, and the possibility of establishing a process to prospectively engage in design and review of payment arrangements to determine if they meet the criteria for being Other Payer Advanced APMs, particularly regarding the assessment of Medicaid APMs. In addition, CMS confirms that it will continue to communicate its work to the HCP-LAN. CMS also states that it intends to inform the public regarding developments in the All-Payer Combination Option and Other Payer Advanced APM criteria through future rulemaking and subregulatory guidance.

In order to determine QP eligibility under the All-Payer Combination Option, CMS proposed that APM Entities and eligible clinicians, for each payment arrangement, be required to submit data on the amounts of payments for services furnished through the arrangement, the total payments from the payer, the numbers of patients furnished any service through the arrangement (that is, patients for whom the eligible clinician is at risk if actual expenditures exceed expected expenditures), and the total numbers of patients furnished any service through the payer. AAHKS urged CMS to adopt a data submission process that minimizes the burden on clinicians, who may not have this information readily available, and on the payers who have to attest that the data is accurate.

In the final rule, CMS is adopting the proposed information submission and payer attestation requirements with no change. However, CMS is seeking further comments on the process for submitting information. CMS states that it intends to consult with stakeholders and implement a process that requires reporting the least amount of information needed to determine participation in Other Payer Advanced APMs while ensuring the integrity of the program.

Further, CMS intends to put in place guidelines that will ensure proprietary information is not disclosed. CMS also states that it will consider existing reporting rules and attestations with payers, such as MA plans, and adopt similar ones where appropriate. CMS intends to use future rulemaking to potentially make changes to this approach.

VII. Participation in Multiple Advanced APMs – Sec. II.F.6.c.(4)

AAHKS Comment: We appreciate that CMS recognizes that physicians, including surgeons, could be participating in multiple arrangements that qualify as Advanced APMs, and that participation in multiple Advanced APMs could count towards the payment and patient count thresholds established for QP-status under an Advanced APM . . . However, given the high threshold for an APM to qualify as an Advanced APM, it is unclear how many of our members would currently meet the QP standards for participation in one Advanced APM, let alone multiple Advanced APMs. Therefore, in addition to the primary care-focused Advanced APMs discussed in the proposed rule, we urge CMS to adopt new models that focus on physician specialists and surgeons.

CMS Response: CMS includes an exception to the QP determination process at the group level for individual eligible clinicians who are identified as part of multiple Advanced APM Entities, none of which meet the QP threshold based on payment or patient count.

In the final rule, CMS adopts the proposal to allow for an individual eligible clinician who participates in multiple Advanced APM Entities but does not achieve QP status through participation in any single APM Entity to be assessed individually to determine QP status based on that individual's combined participation in Advanced APMs. This includes all Advanced APM Entities for which the eligible clinician is represented on either a Participation List or Affiliated Practitioner List that CMS uses for QP determinations. CMS will make adjustments to ensure that patients and payments for services that may be counted in the QP calculations for multiple Advanced APM Entities (for example, payments for services furnished to a beneficiary attributed to an ACO that are also part of an episode in an episode payment model) are not double-counted for the individual.

VIII. Physician-Focused Payment Models

a. *Proposed Criteria – Sec. II.F.10.c*

Under MACRA, CMS is required to establish PFPM criteria to be used by the PTAC to make comments and recommendations on proposed PFPMs to CMS. The proposed rule establishes the PTAC, and applicable criteria to be used in reviewing and assessing additional PFPMs suggested by stakeholders for possible inclusion in the QPP. AAHKS urged CMS to clarify that the PTAC is able to set priorities but should not exercise this authority by blocking access for specialty providers. Instead, proposals should be expected to focus on physicians who do not have the opportunity to participate in other APMs due to the specialty's lack of inclusion in CMS

APM pilot programs. AAHKS sought clarity related to the manner in which CMS will consider PTAC recommendations for new APMs, and asked CMS to confirm that it is not limited to considering PFPMs only on the timeline and recommendation of the PTAC (e.g., the fact that CMS has ultimate decision-making authority for what qualifies as an APM should mean that CMS also has flexibility to propose necessary specialty-related PFPMs).

In the final rule, CMS states that it is open to the PTAC's comments and recommendations and that the PTAC review and recommendation process will be an essential resource for CMS in developing new APMs. CMS declines to establish priorities for PFPMs or to commit in advance to pursue any particular model before knowing its substance, but CMS states that it is committed to giving all models recommended by the PTAC a thorough and thoughtful review, and to testing high-quality PFPMs, within the limits of its resources and other constraints. In response to AAHKS's request for clarification that CMS is not limited to considering PFPMs only on the timeline and recommendation of the PTAC, and that CMS can develop its own specialty-related PFPMs, CMS does specifically confirm that it retains the flexibility to consider and test PFPMs that are developed within CMS.

CMS states that it is mindful of stakeholders' interest in a timely process for the review of proposed PFPMs and that it is committed to reviewing (and where appropriate, implementing) model proposals as quickly as possible. Further, CMS states that it aspires to fostering transparency and cooperation with regard to testing PFPMs, including feedback from consumers and purchasers. Accordingly, CMS has made public the factors that CMMI uses in considering whether to test a model, which would also be relevant to its review of PFPMs (see <https://innovation.cms.gov/Files/x/rfiwebsitepreamble.pdf>). The PTAC also has made public information regarding its process for its review of PFPM proposals (see <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisorycommittee>). CMS intends to provide more information about this process outside of notice and comment rulemaking.

b. Supplemental Information Elements – Sec. II.F.10.d

CMS stated in the proposed rule that it will weigh expedited consideration of recommended PFPMs when the proposal contains “supplemental information elements” not otherwise required by statute or regulation. AAHKS requested that CMS or PTAC be required to provide formal guidance on what constitutes acceptable supplemental information and the precise manner in which supplemental information impacts a PFPM proposal, in order to avoid the creation of a bifurcated system in which entities with the size and resources necessary to develop supplemental information are given priority over smaller proposals from entities that do not have the resources to conduct optional studies.

In the final rule, CMS states that the “supplemental information elements” are meant to increase the transparency of CMS's APM review process, and that such elements are not included within the PFPM criteria (e.g., that the PFPM be anticipated to improve health care

quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost). CMS does not provide further clarification in the final rule on the definition of “supplemental information” or how it impacts a PFFM proposal.

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