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Quality Payment Program Final Rule Summary

On October 13 2016, the Centers for Medicare and Medicaid Services (CMS) released the final criteria for the Quality Payment Program (QPP), as prescribed in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, making several changes consistent with ASTRO recommendations to support greater participation by radiation oncologists.

The final rule includes specific criteria for the establishment of the Merit-Based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under the Physician Fee Schedule. The proposed rule also establishes incentives for participation in Alternative Payment Models (APMs) and includes criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for making comments and recommendations on Physician-Focused Payment Models (PFPM). In the final rule, CMS underscores its commitment to using the initial QPP years as opportunities to focus on educating clinicians on MIPS program participation and increasing opportunities for clinicians to join Advanced APMs.

Based on preliminary review of the changes, it appears CMS made at least some important modifications to the MIPS program in response to concerns from ASTRO and other physician organizations that the initial proposal was too complex and too fast, particularly for smaller practices. In particular, CMS made changes that indicate radiation oncologists have a strong chance of receiving positive payment adjustments in the first year of the program if they meet initial requirements. For the APM program, ASTRO remains concerned about barriers to entry for Advanced APMs applicable to radiation oncologists, although the agency acknowledged ASTRO concerns and made a few adjustments.

Background

Enacted in April 2015, MACRA repealed the sustainable growth rate, creating the new Quality Payment Program or "QPP" for Medicare physician payment and encouraging physician participation in alternative payment models. MACRA provides for a 0.5 percent update for 2016 through 2019, and then zero percent updates for 2020 through 2025; after 2025 the update is .75 percent for qualifying APMs, and 0.25 percent for others.

MACRA also sunsets the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program. The MIPS program replaces those programs with four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities (CPIA) and Resource Use.

CMS' Strategic Objectives in Developing the Quality Payment Program:

1. Improve beneficiary outcomes through patient-centered MIPS and APM policy development and patient engagement and achieve smarter spending through strong incentives to provide the right care at the right time;
2. Enhance clinician experience through flexible and transparent program design and interactions with exceptional program tools:
3. Increase the availability and adoption of alternative payment models;
4. Promote program understanding and participation through customized communication, education, outreach and support;
5. Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders;
6. Deliver IT systems capabilities that meet the needs of users and are seamless, efficient and valuable on the front- and back-end; and
7. Ensure operational excellence in program implementation and ongoing development.

The following is a summary of the final rule and information regarding its potential impact on the field of radiation oncology.

Merit-Based Incentive Payment System (MIPS)

MIPS Eligibility, Identification and Performance Period

CMS finalized the definition of a MIPS eligible clinician as a physician, a physician assistant, nurse practitioner and clinical nurse specialist, a certified registered nurse anesthetist and a group that includes such professionals. In the final rule, CMS changed the MIPS eligible clinician participation criteria in a manner similar to ASTRO's recommendation to exempt more small practices from the program. MIPS eligible clinicians must bill $30,000 or more in Medicare Part B allowed charges or treat 100 or more Medicare patients per year in order to participate in the MIPS program. For the purposes of the 2019 MIPS payment adjustment, the Agency will identify clinicians and groups with low-volume status based on 12 months of data starting from September 1, 2015, to August 31, 2016.

CMS finalized its proposal to use multiple identifiers for performance and participation that allow MIPS eligible clinicians to be measured as an individual or as part of a group. The TIN/NPI identifier will be used for payment purposes and performance assessment regardless of how the eligible clinician reports their performance data (individually or part of a group). Additionally, a billing TIN will be used to assess group performance. Per CMS, a group consists of a single TIN with two or more clinicians, including at least one MIPS eligible clinician.

In the final rule, CMS clarified that locum tenens clinicians are not MIPS eligible clinicians because they bill for the items and services furnished using the NPI of the clinician for whom they are substituting and, as such, do not bill Medicare in their own right.

CMS has designated 2017, the first performance period under QPP, as a transition year, a change that addresses ASTRO's and other concerns. Payment adjustments under the MIPS program will begin in 2019, which is the first payment year under the QPP program. In September 2016, CMS

announced revisions to the performance period participation requirements for 2017 when the Agency introduced the "Pick Your Pace" reporting approach. The final rule provided additional clarity regarding the "Pick Your Pace" program. Eligible Clinicians ready to report in all categories (Quality, Advancing Care Information, Clinical Practice Improvement Activities, and Resource Use) can submit reports for a minimum of a continuous 90 days up to a full calendar year. These eligible clinicians maximize their chances to qualify for a positive payment adjustment, including an exceptional performance adjustment, in 2019. Those Eligible Clinicians who are unable to fully comply with MIPS can submit at a minimum a single measure in the quality performance category, a single activity in the improvement activities performance category or the required measures in the advancing care information performance category, in order to avoid a negative payment adjustment in the first payment year. Eligible Clinicians who choose not to comply with MIPS during the 2017 performance period are subject to a 4 percent payment reduction.

