



May 27, 2016

## MACRA PHYSICIAN QUALITY PAYMENT PROGRAM PROPOSED RULE

### *AT A GLANCE*

#### **At Issue**

On April 27, the Centers for Medicare & Medicaid Services (CMS) published a [proposed rule](#) implementing key provisions of the new quality payment program (QPP) for physicians and other professionals mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Comments on the proposed rule are due by June 27. A final rule is anticipated no later than Nov. 1. Most provisions of the rule would take effect on Jan. 1, 2017.

The MACRA repeals the flawed Medicare sustainable growth rate payment methodology for updates to the physician fee schedule (PFS). It also requires CMS to establish a QPP that affects PFS payments to eligible clinicians starting in calendar year (CY) 2019. Eligible clinicians will participate in one of two tracks – the default Merit-based Incentive Payment System (MIPS) or alternative payment models (APMs). The rule proposes most of the key policies for the 2019 MIPS and APM tracks, including the following:

- Most of the requirements for the CY 2019 MIPS, including eligibility, performance measures, data submission mechanisms, a scoring methodology and payment adjustment methodology. MIPS-eligible groups and clinicians can earn positive or negative payment adjustments of up to 4 percent in CY 2019, rising gradually to +/- 9 percent in CY 2022 and beyond.
- A new framework for the Medicare Electronic Health Record (EHR) Incentive Program for eligible clinicians. Renamed Advancing Care Information (ACI), performance in this category would be reported by eligible clinicians as part of the overall MIPS composite score. CMS proposes changes intended to provide greater flexibility in meeting meaningful use measures and objectives, and that move away from an “all or nothing” scoring approach.
- Criteria for advanced APMs in which a clinician must participate to qualify for the APM incentive. These include use of certified EHR technology, quality measurement and a requirement that the APM participant bear downside financial risk.
- A methodology by which CMS would consider both payment amounts and patient counts when making the determination of whether a clinician has met the threshold to qualify for APM incentives and use whichever method is more advantageous.

The rule also proposes policies related to the blocking of health information and EHR surveillance. These particular policies would apply not only to physicians, but also to hospitals and critical access hospitals (CAHs) participating in the EHR Incentive Program.

### ***Our Take:***

The AHA is pleased that CMS proposes to reduce the number of quality measures that MIPS-eligible clinicians and groups would be required to report. While we are disappointed CMS chose not to propose a MIPS quality measure reporting option for hospital-based clinicians, we are pleased the agency solicits comment on the development of such an option for future years of the MIPS. The AHA also appreciates that CMS has taken steps to introduce greater flexibility in meeting meaningful use requirements in the ACI category. However, we are concerned that CMS's proposals for the ACI bring the meaningful use program for clinicians out of alignment of that for hospitals.

With respect to APM, while we are pleased that CMS has proposed a flexible approach to the certified EHR and quality measurement criteria, we are disappointed that CMS proposed a definition of financial risk that does not consider the significant investment providers make when entering into an APM arrangement. Further, we are concerned that very few APMs would qualify under CMS's proposed criteria. Finally, we are pleased that, as urged by the AHA, the agency proposes to consider both patient counts and payment amounts when assessing APM participation.

### ***What You Can Do:***

- ✓ **[Register](#) to attend the AHA's members-only webinar on the proposed rule on Wednesday, June 1 at 1:30 – 3 p.m., ET.**
- ✓ Share this advisory with your senior management team – including your chief medical officer, chief quality officer, chief financial officer and leaders involved in APMs – and ask them to examine the impact of the proposed rule on your organization.
- ✓ **Submit comments to CMS with your specific concerns by June 27 at [www.regulations.gov](http://www.regulations.gov).** The final rule will be published no later than Nov. 1, with most provisions effective Jan. 1, 2017.
- ✓ Learn more about MACRA and its implications for hospitals by visiting [www.aha.org/MACRA](http://www.aha.org/MACRA) for resources targeting hospital leaders, trustees and others.

### ***Further Questions:***

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## BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published a [proposed rule](#) implementing key provisions of the new physician quality payment program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MACRA repeals the flawed Medicare sustainable growth rate payment methodology for updates to the physician fee schedule (PFS). It also requires CMS to establish a QPP that affects PFS payments to eligible clinicians starting in calendar year (CY) 2019. Eligible clinicians will participate in one of two tracks – the Merit-based Incentive Payment System (MIPS) or alternative payment models (APMs). Comments on the proposed rule are due by June 27. A final rule is anticipated no later than Nov. 1. If finalized, most provisions of the rule would take effect on Jan. 1, 2017.

A detailed summary of the proposed rule follows.

## MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

### **Overview of the MIPS**

The MACRA sunsets three existing physician quality performance programs – the physician quality reporting system (PQRS), Medicare EHR incentive programs for eligible professionals and the value-based payment modifier (VM) – and consolidates aspects of those programs into the MIPS. The MIPS will be the default QPP track for eligible clinicians.

The MIPS must assess eligible clinicians on four performance categories – quality measures, resource use measures, clinical practice improvement activities (CPIAs) and advancing care information (a modified version of the historical “meaningful use” program). For all four categories, CMS proposes to use CY 2017 as the “performance period” for CY 2019 MIPS payment adjustments. Each MIPS performance category has a weight (as outlined in Figure 1 below), and CMS proposes to combine the scores across the categories to create a composite performance score (CPS). Based on their MIPS CPS, eligible clinicians will receive positive, neutral or negative payment adjustments of 4 percent in CY 2019, rising gradually to a maximum of 9 percent in CY 2022 and beyond.

**Figure 1: Proposed MIPS Performance Category Weights**

MIPS Performance Category	CY 2019	CY 2020	CY 2021 and beyond
Quality	50%	45 %	30%
Resource Use	10%	15 %	30%

MIPS Performance Category	CY 2019	CY 2020	CY 2021 and beyond
Clinical Practice Improvement Activities (CPIAs)	15 %	15 %	15 %
Advancing Care Information	25 %	25 %	25 %

The rule proposes all of the main the requirements for the CY 2019 MIPS, including eligibility, performance measures, data submission mechanisms, a scoring methodology and payment adjustment methodology. This section of the advisory describes CMS’s proposed approach for the quality, resource use and CPIA categories of the MIPS. The next section describes CMS’s proposals for the advancing care information portion of the MIPS.

### **Eligibility for the MIPS**

As required by the MACRA, CMS proposes to apply the MIPS to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified registered nurse anesthetists (CRNAs). Similar to the current PQRS program, CMS also proposes that MIPS-eligible clinicians could participate in the MIPS either as individuals or as groups. The agency indicates that in future years, it may also propose to use its discretionary authority under the MACRA to apply the MIPS to other categories of professionals starting in 2021.

Non-patient facing clinicians. The MACRA also requires CMS to define MIPS-eligible clinicians who do not typically furnish services involving “face-to-face” interactions with patients (e.g., pathologists working in a lab, non-interventional radiologists). The agency is permitted to apply alternative measures, CPIAs and performance category weights to non-patient facing clinicians. Thus, CMS proposes to define a “non-patient facing” clinician or group as one that bills for 25 or fewer patient-facing encounters during a MIPS performance period. Patient-facing encounters would be identified by CMS using a list of codes. **However, the AHA is concerned that CMS has not yet made this list of codes publicly available.**

Exemptions. As required by the MACRA, CMS proposes to exempt several categories of clinicians from the MIPS:

- *Qualifying APM participants* – These eligible clinicians meet the proposed requirements for receiving bonuses for participating in advanced APMs (detailed in the APM section of this advisory).
- *Partial qualifying APM participants* – These eligible clinicians participate in advanced APMs that meet CMS’s proposed criteria, but fall just short of receiving a high enough percentage of their payments from advanced APMs to receive the bonus payment. Additional details on this category of participation are provided in

the APM section of this advisory. Partial qualifying APM participants may elect not to report MIPS data.

- *New Medicare-enrolled eligible clinicians* – These are eligible clinicians who enroll in Medicare for the first time during a MIPS performance period and have not previously submitted Medicare claims.
- *Low-volume threshold eligible clinicians* – CMS proposes to define this group as eligible clinicians who, during a MIPS performance period, have Medicare billing charges of \$10,000 or less AND provide care for 100 or fewer Medicare beneficiaries.

### **Identifiers for Eligible Clinicians and Groups**

CMS proposes to use a number of different ways to identify individual eligible clinicians and groups:

- *For eligible clinicians participating as individuals*, CMS proposes to use a combination of the clinician's National Provider Identifier (NPI) and Tax Identification number (TIN) to identify eligible clinicians. The agency would consider each unique TIN/NPI combination to be a different individual eligible clinician. While the agency considered using only an NPI to identify individual clinicians, CMS states that it needs both TIN and NPI to apply payment adjustments. Furthermore, the TIN/NPI combination allows CMS to match payment adjustments to the appropriate practice, especially for clinicians billing under more than one TIN.
- *For group practices*, CMS proposes to identify groups using a group's billing TIN. A MIPS group would be defined as a single TIN with two or more MIPS-eligible clinicians (as identified by NPI) who have reassigned their billing rights to the TIN.

**Notably, CMS would not require groups to register with CMS as a group practice if they report data using third-party entities (e.g., qualified registries, EHRs).** Such groups would be required to work with the entities to identify data as a group submission. However, CMS proposes to require registration by June 30 of a performance year for groups electing to submit data using the web interface data reporting option, or the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Additional details on proposed MIPS data submission mechanisms are described later in this advisory

- *To identify groups participating in APMs*, CMS proposes to use a unique APM participant identifier. The identifier would be developed by CMS, and use a combination of APM identification numbers, NPI and TIN.

## ***Applicability of the MIPS to CAHs and Other Rural Providers***

The rule includes proposals intended to clarify which rural providers are subject to MIPS participation and payment adjustments.

Critical Access Hospitals (CAHs). CMS notes that the applicability of MIPS to CAH payments would depend on the billing method used by CAHs, and whether eligible clinicians practicing in the CAH have reassigned their billing rights to the CAHs. Specifically, payments to CAHs billing under Method I of the CAH billing system **would not** be subject to MIPS payment adjustments. In addition, the agency would not apply MIPS payment adjustments to those CAHs using Method II billing if eligible clinicians do not reassign their billing rights to the CAH.

**However, CMS proposes that MIPS payment adjustments would apply to CAHs billing under Method II when MIPS-eligible clinicians have reassigned their billing rights to the CAH.** CMS uses this same approach under the current PQRS program. Under Method II, CAHs bill and are paid for facility services at 101 percent of reasonable cost, and for professional services “at 115 percent of such amounts as would otherwise be paid...if such services were not included in outpatient [CAH] hospital services.” The agency believes these professional services constitute “covered professional services” under the PFS, and notes that CAH professional service payments are based on the PFS. As a result, the agency believes it is appropriate to apply MIPS payment adjustments to CAH professional service payments.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). The proposed rule notes that MIPS payment adjustments do not apply to facility payments to RHCs and FQHCs. Eligible clinicians providing items and services in RHCs or FQHCs and billing under those respective payment systems **would not** be required to participate in MIPS or be subject to MIPS payment adjustments. However, CMS proposes that if the eligible clinicians practicing in RHCs or FQHCs bill services under the PFS, they would be expected to participate in MIPS and subject to MIPS payment adjustments.

## ***MIPS Data Reporting***

Reporting Mechanisms. For the CY 2019 MIPS, CMS proposes that clinicians and groups would have multiple options for submitting measure data for each MIPS performance category. The proposed mechanisms are outlined in Figure 2 below. Eligible clinicians and groups would be expected to choose only one submission mechanism per MIPS performance category. For example, eligible clinicians could not submit quality data using both claims and qualified registries; they would have to select one mechanism or the other. However, CMS proposes one exception to this rule; that is, groups electing to report the CAHPS survey for the MIPS would be expected to select one additional group data reporting option.



**Figure 2: Proposed MIPS Data Reporting Mechanisms for Individual Eligible Clinicians and Groups**

<b>MIPS Category</b>	<b>Individual Data Reporting Options</b>	<b>Group Data Reporting Options</b>
Quality	<ul style="list-style-type: none"> <li>- Part B claims-based reporting</li> <li>- Qualified Clinical Data Registry (QCDR)</li> <li>- Qualified Registry</li> <li>- EHR</li> </ul>	<ul style="list-style-type: none"> <li>- Qualified Clinical Data Registry (QCDR)</li> <li>- Qualified Registry</li> <li>- EHR</li> <li>- CAHPS Survey Vendor (for groups of 25 or more only)</li> <li>- CMS Web interface (for groups of 25 or more only)</li> </ul>
Resource Use	<ul style="list-style-type: none"> <li>- Part B claims-based reporting (no submission required)</li> </ul>	<ul style="list-style-type: none"> <li>- Part B claims-based reporting (no submission required)</li> </ul>
Clinical Practice Improvement Activities (CPIA)	<ul style="list-style-type: none"> <li>- Attestation</li> <li>- QCDR</li> <li>- Qualified Registry</li> <li>- EHR</li> <li>- Claims-based reporting (when technically feasible)</li> </ul>	<ul style="list-style-type: none"> <li>- Attestation</li> <li>- QCDR</li> <li>- Qualified Registry</li> <li>- EHR</li> <li>- Claims-based reporting (when technically feasible)</li> <li>- CMS Web Interface (for groups of 25 or more only)</li> </ul>
Advancing Care Information (ACI)	<ul style="list-style-type: none"> <li>- Attestation</li> <li>- EHR</li> <li>- QCDR</li> <li>- Qualified Registry</li> </ul>	<ul style="list-style-type: none"> <li>- Attestation</li> <li>- EHR</li> <li>- QCDR</li> <li>- Qualified Registry</li> <li>- CMS Web Interface (for groups of 25 or more only)</li> </ul>

**Submission Deadlines.** CMS proposes to require MIPS data submitted by qualified registry, qualified clinical data registry (QCDR), EHRs, CMS web interface and attestation to be submitted by Mar. 31 of the year immediately following the performance period. For example, the proposed performance period for the CY 2019 MIPS program is CY 2017. As a result, CY 2017 MIPS data would be due to CMS by Mar. 31, 2018. For MIPS data reported using Medicare claims, CMS would use claims that are processed by no later than 90 days after the close of the performance period. CMS states these timeframes are necessary to allow for a sufficient amount of performance data, and to allow enough time to calculate performance, check data for accuracy and apply adjustments.

***MIPS Quality Category***

The rule proposes requirements for the number and type of quality measures that individual eligible clinicians and group practices would be expected to report for CY 2019. In addition, the rule proposes “data completeness” requirements for each reporting mechanism that specify the percentage of patients for which data must be reported. The requirements are outlined in Figure 3 below, with additional explanation immediately following the chart. Table A of the proposed rule’s appendix provides the full list of measures from which clinicians and groups may choose, with labels indicating

what reporting mechanisms are available to report the measure. In addition, Table E of the proposed rule’s appendix includes that same list organized by specialty to help eligible clinicians identify the measures that may be most relevant to them.

**Figure 3: Proposed MIPS Quality Data Submission Requirements\***

Reporting Mechanism	Submission Requirements	Data Completeness Requirements
QCDR, Qualified Registry and EHR	<p>-Report at least six measures, including one cross-cutting measure and one outcome measure</p> <p>-If no outcome measure is available, then report another “high priority” measure (i.e., appropriate use, patient safety, efficiency, patient experience, or care coordination)</p> <p>-If fewer than six measures apply, report on as many applicable measures as possible</p> <p>-Report on <b>both</b> Medicare and non-Medicare patients</p>	Report on 90 percent of eligible clinician or group’s patients that meet measures’ denominator criteria
Part B claims-based reporting (individual eligible clinicians only)	Same as QCDR, Qualified Registry and EHR, except report on Medicare patients only	Report on 80 percent of eligible clinician’s patients
CMS Web Interface (groups of 25 or more only)	Report on all measures included in CMS web interface	<p>Web interface uses an attribution and sampling approach to assign patients to particular practices. Groups report on assigned beneficiaries:</p> <p>- Groups populate the data fields for first 248 assigned Medicare beneficiaries.</p> <p>- If fewer than 248 beneficiaries are assigned, report on 100 percent of assigned patients</p>
CAHPS (groups of 25 or more only)	<p>Use a CMS-approved vendor to collect and submit CAHPS for MIPS survey</p> <p>**Note: The CAHPS survey counts as one measure</p>	CMS applies an attribution and sampling approach to assign beneficiaries to particular practices. CAHPS vendor would collect survey on assigned Medicare Part B patients.

*\*Unless otherwise stated, the proposed requirements apply to both individual eligible clinicians and group practices*

Qualified Registry, QCDR and EHR Reporting. For eligible clinicians and groups using one of these data reporting mechanisms, CMS proposes to require the reporting of at least six measures. Among the six measures, CMS would require the reporting of at least one “cross-cutting” quality measure and one outcome measure. When no outcome measures are applicable to a clinician or group, then CMS would require the reporting of another “high priority” measure. CMS defines “high priority measures” to be measures of appropriate use, patient safety, efficiency, patient experience or care coordination.

*Measures List.* Table A of the proposed rule’s appendix includes labels indicating whether the measures are outcome measures and/or high priority measures. Of note, CMS proposes several measures identified using its “Core Measure Collaborative,” a joint effort between CMS, physician groups and private payers to identify common measure sets that could be used in both Medicare and private payer pay-for-performance programs.

A proposed list of “cross-cutting” measures is provided in Table C of the appendix of the proposed rule. Cross-cutting measures are those that CMS believes are broadly applicable to most physician specialties. The measure includes topics such as preventive screenings and advanced care planning.

*All-payer Data and Data Completeness.* CMS proposes that eligible clinicians and group practices reporting data using registries or EHR option would be expected to report on patients from all-payers – both Medicare and non-Medicare. The agency suggests this approach would provide a more complete and representative picture of quality provided by eligible clinicians and group practices. For each selected measure, clinicians and groups would be expected to report on 90 percent of patients from all payers meeting the measure’s denominator criteria for inclusion in the measure.

Claims-based Reporting. For individual eligible clinicians using Medicare claims to submit quality measures, CMS proposes to require the same number and type of measures that it requires for registry and EHR reporting. As with the existing claims-based reporting option for PQRS, clinicians would be expected to include “quality data codes” on claims that capture the information needed to collect the measures. For each measure, CMS would require clinicians to be able to report data on 80 percent of patients to which the measure denominator applies.

CMS Web Interface. CMS proposes that the web interface reporting option would be available only to groups of 25 or more eligible clinicians. As with the web interface option used in PQRS, CMS would continue to use an attribution and sampling approach to assign patients to particular group practices. In general, CMS attributes patients to practices when they bill for the plurality of primary care services. The proposed reporting requirements for the web interface for MIPS are essentially the same as those for PQRS. That is, practices would be expected to report the required data fields for the first 248 patients assigned to them. When fewer than 248 patients are assigned to the practice, then the practice would need to report data on all of its assigned patients.

CAHPS for MIPS. CMS proposes to allow group practices of 25 or more clinicians to report the CAHPS for MIPS survey. As with the PQRS program, CMS would require practices to use a CMS-approved survey vendor to collect and administer the survey. **Reporting the CAHPS survey would count as only one measure under the MIPS. As a result, practices electing the use the CAHPS would need to select one additional reporting mechanism to submit other measure data.**

Population Measures for Group Practices. For groups of 10 or more eligible clinicians, CMS proposes to calculate up to three Medicare claims-based measures reflecting avoidable hospital admissions and readmissions. These measures would be calculated in addition to the measures reported via one of the other submission mechanisms described above, and included in the quality score. The three proposed measures are described below, and are the same three that are calculated as part of the physician VM:

- *Acute Condition Composite.* Combines the rates of potentially preventable hospital admissions for dehydration, urinary tract infections and bacterial pneumonia.
- *Chronic Condition Composite.* Combines the rates of potentially preventable hospital admissions for diabetes, heart failure and chronic obstructive pulmonary disorder (COPD).
- *All-Cause, All-Condition Hospital Readmission Measure.* Assesses the rate of hospital readmissions among the group practice's population.

To assign patients to particular practices for calculating these three measures, CMS proposes to use a two-step attribution methodology that is very similar to that used in the current law VM program. The attribution generally assigns patients to practices providing the plurality of primary care services from either primary care physicians, or specialists. Additional details on this attribution approach are available on CMS's [website](#).

Groups would be scored on the measures for which they meet the minimum volume requirements. CMS proposes to retain the existing volume requirements for these three measures. Thus, the minimum volume requirement is 20 cases for the acute and chronic condition composite measures, and 200 cases for the hospital readmission measures.

Use of Hospital Quality Program Measures in the MIPS. **The AHA is disappointed that CMS chose not to propose a MIPS measure reporting option in which hospital-based clinicians could use quality and resource use measures from CMS's hospital quality and pay-for-performance programs in the MIPS. However, we are pleased the agency solicits comment on the development of such an option for future years of the MIPS.** Specifically, the agency seeks comments on four issues:

- Under what conditions it would be appropriate to attribute hospital quality measures to clinicians;
- Criteria for attributing a facility’s performance to a MIPS-eligible clinician;
- Specific measures for which the agency can use the hospital’s quality and resource use measures as a proxy for the eligible clinician’s performance; and
- Whether attribution of particular eligible clinicians to hospitals should be done on an “automatic” basis or through the use of a registration process.

Requirements for Non-patient Facing Clinicians. CMS has the authority to modify quality measure reporting requirement for non-patient facing MIPS-eligible clinicians. The “MIPS Eligibility” section of this advisory provides additional information on how CMS proposes to define non-patient facing clinicians. In general, non-patient facing eligible clinicians would be expected to meet the same MIPS quality measure reporting requirements. However, CMS proposes that non-patient facing clinicians would not be required to report a cross-cutting measure.

### ***MIPS Resource Use Category***

Overview of Resource Use Category. To assess performance in the resource use category, CMS proposes a list of over 40 resource use measures drawn from both the current law VM program and the Quality and Resource Use Reports (QRURs) that physicians receive on a period basis. All of the proposed measures in this category are calculated using Medicare claims data drawn from the performance period (i.e., CY 2017 for CY 2019 MIPS payment adjustments). CMS would score eligible clinicians and groups on all of the measures for which they have at least 20 cases. The clinician or group’s overall resource use score would be the average of all of the resource use measures for which they have sufficient data. Additional details on the measures are provided below.

Total Cost Per Capita. CMS proposes to use the same total cost per capita measure in the MIPS that is has used in the VM program since its inception. Additional details on the measure are available on CMS’s [website](#). The measure calculates the mean of all fee-for-service Medicare Part A and B allowed charges for all beneficiaries attributed to an individual clinician or group during the performance period. In the MIPS, CMS proposes that beneficiaries would be attributed to TINs for groups, and to TIN/NPI combinations for individual clinicians. The agency would continue to use a two-step attribution approach very similar to that used for the claims-based quality composite measures. Additional details on this attribution approach are available on CMS’s [website](#).

To calculate the measure, CMS would continue to apply a process known as “payment standardization” that adjusts payments to remove the effects of geographic variations in payment and add-on payments. The measure also includes a clinical risk adjustment model that is intended to account for differences in beneficiary characteristics that affect

costs or utilization, such as prior health conditions. **However, the AHA is concerned that this measure lacks socioeconomic adjustment. We will encourage the agency to examine the measure for the impact of socioeconomic factors, and incorporate adjustment as needed.**

Medicare Spending Per Beneficiary (MSPB). CMS proposes to use a modified version of the MSPB measure that also is used in the VM and hospital value-based purchasing (VBP) program. The measure calculates the mean of all Medicare Part A and Part B payments for hospitalized beneficiaries attributed to an individual eligible clinician or group practice during a defined episode of care. The care episode spans from three days before an inpatient hospital admission through 30 days after discharge. CMS would attribute episodes to particular clinicians or practices based on whether they provide the plurality of Medicare Part B services during the initial hospitalization (i.e., the highest total dollar amount of Medicare Part B services of any group of physicians).

Similar to the total cost per capita measure, the payments for each episode are “standardized” to remove the effects of geographic payment adjustments and other payment factors. The measure also is risk-adjusted to account for age and severity of illness. **However, we are concerned that this measure also lacks socioeconomic adjustment and will urge CMS to consider incorporating such adjustment.**

Clinical Condition and Treatment Episode Measures. In addition to the two measures described above, CMS proposes over 40 measures assessing resource use during episodes of care for clinical conditions (e.g., heart failure) and treatments (e.g., hip replacement). The measures have not been tied to performance in the current law VM program. However, CMS does include them in the QRUR reports that clinicians and groups current receive. **Eligible clinicians and groups would not be scored on every measure.** Rather, CMS would score them on the measures for which they have sufficient volume (i.e., at least 20 cases). Tables 4 and 5 in the proposed rule list all of the measures that CMS is proposing. Additional technical details on the measure can be found on CMS’s MACRA [website](#).

Similar to the MSPB measure, the condition/treatment measures capture Medicare Part A and Part B payments during an episode of care. However, the measures differ from MSPB in that they focus on specific conditions or treatments. Moreover, the condition/treatment measures use software algorithms to identify items and services that “clinically related” to the care for a particular condition or treatment. Each measure has its own “trigger event” that opens an episode of care. In general, the measures capture clinically related services in a 30 to 90-day timeframe following a trigger event. CMS’s MACRA [website](#) includes additional information on each specific measure.