In 2018, the full calendar year will be used as the performance period for the Quality and Resource Use performance categories for the 2020 payment year. Eligible clinicians will still have the opportunity to report on 90 continuous days up to the full calendar year, for the Clinical Practice Improvement Activities and Advancing Care Information performance categories during the 2018 performance period.

CMS has estimated the impact of the MIPS program on eligible clinicians for the 2019 payment year. According to the CMS analysis, the majority of MIPS Eligible Clinicians will receive a positive or neutral payment adjustment for the 2019 MIPS payment year, with less than 10 percent of clinicians receiving a negative adjustment. Depending on participation level, CMS estimates that between 93.5 percent and 95.1 percent of MIPS eligible clinicians who are radiation oncologists will experience a positive or neutral MIPS payment adjustment in 2019. Total positive payment adjustments for the field of radiation oncology are estimated to be between $10 and $11 million (including a $7 million exceptional performance payment) and total negative adjustments are anticipated to amount to between $3 and $4 million in 2019. CMS' estimates are based on historical data from 2015, including PQRS data. However, the analysis does not include estimates for the scores for the Advancing Care Information and Clinical Practice Improvement Activities performance categories.

MIPS Performance Categories and Measures

In the proposed rule, CMS proposed standards for the four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities (CPIA), and Resource Use. In the final rule, CMS finalized the four performance categories. However, the Agency established a phased in approach for the Resource Use that results in modified weights for each of the categories over the next three years. ASTRO agrees with the phased-in approach but continues to believe that Clinical Practice Improvement Activities should have an increased weight considering its greater opportunities to improve patient care.

Performance Category	2017 Performance Year/2019 Payment Year	2018 Performance Year/2020 Payment Year	2019 Performance Year/2021 Payment Year
Quality	60%	50%	30%
Advancing Care Information	25%	25%	25%
Improvement Activities	15%	15%	15%
Resource Use	0%	10%	30%

An eligible clinician's scores in each of the performance categories will be aggregated into a final score. The final score will be compared against a MIPS performance threshold. The final score will be used to determine whether a MIPS eligible clinician receives an upward MIPS payment adjustment, no MIPS payment adjustment, or a downward MIPS payment adjustment. The 2017 performance threshold is set at 3 points to insure that eligible clinicians engaged in the program who successfully report at least one quality measure during a minimum of 90 consecutive days can avoid a downward adjustment. In future years, CMS will require longer performance periods and higher performance thresholds in order to avoid a negative MIPS payment adjustment.

Below is a table summarizing the MIPS Performance Categories and their weights for 2017.

Summary of 2017 MIPS Performance Categories		
Performance Category	**Points Needed to Get a Full Score per Performance Category[1]**	**Maximum Possible Points per Performance Category**
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure. Clinicians also can choose to report a specialty measure set. These measures are reported for a minimum of 90 days	60, bonus points are awarded for submitting specific types of measures and submitting measures using end-to-end electronic reporting	60 Percent
Advancing Care Information: Clinicians will submit the required five measures for a minimum of 90 days. Additional credit will be given to clinicians who submit an additional four measures.	50 Points for five measures, extra credit for each additional measure	25 Percent
Clinical Practice Improvement Activities: Clinicians can choose up to four improvement activities and attest to their completion for a minimum of 90 days. Clinicians participating in the Oncology Care Model will earn full credit. Clinicians in other Advanced APMs will earn at least half credit.	40 Points	15 Percent
Resource Use: CMS will collect cost data based on adjudicated claims, even though the Cost category will not count in the 2017 performance year.	No data submission required. Calculated from adjudicated claims. Counted starting in 2018	0 percent

<u>Quality</u>

In the final rule, the Quality Performance Category was modified to eliminate the requirement of a cost cutting measure during the 2017 transition period. Additionally, the weight of the Quality Performance Category was increased to 60 percent in to account for the reduction in the Resource Use Performance Category. In 2017, eligible clinicians will be required to report at least six measures including at least one outcome measure, if available. If no outcomes measures are available in the measure set, eligible clinicians are required to report another high priority measure. If fewer than six measures apply to the individual eligible clinician or group, then the eligible clinician or group will only be required to report on each measure that is applicable.

Alternatively, the MIPS eligible clinician or group can report on one specialty-specific measure set, or the measure set defined at the subspecialty level, if applicable. In the final rule, CMS finalized specialty specific measures sets. Per ASTRO's request, the Agency moved the Radiation Oncology measures from the Radiology measures set to a subset under Oncology to better align Radiation Oncology with broader Oncology care quality measures. Below is a chart detailing the Radiation Oncology subset of measures, a list of general oncology measures is included in Appendix A.