To attribute episodes of care to particular eligible clinicians or groups, CMS proposes to use the same attribution logic as it does to calculate the measures for the QRURs. Details on the logic are available [here](#). In general, care episodes for acute conditions would be attributed to all eligible clinicians that bill at least 30 percent of inpatient evaluation and management (E&M) visits during the episode “trigger event.” Procedural

episodes would be attribute to all MIPS-eligible clinicians that bill a Part B claim during the trigger event. For both kinds of episodes, it is possible for multiple MIPS-eligible clinicians to be attributed to the same episode of care.

### ***MIPS Clinical Practice Improvement Activity Category***

Overview of CPIA Category. The MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. CMS proposes a list of over 90 CPIAs from which clinicians can select to fulfill this category. The list can be found in the appendix of the proposed rule in Table H. Each activity is assigned a weight towards the overall score. CMS proposes that there would be 60 points possible in the CPIA category. Physicians generally would need to participate in more than one activity to receive the highest score in the category.

Certified Patient-centered Medical Homes (PCMHs). CMS proposes, as required by the MACRA, that eligible clinicians participating in certified PCMHs would automatically receive the highest score (60 out of 60 possible points) in the CPIA category. The agency proposes that PCMHs would meet the criterion of being “certified” if they are accredited by one of the following nationally recognized programs:

- Accreditation Association for Ambulatory Health Care
- National Committee for Quality Assurance (NQCA) PCMH recognition
- NCQA’s Patient-Centered Specialty recognition
- Joint Commission designation
- Utilization Review Accreditation Commission (URAC)

In addition, CMS proposes that clinicians and groups participating in a Medicaid medical home model, or a medical home model also would receive the highest CPIA score.

CMS notes that for group practices, PCMH certification generally is provided for specific practice sites. However, group may include multiple practice sites billing under a single TIN, and MIPS group scoring is done at the TIN level. Thus, the agency solicits comment on how it should score multi-site group practices that do not have PCMH certification for each site.

APM Participation. CMS proposes, as required by the MACRA, that eligible clinicians participating in certain Medicare APMs would receive half of the highest possible score in the CPIA category – that is, 30 out of a possible 60 points. Additional details on the APMs that would qualify are provided in the “Scoring APM Participation in the MIPS” section of this advisory.

Weighting of other CPIAs. In addition to the scoring weights described for PCHMs and APMs, CMS proposes to assign weights of “medium” or “high” to each of the other CPIAs on its proposed list. A “medium” weight CPIA would be worth 10 points, while a “high” weight CPIA would be worth 20 points. Eligible clinicians and groups would then

select from among the list to achieve up to 60 possible points. CMS indicates that it selected certain CPIAs as “high” weight based on their close alignment with CMS national priorities such as the Quality Improvement Network / Quality Improvement Organization (QIN/QIO), Transforming Clinical Practice Initiative and other activities.

Alternate Approach for Non-patient Facing and Rural Clinicians. CMS has the authority under the MACRA to alter scoring approaches to reflect the needs of non-patient facing clinicians (as described in a previous section of this advisory), and clinicians practicing in rural health professional shortage areas (HPSAs). For both kinds of eligible clinicians, CMS proposes not to weight individual CPIAs. Instead, CMS would require that such clinicians participate in any two CPIAs in order to receive the highest score in the category. In other words, non-patient facing and rural HPSA clinicians would receive 30 points for participating in one CIA, and 60 points for participating in two CPIAs.

Period of Time for Performing a CIA. CMS proposes that in order to receive credit for a CIA, eligible clinicians or groups must perform the activity for a minimum of 90 days during the performance period. CMS indicates that the activity could be one that continues from a previous time period, as long as the eligible clinician or group participates in it for at least 90 days during the performance period.

### **MIPS Composite Performance Score**

Overview of MIPS CPS. As required by the MACRA, CMS proposes to calculate a CPS of 0 to 100 points for each eligible clinician and group in the MIPS. The CPS is used to determine whether the clinician or group receives positive, neutral or negative payment adjustments under the MIPS. CMS proposes to use a “unified scoring approach” across the four categories of the MIPS. That is, across all categories, CMS uses the same basic approach:

- Within each category, each measure or activity is worth a certain number of points;
- Eligible clinicians and groups receive a score that compares their performance to the maximum number of points possible in a category;
- It is possible to receive “partial credit” for fulfilling some if not all activities.

The CPS would be calculated using the following formula:

**CPS = 100 x [(Quality Category Score x Category Weight) + (Resource Use Category Score x Category Weight) + (CIA Category Score x Category Weight) + (ACI category score x category Weight)]**

Within each MIPS performance category, CMS proposes specific approaches for assigning points. CMS’s proposed MIPS scoring approach is summarized in Figure 4 below, with some additional details immediately following the table. CMS has provided several examples of how it would apply its scoring methodology in the proposed rule, which are noted in the table below.



**Figure 4: Summary of Proposed MIPS Composite Performance Score Approach, CY 2019**

Category	Weight for CY 2019	How Scored
Quality	50%	<ul style="list-style-type: none"> <li>• Receive 0-10 points for each measure based on decile of performance (see Table 17 of proposed rule for an example)</li> <li>• In general, measure deciles based on 2015 performance data when available. If not, deciles set based on 2017 performance</li> <li>• Measures are averaged to calculate overall category score (e.g., if reporting 9 measures, CMS would determine points on each measure and divide by 90 possible points)</li> <li>• Receive 0 points for any measure on which data are not submitted when applicable data are available</li> <li>• Two kinds of “bonus points” available:               <ul style="list-style-type: none"> <li>○ “High-priority measure” bonus points of up to 5 percent of total possible quality category points available for:                   <ul style="list-style-type: none"> <li>▪ Reporting additional outcome measures (2 points each)</li> <li>▪ Reporting additional “high-priority” measures (1 point each)</li> </ul> </li> <li>○ “EHR Reporting Bonus” of one point for clinicians/groups reporting measures using Certified EHRs</li> </ul> </li> <li>• See Tables 19 and 20 of the proposed rule for examples</li> </ul>
Resource Use	10%	<ul style="list-style-type: none"> <li>• Receive 0-10 points for each measure based on decile of performance (see Table 21 of proposed rule for an example)               <ul style="list-style-type: none"> <li>○ Deciles based on performance period (i.e., 2017) data</li> </ul> </li> <li>• Measures are averaged to calculate overall score (e.g., if reporting 4 measures, CMS would determine points on each measure and divide by 40 possible points)</li> </ul>
CPIA	15%	<ul style="list-style-type: none"> <li>• Receive score out of a possible 60 possible points</li> <li>• Receive points on each CPIA               <ul style="list-style-type: none"> <li>○ “Medium” value activity worth 10 points</li> <li>○ “High” value activity worth 20 points</li> </ul> </li> <li>• Participation in APM: Receive half the highest score (30 points)</li> <li>• Participation in certified PCMH: Receive maximum score (60 points)</li> <li>• See Table 24 of the proposed rule for an example</li> </ul>
Advancing Care Information	25%	<ul style="list-style-type: none"> <li>• Earn up to 100 points (see ACI section of this advisory)               <ul style="list-style-type: none"> <li>○ “Base Score” of 50 points for successfully submitting at least one numerator and denominator (or yes/no statement) for each measure of each objective</li> <li>○ “Performance score” of up to 80 more points for 8 additional measures (10 points each)</li> </ul> </li> </ul>

Bonus Points for Quality Category. In addition to the details outlined in Figure 4 above, CMS provides additional context for its proposal to award “bonus” points towards the quality score. The MACRA requires that CMS encourage the reporting of outcome measures and high priority measures. For these reasons, CMS proposes to award two

bonus points for reporting on outcome measures in addition to the one outcome measure required for reporting. In addition, CMS would award one bonus point for reporting on an additional “high priority” measure beyond what is required. CMS’s definition of “high priority” is discussed in the “MIPS Quality Category” section of this advisory. The total amount of bonus points awarded for outcome and high priority measures cannot exceed 5 percent of the total possible number of quality points for an eligible clinician or group. For example, if a group had 90 possible points, CMS could not award more than 4.5 bonus points.

The MACRA also requires CMS to encourage the use of EHRs to report quality measures. To meet this requirement, CMS proposes to award up to one additional bonus point in the quality category for submitting measures using certified EHRs. The bonus would be **in addition to** the bonus for reporting outcome/high-priority measures.

Topped Out Quality Measure Scoring. For all measures, CMS proposes to score clinicians and groups out of 10 possible points. For most measures, clinicians and groups could earn 0 to 10 points. However, CMS proposes to limit the number of points clinicians and groups could earn for measures that are “topped out” in performance. CMS proposes to define a topped out measure as meeting the following criteria:

- A truncated coefficient of variation (TCV) of less than 0.10;
- The 75<sup>th</sup> and 90<sup>th</sup> percentile of measure performance are within two standard errors of each other; and
- For process measures, the median score is 95 percent or greater.

CMS conducted an analysis showing that roughly half of the PQRS measures reported in 2014 – some of which are proposed for the MIPS – meet the proposed definition of topped out performance. The agency does not wish to remove topped out measures from the MIPS for fear that it may be difficult for some specialties to find relevant measures if it removes too many measures. Nevertheless, the agency does not believe that clinicians and groups reporting “topped out” measures should receive the same maximum score as others.

As a result, the agency proposes to limit the points clinicians and groups could earn by identifying clusters of performance within topped out measures, and assigning the same number of points to clinicians within that particular cluster. The agency would do this by taking the midpoint of the highest and lowest scores within the cluster. Table 18 of the proposed rule provides an example of how the agency would apply this proposed methodology.

### ***Alternative Scoring for MIPS Clinicians/Groups Participating in Certain APMs***

As described later in this advisory, CMS proposes the criteria for how to qualify for the “Advanced APM” track. The agency’s proposals significantly restrict the clinicians and groups that would qualify for the advanced APM track – including participants in most existing Medicare APMs. As a result, the vast majority of clinicians and group would

instead be subject to the MIPS, including those participating in Medicare APMs excluded from the Advanced APM track.

In the proposed rule, CMS states that it recognizes that these APMs generally assess participants on cost and quality, and require participation in improvement activities. In other words, these APMs reflect some of the same areas captured in the MIPS's performance categories. For this reason, CMS proposes to adopt alternative MIPS scoring standards certain APMs – termed “MIPS APMs” in the proposed rule. The agency believes adopting alternative scoring standards is appropriate because it would reduce duplicative reporting requirements, and ensure that APM participants are not assessed in different ways for performing the same activities.

Criteria for MIPS APMs. CMS proposes to define MIPS APMs as meeting the following criteria:

- The APM entity participates in an APM under an agreement with CMS;
- The APM entity includes one or more MIPS-eligible clinicians on a participation list; and
- The APM bases payment incentives on performance (either at APM entity or individual eligible clinician level) on cost/utilization and quality measures.

CMS also notes that these proposed criteria are independent of those proposed for its advanced APM track. As a result, it is possible that an APM entity could meet the criteria to be a MIPS APM, but not the criteria for being an advanced APM. In addition, an advanced APM may not meet the criteria for being a “MIPS APM” because it may not include MIPS-eligible clinicians as participants.

CMS notes several Medicare APMs that it believes would not qualify as a MIPS APM. For example, the agency would exclude MIPS-eligible clinicians involved in the Comprehensive Care for Joint Replacement (CJR) model because facilities (i.e., hospitals) are considered to bear the risk for performance. The agency also would exclude the Accountable Health Communities model because it does not base payment on cost or quality. However, the agency specifically identifies and proposes scoring approaches for two APMs that meet its criteria for a MIPS APM, and that would therefore be eligible for alternative scoring:

- Medicare Shared Savings Program (MSSP)
- Next Generation Accountable Care Organization (ACO) Model.

Identifying MIPS APM Participants. To identify participants in MIPS APMs, CMS proposes to use an APM identifier. The identifier would be constructed using a participant database developed by CMS that captures information on APM entities and the TINs and NPIs associated with those entities. This database would include both MIPS APMs and advanced APMs.

**CMS notes that the MIPS APM scoring approach would be applied to all unique TIN/NPI combinations associated with a particular MIPS APM. That is, all individual clinicians and groups an APM entity would contribute to and share the same CPS for the purposes of the MIPS.** The agency believes this is appropriate since APM participants must agree to participate in APMs and comply with program requirements.

Alternate Scoring Approach for MSSP and Next Generation ACO Participants. CMS proposes to waive scoring on the MIPS cost/resource use category for MSSP and Next Generation ACO participants. The agency believes this is appropriate because the methodology for determining cost performance in both programs differs significantly from the resource use measures used for other participants in the MIPS. As a result, the agency would re-weight the other CPS performance categories so that MSSP and Next Generation ACO participants would be scored as detailed in Figure 5 below.

**Figure 5: Proposed MSSP and Next Generation ACO Participant Scoring in the MIPS**

MIPS Category	Weight	Requirements
Quality	50%	Report measures using the CMS web interface
Resource Use	0%	Waived due to differences in scoring methodology between resource use measures and the two programs
CPIA	20%	All TINs in the ACO automatically receive 50% of highest possible score. Remaining performance aggregated by calculating a weighted average across all TINs in the ACO
ACI	30%	Performance aggregated by calculating a weighted average across all TINs in the ACO

CMS does not propose to waive the quality category because participants in both programs report measures using the CMS web interface, one of the same measure reporting options used for other MIPS participants. Additional details on the requirements for reporting via the web interface are found in the “MIPS Quality Category” section of this advisory.

Alternative Scoring for MIPS APMs other than MSSP and Next Generation ACO. While CMS does not identify any other specific APMs meeting its criteria for being a MIPS APM, it proposes a scoring approach for any such APMs that may emerge. Specifically, the agency proposes not to score participants in such APMs on either the quality or resource use categories of the MIPS. As a result, 25 percent of the CPS would be based on meeting the requirements of the CPIA category, while the remaining 75 percent would be based on performance in the ACI category.

### ***MIPS Payment Adjustment Approach***

As required by the MACRA, CMS must implement MIPS payment adjustments in a budget-neutral manner. That is, the agency may not pay out more in incentive payments than it recoups in penalties. However, for CYs 2019 through 2024, CMS also must pay out \$500 million in “exceptional performance bonuses” to groups that perform

exceptionally well on the MIPS. This exceptional performance bonus is above and beyond the budget-neutral MIPS payment adjustment.

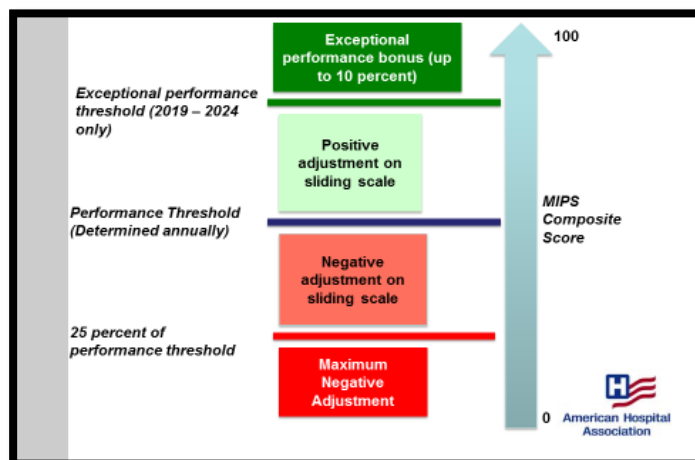
As outlined in Figure 6 below, CMS is required by law to identify several threshold CPS scores to translate MIPS CPSs into a payment adjustment:

- **A performance threshold CPS** above which there are positive payment adjustments, and below which there are negative payment adjustments. The MACRA requires that CMS publish this number prior to the start of the performance period so that MIPS participants know what level of performance is expected in order to receive positive or negative adjustments. For the CY 2019 MIPS payment adjustments, the performance period is CY 2017.

For CY 2019, CMS proposes to define the performance threshold as the CPS above which approximately half of eligible clinicians would receive positive payment adjustments, and half would receive negative adjustments. CMS would estimate the performance threshold CPS by using PQRS data submitted in 2014 and 2015 and QRUR reports.

- **25 percent of the performance threshold CPS**, at or below which MIPS-eligible clinicians and groups receive the maximum negative payment adjustment (-4 percent in CY 2019). CMS would calculate this number once the performance threshold CPS is established. For example, if the performance threshold CPS were 60 points, then the CPS at or below which the maximum negative adjustment would apply would be 15 points.
- **An exceptional performance threshold CPS** at or above which MIPS-eligible clinicians and groups are eligible for an additional bonus beyond their positive MIPS adjustment. For CY 2019, CMS proposes to define this threshold as the 25<sup>th</sup> percentile of the range of possible CPSs above the performance threshold. For example, if the performance threshold score were 60, the range of scores above it would be 61 to 100. The 25<sup>th</sup> percentile of that range would be 70 points. Therefore, all clinicians and groups receiving a score at or above 70 would be eligible for exceptional performance bonuses.

**Figure 6: Translating MIPS CPS into Payment Adjustments**



Scaling Factor for Positive Payment Adjustments. CMS proposes, as required by the MACRA, to apply a scaling factor of up to 3.0 to positive payment adjustments to maintain the budget neutrality of the MIPS. The scaling factor likely would be applied in years where CMS is taking in a significant amount in MIPS performance penalties. In CY 2019, this means that clinicians and groups could receive positive payment adjustments as high as 12 percent. However, CMS has noted that they believe it is unlikely they would need to apply the full scaling factor.

## **MIPS – ADVANCING CARE INFORMATION CATEGORY**

CMS proposes a new framework for the Medicare EHR Incentive Program for eligible clinicians. The meaningful use of certified health information technology (IT) is one of the four performance categories under the MIPS. The program would be renamed the Advancing Care Information (ACI) performance category and performance in this category would be reported by eligible clinicians as part of the overall MIPS composite score. CMS proposes to define a meaningful EHR user under MIPS as a MIPS-eligible clinician who possesses a certified EHR, uses the functionality of certified EHR, and reports on objectives and measures specified for the ACI performance category for a specified performance period.

### ***ACI Performance Category Reporting Requirements***

CMS generally proposes that MIPS-eligible clinicians meet objectives and measures based upon objectives and measures adopted in the EHR Incentive Program Stage 3. Those objectives and measures are supported by 2015 Edition certified EHR Technology. CMS proposes reporting on the objectives and measures in a methodology that includes a score for participation and reporting – a base score – and a score for

performance at varying levels – a performance score. CMS proposes two variations of a scoring methodology for the base score – a primary proposal and an alternate proposal. Each proposal is based upon the Stage 3 objectives but the proposals differ in the number of objectives and measures that CMS proposes that the MIPS-eligible clinicians report. Specifically, the primary proposal would drop reporting on clinical decision support and computerized provider order entry (CPOE), while the alternate proposal would keep them. Thus, the primary proposal would include reporting on 10 required and four optional within six objectives, while the alternate proposal would include reporting on 15 required and four optional measures within eight objectives.

#### Base Score Primary Proposal Objectives Based on Stage 3

- Protect patient health information
- Electronic prescribing (eRX)
- Patient electronic access
- Patient-specific education
- Health information exchange
- Public health and clinical data registry reporting

#### Base Score Alternate Proposal Objectives Based on Stage 3

- Protect patient health information
- eRX
- Clinical decision support (CDS)
- CPOE
- Patient electronic access
- Patient-specific education
- Health information exchange
- Public health and clinical data registry reporting

In recognition that the technology to support Stage 3 may not be available to all clinicians in 2017, CMS also proposes that MIPS-eligible clinicians using a 2014 Edition certified EHR in 2017 report a modified primary and alternate proposal for the base score that includes the objectives in the EHR Incentive Program Modified Stage 2. Here, too, CMS includes reporting CDS and CPOE. In all, the primary Modified Stage 2 proposal includes reporting on 11 measures within eight objectives, while the alternate Modified Stage 2 proposal includes reporting on 16 measures within 10 objectives. CMS states that reporting Modified Stage 2 in 2017 will allow MIPS-eligible clinicians to continue moving toward advanced use of a certified EHR in 2018

#### Base Score Modified Primary and Alternate Proposal Objectives for Modified Stage 2 in 2017

- Protect patient health information
- eRX
- CDS (Alternate only)
- CPOE (Alternate only)
- Patient electronic access
- Patient-specific education

- Secure messaging
- Health information exchange
- Medication reconciliation
- Public health reporting

In the modified primary and alternative proposal, MIPS-eligible clinicians would report on different measures for the Coordination of Care through Patient Engagement, Health Information Exchange and Public Health Reporting objectives than those reporting under the options based on Stage 3. The specific measures that are proposed for the reporting on the three base score options are described below and included in Appendix 1 and Appendix 2 of this advisory.

In addition to a base score, CMS proposes that MIPS-eligible clinicians would earn additional points above the base score by reporting on eight measures in the Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange objectives to achieve a performance score. Figure 7 includes the measures in the performance score.

**Figure 7: ACI Performance Score Measures by Objective**

Objective	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange		
	Measures	Patient Access	Patient-Specific Education	View/Download/Transmit	Secure Messaging	Patient-Generated Health Data	Patient Care Record Exchange	Request/Accept Patient Care Record

### **ACI Scoring**

CMS proposes to assign points to MIPS-eligible clinicians that report on the objectives and measures included in the base and performance score. CMS proposes that MIPS-eligible clinicians that successfully submit a numerator of at least one and a denominator or “yes/no” statement for each measure of each objective would earn a base score of 50 percent for the ACI performance category. Failure to meet the submission criteria and measure specifications for any measure in any of the objectives would result in a score of zero for the ACI performance category base score. For the Public Health and Clinical Data Registry reporting objective, CMS proposes that the Immunization Registry Reporting measure is the only measure that earns points in the base score primary or alternate proposal. The measure is a “yes/no” statement, rather than a numerator and denominator statement of whether the MIPS-eligible clinician has completed the measure. Only a “yes” statement would qualify for credit toward the base score.

CMS proposes that each of the eight measures in the performance score would be assigned a maximum of 10 possible points, allowing a MIPS-eligible clinician to earn up to 10 percent of their performance score for a given measure. The points will be based



on the clinician's reported performance on each measure (generally scaled from 0 to 100). Under this proposal, a MIPS-eligible clinician has the potential to earn a performance score of up to 80 percent for the ACI performance category. CMS states that the performance score flexibility allows MIPS-eligible clinicians to focus on measures that are most relevant to their practice to achieve a maximum performance score.

CMS proposes to determine the MIPS-eligible clinician's overall ACI performance category score by the sum of the base score, performance score and the potential Public Health and Clinical Data Registry Reporting bonus point. The maximum score that could be earned in the category is 100 percent. CMS proposes that the total percentage score, out of 100, for the ACI performance category would be applied to the 25 points allocated for the ACI performance category and incorporated in to the MIPS CPS.

CMS proposes that reporting additional measures under the Public Health and Clinical Data Registry Reporting objective would earn one additional bonus point in the ACI performance category.

CMS proposes that the Protect Patient Health Information objective and measure must be met in order for the MIPS-eligible clinician to earn any score within the ACI performance category. Failure to do so would result in a base score of zero under the base score primary proposal or the base score alternate proposal as well as a performance score of zero.

CMS proposes a reporting period of a full year for the ACI performance category and states that MIPS-eligible clinicians must submit the data that they possess for the reporting period although it may be less than the full-year reporting period.

CMS proposes that performance in the ACI performance category will comprise 25 percent of a MIPS-eligible clinician's CPS for payment year 2019 and each year thereafter. CMS also states that MACRA provides that in any year in which the Secretary of Health and Human Services estimates that the proportion of eligible professionals who are meaningful EHR users is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the ACI performance category in the MIPS CPS, but not below 15 percent.

CMS proposes to estimate the proportion of physicians who are meaningful EHR users as those physician MIPS-eligible clinicians who earn an ACI performance category score of at least 75 percent under the proposed scoring methodology. This would require the MIPS-eligible clinician to earn the ACI base score of 50 percent, and an ACI performance score of at least 25 percent or 24 percent plus a bonus point for Public Health and Clinical Data Registry Reporting for an overall performance category score of 75 percent. CMS also proposes an alternative, requiring the MIPS-eligible clinician to earn the ACI performance category score of 50 percent under the scoring methodology. For the purpose of determining the estimate of the physician MIPS-eligible clinicians,

CMS proposes to exclude certain hospital-based physicians and other physicians from the estimation.

### **ACI Public Reporting**

CMS proposes to include information on how eligible clinicians perform on the objectives and measures of meaningful use on *Physician Compare*. Specifically, CMS proposes to include an indicator for any eligible clinician or group who successfully meets the ACI performance category, as technically feasible, on *Physician Compare*. Also, as technically feasible, CMS proposes to include additional indicators, including but not limited to, identifying if the eligible clinician or group scores high on performance in patient access, care coordination and patient engagement, or health information exchange. CMS states that any ACI objectives and measures must meet the public reporting standards to be posted on *Physician Compare*, either on the profile pages or in the downloadable database. This includes all available objectives or measures reported via all available submission methods, and applies to both MIPS-eligible clinicians and groups. Statistical testing and consumer testing will determine how and where objectives and measures are reported on *Physician Compare*.

### **Clinical Quality Measure Reporting**

CMS proposes that MIPS-eligible clinicians will report clinical quality measures within the Quality performance category and will not include quality measure reporting within the ACI performance category. CMS states that this will promote alignment and simplification of quality reporting requirements. Certified EHRs are proposed to be one of several options available for quality measure reporting.

### **ACI Objectives and Measures**

CMS proposes measures for each of the objectives included in the ACI base and performance categories. As noted above, some base measures vary across the Stage 3 and Modified Stage 2 proposals. However, the objectives and measures for the performance category do not vary, and are all based on Stage 3 measures. While the base score only requires a yes/no or single patient reported in the numerator, the performance score will be based on the value of each measure.

Protect Patient Health Information (PHI). CMS proposes that MIPS Eligible Clinicians conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS-eligible clinician's risk management process.

ePrescribing. CMS proposes that at least one permissible prescription written by the MIPS-eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology. The denominator is the number of prescriptions written

for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period.

CMS also proposes for both the MIPS and the EHR Incentive Programs that providers would continue to have the option to include or not include controlled substances that can be electronically prescribed in the denominator. Providers may choose to include controlled substances in the definition of “permissible prescriptions” at their discretion where feasible and allowable by law in the jurisdiction where they provide care. Providers also may choose not to include controlled substances in the definition of “permissible prescriptions” even if such electronic prescriptions are feasible and allowable by law in the jurisdiction where they provide care.

CMS proposes that MIPS-eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value. CMS does not propose an exclusion for eligible professionals who write fewer than 100 permissible prescriptions during the reporting period. CMS states that the electronic prescribing objective is not proposed for inclusion in the performance score and therefore MIPS-eligible clinicians who write very low numbers of permissible prescriptions would not be at a disadvantage in relation to other MIPS-eligible clinicians when seeking to achieve a maximum advancing care information performance category score.

Clinical Decision Support (*Base Score Stage 3 Alternate Proposal or Base Score Modified Stage 2 Alternate Proposal Only*). CMS proposes two measures for this objective to implement CDS interventions focused on improving performance on high-priority health conditions. Measure one would require the MIPS-eligible clinician to implement three clinical decision support interventions related to three CQMs at a relevant point in patient care for the entire performance period. Absent three CQMs related to a MIPS-eligible clinician’s scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. Measure two would require the MIPS-eligible clinician to enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire performance period.

Computerized Provider Order Entry (*Stage 3 Base Score Alternate Proposal or Modified Stage 2 Base Score Only*). CMS proposes three measures for this objective to use CPOE for medication, laboratory, and diagnostic imaging orders directly entered in by any licensed health care professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local and professional guidelines. Measure one would require at least one medication order created by the MIPS-eligible clinician during the performance period is recorded using CPOE. Measure two would require at least one laboratory order created by the MIPS-eligible clinician during the performance period is recorded using CPOE. Measure three would require at

least one diagnostic imaging order created by the MIPS-eligible clinician during the performance period is recorded using CPOE. The denominator would be the number of medication orders, laboratory orders or diagnostic imaging orders, respectively, created by the MIPS-eligible clinician during the performance period.

Patient Electronic Access (Stage 3 Base, Modified Stage 2 Base, and Performance).

CMS proposes two measures for this objective to provide patients (or a patient authorized representative) with timely electronic access to their health information and patient-specific education. Measure one, the patient access measure, would require that for at least one patient seen by the MIPS-eligible clinician during the reporting period, the patient or the patient authorized representative is provided timely access to view online, download, and transmit their health information and the MIPS-eligible clinician ensures the patient's health information is available for the patient or patient authorized representative to access using any application (app) of their choice configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS-eligible clinician's certified EHR. The denominator is the number of unique patients seen by the MIPS-eligible clinician during the performance period. Measure two, the patient-specific education measure, would require the MIPS-eligible clinician to use clinically relevant information from the certified EHR to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS-eligible clinician. The denominator is the number of number of unique patients seen by the MIPS-eligible clinician during the performance period.

CMS proposes that MIPS-eligible clinicians that choose to report the Modified Stage 2 Base Score Primary and Alternate Proposal will report two measures for the Patient Electronic Access objective that are aligned with measures included in the EHR Incentive Program Modified Stage 2. Measure one would require that for at least one patient seen by the MIPS-eligible clinician during the performance period, the patient or the patient authorized representative is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS-eligible clinician's discretion to withhold certain information. The denominator is the number of unique patients seen by the MIPS-eligible clinician during the performance period. Measure two would require that at least one patient seen by the MIPS-eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period.

Coordination of Care through Patient Engagement (Stage 3 Base Score, Modified Stage 2 Base Score and Performance Score).

CMS proposes three measures for this objective to use a certified EHR to engage with patients or their authorized representatives about the patient's care. For measure one, CMS proposes 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 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 apps chosen by the patient

and configured to the API in the MIPS-eligible clinician's certified EHR technology; or a combination of 1) and 2). The numerator includes the number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.

For measure two, CMS proposes to require that a secure message be sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) for at least one unique patient by the MIPS-eligible clinician during the performance period. The denominator is the number of unique patients seen by the MIPS-eligible clinician during the performance period.

For measure three, CMS proposes to require that patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR for at least one unique patient seen by the MIPS-eligible clinician during the performance period. The denominator is the number of unique patients seen by the MIPS-eligible clinician during the performance period.

CMS proposes that MIPS-eligible clinicians that choose to report the Base Score Modified Stage 2 Primary and Alternate Proposal will report Patient-Specific Education and Secure Messaging objectives and measures that align with the objectives included in the EHR Incentive Program Modified Stage 2. These providers will not be able to report on patient-generated health data.

Patient-specific Education (Stage 3 Base Score and Performance Score). CMS proposes that the MIPS-eligible clinician uses clinically relevant information from the certified EHR to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS-eligible clinician. The denominator is number of unique patients seen by the MIPS-eligible clinician during the performance period.

Secure Messaging (Stage 3 Base Score, Modified Stage 3 Base Score and Performance Score). CMS proposes that a secure message is sent using the electronic messaging function of a certified EHR to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) for at least one patient seen by the MIPS-eligible clinician during the performance period. The denominator is the number of unique patients seen by the MIPS-eligible clinician during the performance period.

Health Information Exchange (Stage 3 Base Score, Modified Stage 2 Base Score and Performance Score). CMS proposes three measures for the objective to provide a summary of care record when a patient transitions, is referred or received by another

care setting or when the MIPS-eligible clinician has the first patient encounter with a new patient and incorporates summary of care information into their EHR.

For measure one, patient care record exchange, CMS proposes that for at least one transition of care or referral, the MIPS-eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care record using certified EHR and (2) electronically exchanges the summary of care record. The denominator is the number of transitions of care and referrals during the performance period for which the MIPS-eligible clinician was the transferring or referring clinician.

For measure two, CMS proposes the MIPS-eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document for at least one transition of care or referral received or patient encounter in which the MIPS-eligible clinician has never before encountered the patient. The denominator is the number of patient encounters during the performance period for which a MIPS-eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

For measure three, CMS proposes the MIPS-eligible clinician implements clinical information reconciliation for the following three clinical information sets: medications, medication allergy and current problem list. The denominator is the number of transitions of care or referrals during the performance period for which the MIPS-eligible clinician was the recipient of the transition or referral or has never before encountered the patient.

CMS proposes that MIPS-eligible clinicians that choose to report the Base Score Modified Stage 2 Primary and Alternative Proposal will report on use of a certified EHR to create a summary of care record and electronically transmit such summary to a receiving health care provider for at least one transition of care or referral. The denominator is the number of transitions or care and referrals during the performance period for which the eligible professional was the transferring or referring health care provider.

Medication Reconciliation (Modified Stage 2 Base Score Only). CMS proposes that MIPS-eligible clinicians that choose to report the Base Score Modified Primary and Alternate Proposal will report the Medication Reconciliation objective that aligns with the objective included in the EHR Incentive Program Modified Stage 2 rather than the clinical information reconciliation measure included in Stage 3 Health Information Exchange objective. For this objective, CMS proposes that the MIPS-eligible clinician performs medication reconciliation for at least one transition of care in which the patient is transitioned into the care of the MIPS-eligible clinician. The denominator is the number of transitions of care or referrals during the performance period for which the MIPS-eligible clinician was the recipient of the transition or referral or has never before encountered the patient. CMS proposes that the numerator is the number of transitions

of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list, medication allergy list, and current problem list. These clinicians would not be able to report on clinical information reconciliation for the performance score.

Public Health and Clinical Data Registry Reporting (Stage 3 Base Score and Modified Stage 2 Base Score Only). CMS proposes that the MIPS-eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice. CMS proposes that MIPS-eligible clinicians are required to report for one measure and four measures are optional.

- *Measure 1 – Immunization Registry Reporting (required)*. The MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). CMS proposes to maintain the previously established exclusion for the Immunization Registry Reporting for clinicians who do not administer immunizations, specifically proposing that MIPS-eligible clinicians may elect to report their yes/no statement or they may report a null value for purpose of the base score.
- *Measure 2 – Syndromic Surveillance Reporting (optional)*. The MIPS-eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.
- *Measure 3 – Electronic Case Reporting (optional)*. The MIPS-eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.
- *Measure 4 – Public Health Registry Reporting (optional)*. The MIPS-eligible clinician is in active engagement with a public health agency to submit data to public health registries.
- *Measure 5 – Clinical Data Registry Reporting (optional)*. The MIPS-eligible clinician is in active engagement to submit data to a clinical data registry.

CMS proposes that MIPS-eligible clinicians that choose to report the Modified Stage 2 Base Score will report the Public Health Reporting objective that aligns with the objective included in the EHR Incentive Program Modified Stage 2. Three measures would be required for this objective:

- *Measure 1 - Immunization Registry Reporting (required)*. The MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data.
- *Measure 2 – Syndromic Surveillance Registry Reporting (required)*. The MIPS-eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.
- *Measure 3 – Specialized Registry Reporting (required)*. The MIPS-eligible clinician is in active engagement to submit data to a specialized registry.

With the exception of the exclusions available for e-prescribing and the immunization registry reporting, CMS does not propose to maintain any of the other exclusions established under the EHR Incentive Program.

### **ACI Reporting Requirements and Certified Electronic Health Records**

CMS proposes to adopt a definition of certified EHR technology for MIPS-eligible clinicians that is based on the definition that applies in the EHR Incentive Programs under 42 CFR 495.4. For 2017, CMS proposes that MIPS-eligible clinicians would be able to use either the 2014 edition or 2015 edition certified EHR technology to meet the ACI reporting requirements. Figure 8 below indicates the edition of certified EHR that would be required for the reporting of proposed objectives and measures for the ACI performance category.

**Figure 8: Edition of Certified EHR and Proposed ACI Reporting Requirements for 2017**

<b>Edition of Certified EHR</b>	<b>Proposed ACI Reporting Option</b>
2014 Edition Certified EHR	MIPS-eligible clinicians would be required to report on the alternate objectives and measures specified that correlate to modified Stage 2 objectives and measures and will not be able to report on any of the measures that correlate to Stage 3 measure and require support of technology certified to 2015 Edition EHR.
A combination of 2015 Edition and 2014 Edition Certified EHR	MIPS-eligible clinicians may choose to report: (1) on the objectives and measures specified that correlate to Stage 3; or (2) on the alternate objectives and measures specified that correlate to modified Stage 2, if they have the appropriate mix of technologies to support each measure selected.
2015 Edition Certified EHR	MIPS Eligible Clinician may choose to report: (1) on the objectives and measures that correlate to Stage 3 requirements; or (2) on the alternate objectives and measures which correlate to modified Stage 2 requirements.



For the 2018 reporting period, CMS proposes that all MIPS-eligible clinicians must only use technology certified to the 2015 Edition to meet the objectives and measures in the ACI performance category.

### ***ACI Performance Category Method of Data Submission***

CMS proposes to allow MIPS-eligible clinicians to submit ACI performance category data through EHR, qualified registry, QCDR, attestation and CMS web interface submission methods. CMS proposes that all MIPS-eligible clinicians must follow the reporting requirements for the objectives and measures to meet the requirements of the ACI performance category. CMS states that 2017 would be the first year that EHRs (through the QRDA submission method), QCDRs and qualified registries would be able to submit EHR Incentive Program objectives and measures as adopted for the ACI performance category to CMS, and the first time this data would be reported through the CMS web interface.

CMS proposes a group reporting mechanism for individual MIPS-eligible clinicians to have their performance assessed as a group for all performance categories, including the ACI performance category. As a result, CMS proposes that the ACI objectives and measures would be assessed and reported at the group level and the data submission criteria would be the same when submitted at the group-level as if submitted at the individual-level. The data submitted would be aggregated for all MIPS-eligible clinicians within the group practice.

### ***Reweighting the ACI Performance Category for Select MIPS-eligible Clinicians***

CMS proposes to reweight the ACI performance category to zero in the MIPS composite score where the ACI measures proposed may not be available or applicable to the following types of MIPS-eligible clinicians:

- Hospital-based eligible clinicians
- Nurse practitioners
- Physician assistants
- Clinical nurse specialists
- Certified registered nurse anesthetists
- MIPS-eligible clinicians facing a significant hardship

### ***Medicaid-specific Changes***

CMS does not propose changes to the objectives and measures established for the Medicaid EHR Incentive Program and eligible professionals participating in that program must continue to report on the objectives and measures under the guidelines and regulations of that program. Reporting on the objectives and measures for the ACI performance category under MIPS cannot be used as a demonstration of meaningful use for the Medicaid EHR Incentive Program. CMS also states that demonstrating meaningful use in the Medicaid EHR Incentive Program cannot be used for purposes of reporting under MIPS. MIPS-eligible clinicians who are also participating in the Medicaid

EHR Incentive Programs must report their data for the ACI performance category through the submission methods established for MIPS in order to earn a score for the ACI performance category under MIPS and must separately demonstrate meaningful use in their state's Medicaid EHR Incentive Program in order to earn a Medicaid incentive payment. The Medicaid EHR Incentive Program continues through payment year 2021, with 2016 being the final year an eligible professional can begin receiving incentive payments.

## **ALTERNATIVE PAYMENT MODEL INCENTIVES**

The MACRA provides incentives for physicians who participate in advanced APMs. These include a lump-sum bonus payment of 5 percent of payments for professional services in 2019 through 2024; exemption from MIPS reporting requirements and payment adjustments; and higher base payment updates beginning in 2026. In this rule, CMS proposes the criteria by which clinicians would be determined to be qualified APM participants (QPs) to receive these incentives.

CMS proposes the following general process to determine whether a clinician participating in an APM is a QP:

- Determine whether the APM meets the criteria to be deemed an advanced APM;
- Identify the APM entity, which is the entity that is primarily responsible for the cost and quality of care provided to beneficiaries under the terms of a direct agreement with CMS; and
- Determine whether the eligible clinicians in the APM entity collectively meet the specified threshold of APM participation.

CMS proposes that it will assess clinicians' participation in APMs in 2017 for the 2019 incentive payment. The agency states that it believes using a performance period that aligns with the MIPS performance period would reduce operational complexity.

### ***Advanced APM Determination***

The MACRA defines broad categories of Medicare payment models that may qualify as advanced APMs. Those include a demonstration model under Center for Medicare and Medicaid Innovation (CMMI) authority; the MSSP; and certain other demonstrations under federal law. Further, the statute requires that, to qualify as an advanced APM, a model must:

- Require participants to use certified EHR technology;
- Condition some amount of payment for covered professional services on quality measures comparable to those in the MIPS quality performance category; and

- Require that APM entities bear risk for monetary losses of more than a nominal amount. Alternatively, the APM entity may be a medical home under a model expanded under CMMI authority.

For APMs with multiple participation options or tracks, CMS proposes to assess each option or track under these advanced APM criteria.

Use of Certified EHR Technology. CMS proposes to adopt the same definition of certified EHR technology for advanced APMs as it has proposed for the MIPS. The agency notes that aligning the MIPS and APM definitions of certified EHR technology would allow QPs to share EHR systems with clinicians subject to MIPS, and would also allow for movement between advanced APMs and MIPS without needing to change or upgrade systems.

In addition, the agency proposes that in 2017, an advanced APM must require at least 50 percent of eligible clinicians who are enrolled in Medicare (or each hospital, if the hospital is the APM participant) to use the certified health IT functions to document and communicate clinical care with patients and other health care professionals. This threshold would increase to 75 percent of eligible clinicians beginning in 2018. The agency notes that an APM's designation as an advanced APM does not depend on actual achievement of this requirement by participants, merely that the APM incorporates the requirement. Since the MSSP does not currently include this requirement, and adding it would require additional rulemaking, CMS proposes that the MSSP meets the criterion because it holds APM entities accountable by applying a financial penalty or reward based on certified EHR technology use.

Comparable Quality Measures. CMS proposes that this criterion is satisfied if a model incorporates quality measure results as a factor when determining payment to participants under the terms of the APM. Recognizing that different measures may be appropriate for different payment models, CMS proposes a flexible approach by which the quality measures on which an advanced APM bases payment must include at least one of the following types of measures, provided the measures have an evidence-based focus and are reliable and valid:

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
- Quality measures that are endorsed by a consensus-based entity;
- Quality measures developed under CMS's authority to develop new measures;
- Quality measures submitted in response to the MIPS call for quality measures; or
- Other measures that CMS determines to have an evidence-based focus and be reliable and valid.

CMS notes that it believes measures endorsed by the National Quality Forum (NQF) would meet these criteria. It proposes to establish a CMMI quality measure review process for measures that are not NQF-endorsed or included on the final MIPS

measures list to assess if the measures have an evidence-based focus and are reliable and valid.

To encourage the use of outcome measures, CMS proposes an additional requirement that an advanced APM must include at least one outcome measure if an appropriate measure is available on the MIPS list of measures for the performance period when the APM is first established. If there is no such measure available, CMS would not require an outcome measure to be included after the APM's implementation.

Financial Risk for Monetary Loss. CMS proposes two standards for financial risk for monetary loss – one that applies generally to entities participating in advanced APMs, and another that applies to medical home models.

The generally applicable financial risk standard proposed by CMS would require that an APM entity incur some of the financial loss when “actual expenditures exceed projected expenditures” – commonly referred to as downside risk. The loss could occur through withheld payments for services, reduced payment rates, or required repayment to CMS. **The AHA is disappointed by this proposed definition of financial risk, which fails to recognize the significant financial investment made by providers who enter into APMs.**

For medical home models, CMS proposes that the model must potentially withhold payment for services; reduce payment rates; require repayment to CMS; or eliminate the right to all or part of an otherwise guaranteed payment(s) if either actual expenditures for which the entity is responsible exceed expected expenditures, or the entity's performance on specified performance measures does not meet or exceed expected performance. Beginning in 2018, CMS proposes to limit the medical home model financial risk standard to APM entities owned and operated by organizations with 50 or fewer clinicians. The agency states that this limitation is appropriate because larger organizations have demonstrated the capacity and interest in taking on higher levels of two-sided risk and thus should be held to the more stringent, generally applicable financial risk standard.

Finally, CMS proposes that capitation arrangements that involve full risk for the population of beneficiaries covered by the arrangement would meet the financial risk criterion. However, the agency notes that Medicare Advantage (MA) is not a Medicare advanced APM since the statute limits such models to Medicare fee for service (FFS).

Nominal Risk Standard. CMS proposes three parameters for the amount of risk an entity must accept: a maximum allowable minimum loss rate (MLR), or the percentage by which actual expenditures can exceed projected expenditures without triggering financial loss; marginal risk, or the percentage of loss an entity must accept if actual expenditures exceed projected expenditures; and total potential risk, or the maximum potential payment for which an entity could be liable. Specifically, CMS proposes a maximum MLR of 4 percent, which means that the entity's actual expenditures could exceed projected expenditures by no more than 4 percent without triggering

responsibility for repayment. Further, the entity must be responsible for at least 30 percent of any losses, and total potential losses could not be capped (such as by a stoploss) at less than 4 percent of projected expenditures. CMS proposes that an arrangement with a higher MLR could qualify for an exception if the agency determines that despite the higher MLR, participants in the model still have the potential for financial losses based on statistically significant expenditures in excess of the benchmark.

For medical home models, CMS proposes that the total amount that an APM entity potentially forgoes or owes CMS must be at least the following percentage of the entity's total Medicare Parts A and B revenue:

- 2017 – 2.5 percent
- 2018 – 3 percent
- 2019 – 4 percent
- 2020 and beyond – 5 percent

The agency states that it is appropriate to implement a different nominal risk standard for medical homes since few medical homes have had experience with financial risk and many would be financially unable to provide sufficient care, or even remain viable, if subject to a higher level of risk.

Medical Home Definition. CMS proposes that to be eligible as APMs, medical home models (including Medicaid medical homes, beginning in 2021) must include the following elements:

- Model participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- Each patient must be empaneled to a primary clinician.

In addition, a medical home model must include at least four of the following elements:

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, FFS payments (e.g., shared savings or population-based payments).

To qualify for the medical home alternative to the generally applicable financial risk requirement, a medical home model must be “expanded” by CMMI. By law, CMMI may only expand a model if the Secretary determines expansion is expected to reduce Medicare spending without reducing the quality of care, or improve the quality of patient care without increasing spending; CMS's chief actuary certifies that expansion would

reduce (or not increase) net program spending; and the Secretary determines expansion would not deny or limit coverage or provision of Medicare benefits. No medical home models have yet been expanded under this authority.

Application of Criteria to Current APMs. Applying the proposed criteria to current APMs, CMS notes that the only models that would qualify as advanced APMs are MSSP Tracks 2 and 3, the Next Generation ACO model, the Comprehensive End-stage Renal Disease Care model, the two-sided risk model in the Oncology Care program (not yet implemented) and the newly announced, but not yet implemented, Comprehensive Primary Care Plus initiative. **The AHA is concerned that given the small number of models that would qualify as advanced APMs, it will be very difficult for physicians who partner with hospitals and health systems to qualify as QPs.**

### ***Qualified Participant and Partial QP Determination***

The MACRA creates two categories of physicians who meet certain thresholds of advanced APM participation. Clinicians determined to meet the statutory APM participation threshold as QPs are exempt from the MIPS and receive APM payment incentives. Physicians who do not meet the threshold to become a QP but meet a slightly lower threshold of advanced APM participation are deemed partial QPs. Partial QPs do not receive the APM incentives but are exempt from the MIPS, though they may choose to report and receive MIPS payment adjustments voluntarily. In 2019 and 2020, CMS may only consider Medicare Part B professional services attributable to an APM when determining QP status; starting in 2021, there also will be an all-payer option. However, in all years, regardless of whether QP status is determined based on Medicare or all-payer advanced APM participation, the statute includes a base requirement that at least 25 percent of Medicare Part B professional payments are attributable to an advanced APM for a clinician to qualify as a QP.

The statute gives CMS the authority to consider either payment amounts or patient counts when determining a clinician's QP status. The agency proposes to calculate a threshold score using both methods and apply whichever method is favorable to the applicable clinician or group of clinicians. **The AHA urged CMS to consider both options in a 2015 MACRA request for information, and is pleased that the agency has proposed this approach.** Further, while the statute specifies the participation thresholds that apply to payment amounts, it gives CMS discretion to set comparable thresholds if it elects the patient count option. CMS interprets this flexibility as an intention to be fairly inclusive when determining QP status; therefore, CMS proposes slightly relaxed thresholds applicable to patient counts. Figures 9 and 10 contains the applicable thresholds for each year under the payment amount and patient counts methodologies for the Medicare and all-payer options.

**Figure 9: QP Payment Amount Thresholds**

		2019-2020	2021-2022		2023 and beyond	
Medicare Option	QP	25%	50%		75%	
	Partial QP	20%	40%		50%	
All-payer Option	QP	N/A	25%	50%	25%	75%
	Partial QP	N/A	20%	40%	20%	50%
			Medicare	Total	Medicare	Total

**Figure 10: QP Patient Count Thresholds**

		2019-2020	2021-2022		2023 and beyond	
Medicare Option	QP	20%	35%		50%	
	Partial QP	10%	25%		35%	
All-payer Option	QP	N/A	20%	35%	20%	50%
	Partial QP	N/A	10%	25%	10%	35%
			Medicare	Total	Medicare	Total

CMS proposes a process by which it would first determine QP status by comparing participation in Medicare advanced APMs to the specified threshold for the relevant performance year. Beginning in 2021, if Medicare APM participation is not sufficient for QP status but the 25 percent base Medicare advanced APM threshold is met, the agency would then compare participation in advanced APM participation across all payers to the specified threshold. If neither option results in QP status, CMS would compare Medicare and all-payer advanced APM participation to the lower thresholds to determine whether partial QP status would apply. CMS notes that it does not anticipate that it will be able to notify clinicians of their QP or partial QP determinations before the summer following the end of a performance period.

Group Determinations. CMS proposes to make QP determinations at the group level. Specifically, it would calculate a collective threshold score for all clinicians in an APM entity. If the threshold score meets the relevant advanced APM threshold, the QP determination would apply to all clinicians who are identified as part the APM entity. CMS notes that although this could result in some clinicians being designated as QPs when they would not have met the criteria individually, it believes this approach is appropriate because clinicians may provide care to beneficiaries in line with APM objectives, but their services are not counted toward the APM’s attribution methodology.

To determine which clinicians are participants in an advanced APM entity for a performance period, CMS proposes to use the participant list provided to CMS under the terms of the specific APM. The agency would define the APM entity group as those clinicians who are listed on the APM entity's participants list on Dec. 31 of each performance year. Participants may be clinicians or groups of clinicians who participate in an APM under an agreement with CMS or statute/regulation, and who are directly tied to attribution, quality measurement or cost measurement under the APM. In some APMs, the APM entity may not include clinicians – for example, a model where the hospital is the APM entity participating in the model and clinicians working with the hospital are not considered participants. However, there are clinicians who are affiliated with and support the APM entity in its APM participation, such as through a gainsharing arrangement. In this case, CMS proposes that the APM entity could provide a list of affiliated clinicians who have a contractual relationship with the APM entity based as least in part on supporting the APM entity's cost or quality goals under the APM.

Individual Determinations. CMS proposes an exception to the group QP determination for instances where a clinician participates in more than one advanced APM and no one single APM entity meets the appropriate threshold. In that case, CMS will assess whether the individual clinician meets the threshold, using combined information for services provided by the clinician across all advanced APMs.

Partial QP MIPS Election. By statute, clinicians determined to be partial QPs may choose whether to participate in MIPS. CMS proposes that each advanced APM entity must elect each year on behalf of all of its participating clinicians whether to report under MIPS in the event that the entity's clinicians are determined to be partial QPs. The entity would be able to change this election at any time during the performance period, but the election would become permanent once the performance period ends. CMS notes that this approach would require entities to elect whether to report under MIPS before QP status actually is known; however, the agency believes it would not be operationally feasible to allow partial QPs to wait to make a decision to be included in the MIPS after the MIPS performance period has closed.

Calculation of Threshold Score – Medicare Option. CMS proposes methodologies for calculating clinicians' threshold score for advanced APM participation using both payment amounts and patient counts. In general, when calculating the percentage of payment amounts or patient counts through an advanced APM, CMS proposes to use as the numerator those patients attributed to the advanced APM entity using the advanced APM's attribution methodology. For the denominator, CMS will use the number of attribution-eligible beneficiaries, defined as those beneficiaries who:

- Are not enrolled in an MA or Medicare cost plan;
- Do not have Medicare as a secondary payer;
- Are enrolled in both Medicare Parts A and B;
- Are at least 18 years of age;
- Are United States residents, and



- Have a minimum of one claim for evaluation and management services by an eligible clinician or group of clinicians within the APM entity during the performance period.

CMS states that by using as the denominator those beneficiaries who are attributable to the advanced APM, rather than all Medicare beneficiaries, it hopes to avoid penalizing APM entities that provide services to a large population of beneficiaries who are not attributable to their particular model.

To calculate the threshold score based on payment amounts, CMS proposes to divide the aggregate of all payments for Medicare Part B professional services furnished by eligible clinicians in the advanced APM entity to attributed beneficiaries by the aggregate of all payments for Medicare Part B professional services furnished by eligible clinicians in the advanced APM entity to attribution-eligible beneficiaries.

Similarly, to calculate the threshold score based on patient counts, CMS proposes to divide the number of unique attributed beneficiaries to whom eligible clinicians in the advanced APM entity furnish Medicare Part B professional services by the number of attribution-eligible beneficiaries to whom eligible clinicians in the advanced APM entity furnish Medicare Part B professional services. If a beneficiary receives services from more than one APM entity, CMS would include the beneficiary in the calculations for each. If an APM entity participates in more than one advanced APM, and at least one of the APMs is an episode payment model, CMS would add the number of unique beneficiaries in the episode payment model to the beneficiaries in the non-episode payment model when calculating the numerator. This would allow the agency to assess the degree of participation in advanced APMs overall, rather than the degree of participation in just one advanced APM.

CMS proposes that professional services provided by CAHs billing under Method II would count toward the QP determination threshold calculations under both the Medicare payment and patient count methodologies. CMS also proposes that professional services furnished at RHCs and FQHCs that participate in ACOs and that are paid under the RHC all-inclusive rate or the FQHC prospective payment would count toward the patient count methodology, but not the payment methodology.

Calculation of Threshold Score – Other Payer Option. When calculating the payment amount threshold score under the other payer option, CMS proposes to divide a numerator equal to the aggregate of all payments from payers (including Medicare) to the APM entity under the terms of the applicable APM(s), by a denominator equal to the aggregate of all payments from all payers to the APM entity. Similarly, when calculating the patient count threshold score, CMS proposes to divide a numerator equal to the number of unique patients to whom eligible clinicians in the APM entity furnish services that are included in the measures of aggregate expenditures used under the terms of all of their advanced APMs under all payers (including Medicare), by a denominator equal to the number of unique patients to whom clinicians in the APM entity furnish services under all payers. CMS proposes to exclude from the calculations Medicaid payments or

patients unless the state has at least one Medicaid medical home or Medicaid APM determined to be an advanced APM. This would avoid penalizing clinicians who do not have the possibility of participation in an other payer APM under Medicaid.

CMS proposes to require that APM entities or eligible clinicians submit certain information so that CMS may assess whether the APM arrangement meets the applicable requirements and to calculate the threshold score. The information may be provided by either the APM entity or the clinician and must include:

- Payment arrangement information necessary to determine whether the other payer APM qualifies as an advanced APM. This would include information on financial risk arrangements, use of certified EHR technology and payment tied to quality measures.
- Total revenues from the payer, the number of patients furnished by service through the arrangement (patients for whom the clinician is at financial risk), and the total number of patients furnished any service through the payer.
- CMS proposes that each payer must attest to the accuracy of all submitted information; otherwise, the agency will not assess the data under the other payer option.

In order for the agency to make a determination on whether an other payer APM qualifies as an advanced APM, the relevant data would need to be submitted at least 60 days before the beginning of a performance period. CMS requests comment on a number of issues related to this data submission, including:

- The type of information on payment arrangements that would be necessary for the agency to assess whether an other payer APM qualifies as an advanced APM;
- The level of detail the agency should require;
- The timing of when CMS could expect to receive this information; and
- The possibility of receiving information directly from other payers, in order to minimize the reporting burden for APM entities and clinicians.

### **All-payer APM Criteria**

CMS proposes criteria that must be met by APM arrangements through MA, private payers and state Medicaid programs in order to qualify as advanced APMs in the all-payer option (which CMS has dubbed the “other payer option”) beginning in 2021. The MACRA imposes requirements for all-payer advanced APMs similar to those for Medicare APMs. Specifically, the arrangement must meet three criteria: certified EHR technology must be used; quality measures comparable to those in the MIPS quality category must be used; and the APM must entity bear more than nominal financial risk, or be a Medicaid medical home (as defined above).

Although the criteria for other payer APMs are phrased differently in the statute than those for Medicare advanced APMs, CMS notes that there is a benefit to keeping the

requirements as consistent as possible. For the certified EHR requirement, CMS proposes that the other payer APM must require that participants use certified EHR as defined for the MIPS and APMs. The advanced APM must require at least 75 percent of eligible clinicians in each APM entity (or each hospital, if the hospital is the APM entity) to use the certified health IT functions outlined in the proposed definition of certified EHR technology to document and communicate clinical care with patients and other professionals. For the quality measurement category, CMS proposes a similar requirement to that for Medicare advanced APMs.

CMS also proposes the standards for financial risk applicable to other payer APM arrangements. As it did for Medicare advanced APMs, CMS proposes different criteria for Medicaid medical homes than those generally applicable to other payer APMs. CMS's proposed standard for financial risk and nominal amount of loss are the same as those proposed for Medicare advanced APMs. For Medicaid medical homes, CMS proposes the minimum amount that an APM entity must potentially owe or forgo must be at least the following percentage of the entity's total revenue under the medical home arrangement:

- 2019 – 4 percent
- 2020 and beyond – 5 percent

As with the Medicare APM option, CMS proposes that full capitation risk arrangements would meet the financial risk criterion. CMS also specifies that MA arrangements could qualify as other payer advanced APMs, but they must meet the financial risk criterion. This means that MA arrangements that pay clinicians on a FFS basis would not qualify.

### ***APM Incentive Payment***

CMS proposes a lump-sum APM incentive payment equal to 5 percent of the estimated amount a QP is paid for Medicare Part B professional services across all TINs associated with the QP's NPI. The agency proposes to calculate the payment based on an incentive payment base period that is the full calendar year preceding the payment year. The agency would use data available three months after the end of the base period. For example, for payment year 2019, CMS would use claims with a date of service from Jan. 1 through Dec. 31, 2018, with processing dates between Jan. 1, 2018 through March 31, 2019. The agency notes that this would allow for a timely incentive payment while accounting for the vast majority of claims incurred during the base period.

CMS proposes to exclude certain payments adjustments when calculating the amount of APM incentive payment. Specifically, the agency would exclude any MIPS, VM, MU and PQRS payment adjustments when calculating the estimated aggregate Part B payment amounts. Further, the agency would exclude financial risk payments such as shared savings payments or net reconciliation payments (through a bundled payment arrangement). It would consider certain other payments, such as per-beneficiary per-month payments made for case management services, on a case-by-case basis, and

would include them if they are made in lieu of services that otherwise would be paid through the PFS.

Finally, CMS proposes to make the APM incentive payment to the TIN that is affiliated with the APM entity through which the eligible clinician met the threshold test for APM participation. If a clinician changes affiliation between the APM performance period and the payment year, CMS would make the payment to the TIN provided on the clinician's current Electronic Funds Transfer Authorization (CMS-588 EFT) Agreement. If the clinician's QP designation is made based on participation in multiple APM entities, CMS would split the incentive payment proportionately across all of the TINs associated with the QP's APM entities.

## **PHYSICIAN-FOCUSED PAYMENT MODELS**

The MACRA establishes a process for the proposal of physician-focused payment models (PFPMs) to a Physician-focused Payment Model Technical Advisory Committee (PTAC), which will make recommendations to CMS on the approval of proposed models. CMS proposes to define PFPMs as payment models that include physician group practices or individual physicians as APM entities and that target the quality and costs of physician services. The models must include Medicare as a payer but may also include other payers. Further, the model need not be limited to physicians and physician services – it may also include additional types of entities and services.

The agency also proposes criteria that proposed PFPMs must meet to be considered for approval. Generally, the criteria are organized into three categories: promoting payment incentives for higher-value care; addressing care delivery improvements that promote better care; and addressing information enhancements that improve the availability of information to guide decision-making.

In addition, the agency identifies informational elements of a proposed PFPM that are essential for CMMI to evaluate a proposed PFPM. Those include:

- A description of the anticipated size and scope of the model in terms of eligible clinicians, beneficiaries and services;
- A description of the burden of disease, illness or disability on the target patient population; and
- An assessment of the financial opportunity for APM entities, including a business case for how their participation in the model could be more beneficial to them than participation in FFS Medicare.

CMS notes that it defers to the PTAC to develop its process for accepting and reviewing proposed PFPMs.

## **INFORMATION BLOCKING AND EHR SURVEILLANCE**

CMS proposes three attestations by MIPS-eligible clinicians, Eligible Professionals (EPs), eligible hospitals (EHs) and CAHs.

### ***Cooperation with Surveillance and Direct Review of Certified EHR Technology***

CMS proposes to require EPs, EHs and CAHs attest, as part of their demonstration of meaningful use under the Medicare and Medicaid EHR Incentive Programs that they have cooperated with the surveillance of certified EHR technology under the Office of National Coordinator for Health IT (ONC) Certification Program. CMS also proposes to require such an attestation from all eligible clinicians under the ACI performance category of MIPS, including eligible clinicians who report on the ACI performance category as part of an APM entity group under the APM Scoring Standard.

As part of demonstrating use of certified EHRs in a meaningful manner, CMS proposes that an eligible clinician, EP, EH or CAH must demonstrate its cooperation with these authorized surveillance and oversight activities. CMS proposed to revise the definition of a meaningful EHR user at §495.4, as well as the attestation requirements to require EPs, eligible hospitals, and CAHs to attest their cooperation with certain authorized health IT surveillance and direct review activities, described in more detail in this section of the rule, as part of demonstrating meaningful use under the Medicare and Medicaid EHR Incentive Programs. Similarly, CMS is proposing to include an identical attestation requirement in the submission requirements for eligible clinicians under the proposed ACI performance category.

CMS proposes that eligible clinicians, EPs, EHs and CAHs would be required to attest to cooperation in good faith with the surveillance and ONC direct review of their health IT certified under the ONC Health IT Certification Program. Good faith cooperation is proposed to include responding in a timely manner and in good faith to requests for information about the performance of the certified EHR capabilities in use by the provider in the field. CMS also proposes that provider cooperation would include accommodating requests from ONC-authorized certification bodies or from ONC for access to the provider's certified EHR and data stored in such certified EHR as deployed by the provider in its production environment, for the purpose of carrying out authorized surveillance or direct review and to demonstrate capabilities and other aspects of the technology that are the focus of surveillance, to the extent that doing so would not compromise patient care or be unduly burdensome for the eligible clinician, EP, EH or CAH.

### ***Support for Health Information Exchange and the Prevention of Information Blocking***

CMS proposes to require that, to be a meaningful EHR user, an EP, EH or CAH must demonstrate that the provider has not knowingly and willfully taken action, such as disable functionality to limit or restrict the compatibility or interoperability of certified

EHR technology. CMS proposes that the demonstration is made through an attestation comprising three statements related to health information exchange and information. CMS proposes to revise the definition of a meaningful EHR user at §495.4 and the attestation requirements at §495.40(a)(2)(i)(I) and §495.40(b)(2)(i)(I) to provide that for attestations submitted on or after April 16, 2016, an EP, eligible hospital, or CAH under the Medicare and Medicaid EHR Incentive Programs must attest to this three-part attestation. CMS also proposes to require the attestation from all MIPS-eligible clinicians under the ACI performance category, including eligible clinicians who report on the ACI performance category as part of an APM entity group under the APM scoring standard.

## **NEXT STEPS**

**Members should attend the AHA's member-only webinar on the proposed rule on Wednesday, June 1 at 1:30 – 3 p.m., ET. Register at AHA's [website](#).**

All comments are due to CMS by June 27 and may be submitted electronically at [www.regulations.gov](http://www.regulations.gov). Follow the instructions for "Comment or Submission" and enter the file code CMS-5517-P to submit comments on this proposed rule. You also may submit written comments (an original and two copies) to CMS.

Via regular mail:

Centers for Medicare & Medicaid  
Services  
Department of Health and Human  
Services  
Attention CMS-5517-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

Via overnight or express mail:

Centers for Medicare & Medicaid  
Services  
Department of Health and Human  
Services  
Attention: CMS-5517-P  
Mailstop: C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

## **FURTHER QUESTIONS**

Please contact Akin Demehin, senior associate director of policy, at (202) 626-2365 or [ademehin@aha.org](mailto:ademehin@aha.org), or Melissa Jackson, senior associate director of policy, at (202) 626-2356 or [mjackson@aha.org](mailto:mjackson@aha.org).

## APPENDIX 1

### Appendix 1: Base Score Primary Proposal and Base Score Alternate Proposal ACI Objectives and Measures and the EHR Incentive Program Stage 3 Objectives and Measures

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
1. Protect electronic health information: Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (certified EHR) through the implementation of appropriate technical, administrative, and physical safeguards.	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS-eligible Clinician's risk management process.	Measure: same as Base Score Primary Proposal	Measure: Conduct or review a security risk analysis per Health Information Portability and Accountability Act (HIPAA), including assessing the security (including encryption) of data created or maintained by certified EHR) in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.
2. Electronic prescribing: Eligible hospitals (EHs) and critical access hospitals	Measure: At least one permissible prescription written by the MIPS-eligible	Measure: same as Base Score Primary Proposal	Measure: More than 60 percent of all permissible prescriptions written by the EP

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
(CAHs) must generate and transmit permissible discharge prescriptions electronically (eRx).	clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.		are queried for a drug formulary and transmitted electronically using certified EHR.
3. Clinical decision support (CDS): Implement CDS interventions focused on improving performance on high-priority health conditions.	Objective not available for the Base Score Primary Proposal	<p>Measure 1: Implement three clinical decision support interventions related to three CQMs at a relevant point in patient care for the entire performance period. Absent three CQMs related to a MIPS-eligible clinician's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions.</p> <p>Measure 2: Enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire performance period</p>	<p>Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period.</p> <p>Measure 2: Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>



Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
<p>4. Computerized Provider Order Entry (CPOE): Use CPOE for medication, laboratory, and diagnostic imaging orders.</p>	<p>Objective not available for the Base Score Primary Proposal</p>	<p>Measure 1: At least one medication order created by the MIPS-eligible Clinician during the performance period is recorded using CPOE.</p> <p>Measure 2: At least one laboratory order created by the MIPS-eligible clinician during the performance period is recorded using CPOE.</p> <p>Measure 3: At least one diagnostic imaging order created by the MIPS-eligible clinician during the performance period is recorded using CPOE.</p>	<p>Measure 1: CPOE for medication - More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.</p> <p>Measure 2: CPOE for labs - More than 60 percent of laboratory orders created the EP during the EHR reporting period are recorded using CPOE.</p> <p>Measure 3: CPOE for diagnostic imaging – More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using CPOE.</p>
<p>5. Patient electronic access to health information: Use the certified EHR functionality to provide patient access health information or</p>	<p>Measure 1: For at least one unique patient seen by the MIPS-eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online,</p>	<p>Measure: same as Base Score Primary Proposal</p>	<p>Measure 1: For more than 80 percent of unique patients, either: (i) the patient (or patient-authorized representative) is provided timely access to view</p>

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
<p>patient-specific educational resources.</p>	<p>download, and transmit his or her health information; and (2) The MIPS-eligible Clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS-eligible clinician's certified EHR.</p> <p>Measure 2: Use clinically relevant information from certified EHR to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS-eligible clinician.</p>		<p>online, download, and transmit their health information - and (ii) the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's certified EHR.</p> <p>Measure 2: Use certified EHR to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients.</p>

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
<p>6. Coordination of Care through Patient Engagement: Use certified EHR functionality to engage with patients or their authorized representatives. Eligible Professionals must attest/report the numerators/denominators for all three measures and must meet thresholds for two out of three measures.</p>	<p>Measure 1: 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 either (1) view, download or transmit to a third party their health information; or (2) access 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 certified EHR; or (3) a combination of (1) and (2).</p> <p>Measure 2: For at least one unique patient seen by the MIPS-eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified EHR</p>	<p>Measure: same as Base Score Primary Proposal</p>	<p>Measure 1: More than 10 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either of the following (i) view, download, or transmit to a third party their health information, (ii) access 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 provider's certified EHR or combination of (i) and (ii).</p> <p>Measure 2: For more than 25 percent of all unique patients or patient’s authorized representative seen by the EP, a secure message was sent using electronic messaging functionality of certified EHR.</p> <p>Measure 3: Patient generated data or data from a non-clinical setting for more than 5 percent of all unique patients.</p>

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
	<p>technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative).</p> <p>Measure 3: Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR for at least one unique patient seen by the MIPS-eligible clinician during the performance period.</p>		
<p>7. Health information exchange: provide a summary of care record when transitioning or referring their patient to another setting of care, or retrieve a summary of care record upon the first patient encounter with a new patient. Eligible Professional must attest/report the numerators/deno</p>	<p>Measure 1: For at least one transition of care or referral, the MIPS-eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care record using certified EHR; and (2) Electronically exchanges the summary of care record.</p> <p>Measure 2: For at least one transition of care or referral received or patient encounter in</p>	<p>Measure: same as Base Score Primary Proposal</p>	<p>Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using the certified EHR; and (2) electronically exchanges the summary of care record.</p>

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
<p>minators for all three measures. Must meet threshold on two of three measures.</p>	<p>which the MIPS-eligible clinician has never before encountered the patient, the MIPS-eligible clinician receives or retrieves and incorporates into the patient’s record an electronic summary of care document.</p> <p>Measure 3: For at least one transition of care or referral received or patient encounter in which the MIPS-eligible clinician has never before encountered the patient, the MIPS-eligible clinician performs clinical information reconciliation. The clinician must implement clinical information reconciliation for the following three clinical information sets: medication, medication allergy and current problem list.</p>		<p>Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, the EP incorporates into the patient’s EHR an electronic summary of care document.</p> <p>Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The EP must implement clinical information reconciliation for two of the following three clinical information sets: medication, medication allergy, and current problem list.</p>

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
<p>8. Public health and clinical data registry reporting: Active engagement with a public health agency (PHA) or clinical data repository (CDR) to submit electronic public health data in a meaningful way using certified EHR, except where prohibited and in accordance with applicable law. Eligible Professionals must attest/report on two measures. The registry measures may be counted more than once if multiple registries are available.</p>	<p>Measure 1: Immunization registry reporting. The MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</p> <p>Measure 2 Syndromic surveillance reporting (optional): The MIPS-eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.</p> <p>Measure 3 Electronic Case reporting (optional): The MIPS-eligible clinician is in active engagement with a public health agency to electronically submit</p>	<p>Measure: same as Base Score Primary Proposal</p>	<p>Measure 1: Immunization registry reporting. The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</p> <p>Measure 2: Syndromic surveillance reporting. The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.</p> <p>Measure 3: Case reporting. The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.</p>

Stage 3 Objective	Base Score Primary Proposal ACI Objectives and Measures	Base Score Alternate Proposal ACI Objectives and Measures	Stage 3 Measures
	<p>case reporting of reportable conditions.</p> <p>Measure 4 Public Health Registry Reporting (optional): The MIPS-eligible clinician is in active engagement with a public health agency to submit data to public health registries.</p> <p>Measure 5 Clinical data registry reporting (optional): The MIPS-eligible clinician is in active engagement to submit data to a clinical data registry.</p>		<p>Measure 4: Public Health Registry Reporting. The EP is in active engagement with a public health agency to submit data to public health registries.</p> <p>Measure 5: Clinical data registry reporting. The EP is in active engagement to submit data to a clinical data registry</p>

## APPENDIX 2

### **Appendix 2: Base Score Modified Primary and Alternate Proposal ACI Objectives and Measures Reporting for Modified Stage 2 in 2017 and the EHR Incentive Program Modified Stage 2 Objectives and Measures**

<b>Modified Stage 2 Objectives</b>	<b>Proposed Base Score Modified Primary and Alternate Proposals ACI Measures (in 2017)</b>	<b>Modified Stage 2 Measures for 2017</b>
Protect electronic health information	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS-eligible clinician's risk management process.	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of electronic protected health information created or maintained by Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.
e-Prescribing	Measure: At least one permissible prescription written by the MIPS-eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR.	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using Certified EHR Technology.
Clinical decision support *	Measure 1: Implement three clinical decision support interventions related to three CQMs at a relevant point in patient care for the entire performance period. Absent three CQMs related to a MIPS-eligible clinician's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions.	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related



Modified Stage 2 Objectives	Proposed Base Score Modified Primary and Alternate Proposals ACI Measures (in 2017)	Modified Stage 2 Measures for 2017
	<p>Measure 2: The MIPS-eligible clinician has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire performance period.</p>	<p>to high-priority health conditions.</p> <p>Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>
<p>Computerized provider order entry (CPOE) *</p>	<p>Measure 1: At least one medication order created by the MIPS-eligible clinician during the performance period is recorded using CPOE.</p> <p>Measure 2: At least one laboratory order created by the MIPS-eligible clinician during the performance period is recorded using CPOE.</p> <p>Measure 3: At least one diagnostic imaging order created by the MIPS-eligible clinician during the performance period is recorded using CPOE.</p>	<p>Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.</p> <p>Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.</p> <p>Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.</p>
<p>Patient electronic access (view, download and transmit)</p>	<p>Measure 1: At least one patient seen by the MIPS-eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS-eligible clinician's discretion to withhold certain information.</p> <p>Measure 2: At least one patient seen by the MIPS-eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period.</p>	<p>Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.</p> <p>Measure 2 For 2017: More than 5 percent of unique patients seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads, or transmits their health information to a third</p>

Modified Stage 2 Objectives	Proposed Base Score Modified Primary and Alternate Proposals ACI Measures (in 2017)	Modified Stage 2 Measures for 2017
		party during the EHR reporting period.
Patient-Specific Education	Measure: The MIPS-eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS-eligible clinician.	Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.
Secure Messaging	Measure: For at least one patient seen by the MIPS-eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient authorized representative) during the performance period.	Measure For 2017: For more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of Certified EHR Technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

<b>Modified Stage 2 Objectives</b>	<b>Proposed Base Score Modified Primary and Alternate Proposals ACI Measures (in 2017)</b>	<b>Modified Stage 2 Measures for 2017</b>
Health information exchange	Measure 1: The MIPS-eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) uses certified EHR technology to create a summary of care record; and (2) electronically transmits such summary to a receiving health care provider for at least one transition of care or referral.	Measure: The EP that transitions or refers their patient to another setting of care or provider of care (1) uses Certified EHR Technology to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
Medication reconciliation	Measure: The MIPS-eligible clinician performs medication reconciliation for at least one transition of care in which the patient is transitioned into the care of the MIPS-eligible clinician.	Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Public health Reporting	<p>Measure 1- Immunization Registry Reporting: The MIPS-eligible clinician is in active engagement with a public health agency to submit immunization data.</p> <p>Measure 2 – Syndromic Surveillance Reporting: The MIPS-eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.</p> <p>Measure 3 – Specialized Registry Reporting: The MIPS-eligible clinician is in active engagement to submit data to a specialized registry.</p>	<p>Measure 1 – Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.</p> <p>Measure 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.</p> <p>Measure 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.</p>

\* Included in base score alternate proposal only.