Radiation Oncology Subset Measures

MEASURE NAME	MEASURE DESCRIPTION	NQF	QUAL. ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE
Oncology: Medical and Radiation - Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	384	143	Person and Caregiver-Centered Experience and Outcomes	Process	Yes
Oncology: Medical and Radiation - Plan of Care for Pain	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	383	144	Person and Caregiver-Centered Experience and Outcomes	Process	Yes
Oncology: Radiation Dose Limits to Normal Tissues	Percentage of patients, regardless of age, with a diagnosis of breast, rectal, pancreatic or lung cancer receiving 3D conformal radiation therapy who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues	382	156	Patient Safety	Process	Yes

Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	389	102	Efficiency and Cost Reduction	Process	Yes

Clinical Practice Improvement Activities

Clinical Practice Improvement Activities or "Improvement Activities" are activities that support broad aims within healthcare delivery, including care coordination, beneficiary engagement, population management, and health equity. CMS finalized the establishment of the Clinical Practice Improvement Activities category with several modifications. The Agency will reduce the number of activities required to achieve full credit from six medium-weighted or three high-weighted activities to four medium-weighted or two-high weighted activities to receive full credit for 2017.

Clinicians may report on activities that match their practices' goals from a list of more than 90 options. Those options include participation in an AHRQ listed patient safety organization (PSO), such as the RO-ILS: Radiation Oncology Incident Learning System®, which is part of Clarity PSO. Additionally, ASTRO conducted a comparison of the CPIA activities and the APEx standards and mapped approximately 15 activities to APEx evidence indicators required for accreditation, and therefore a practice achieving APEx accreditation would *exceed* the 40-point maximum threshold.

Points will be assigned for each reported activity within two categories: medium-weighted and high-weighted activities. Medium-weighted activities, such as participation in an AHRQ listed PSO, are worth 10 points and high-weighted activities are worth 20 points.

Advancing Care Information

Measures and objectives in the Advancing Care Information Category focus on the secure exchange of health information and the use of certified electronic health record technology (CEHRT) to support patient engagement and improved healthcare quality. In the final rule, CMS finalized the weight for the Advancing Care Information Category at 25 percent, as required by MACRA, and reduced the number of required measures from 11 to five. All other measures will be optional for reporting. The Agency also established two measure set options for reporting based on the electronic health record edition used by the eligible clinician. Appendix B lists the measures for each reporting option.

Eligible clinicians will earn 50 percent of their MIPS score for reporting on all five of the required measures. Reporting on the optional measures will allow the clinician to earn a higher score. For the 2017 transition year, MIPS eligible clinicians may use EHR technology certified to 2014 Edition or the 2015 Edition or a combination of the two. MIPS eligible clinicians who only have technology certified to the 2014 Edition will not be able to report certain measures specified for the advancing care information performance category that correlates to a Stage 3 measure for which there is no Stage 2 equivalent. These eligible clinicians may instead report the objectives and measures specified for the advancing care information performance category which correlate to Modified Stage 2 objectives and measures. Additionally, CMS is committed to awarding a bonus score for improvement activities that utilize CEHRT and for reporting to public health or clinical data registries, thus aligning the Advancing Care Information performance category with the Practice Improvement performance category.

Finally, beginning in 2018, MIPS eligible clinicians must use EHR technology certified to the 2015 edition.

Resource Use

ASTRO requested that given significant issues involving CMS's proposal for the Resource Use/Cost Performance Category that CMS initially reduce the performance weighting of this category, and in the final rule, CMS reduced the weight to zero for 2017. Although cost data will not be used to determine MIPS performance scores for the 2019 payment year, data will still be collected from adjudicated claims to inform performance feedback shared with eligible clinicians, including the calculation of a total per capita costs for all attributed beneficiaries and a Medicare Spending per Beneficiary (MSPB) measure.

Starting with the 2018 performance year, as performance feedback is available on at least an annual basis, the cost performance category contribution to the final MIPS performance score will increase to 10 percent for the 2020 payment year, and the increase to 30 percent in the 2019 performance year for the 2021 payment year

When the Resource Use Performance Category is fully integrated into the MIPS program, the score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category will use episode-based measures, as well as patient attribution methodologies, to account for cost differences among eligible clinicians and specialties.

MIPS Composite Score Methodology

CMS finalized the proposed unified scoring system for the four MIPS performance categories. According to CMS, the methodology is meant to be simple and flexible so that it can be made applicable to a variety of practice types and reporting options. The composite methodology applies to both eligible clinicians and groups of eligible clinicians. CMS finalized the following policies related to the scoring system:

- For the quality and resource use performance categories, all measures will be converted to a 10-point scoring system to permit comparison across measures and different types of MIPS eligible clinicians.

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

- Unlike the PQRS or the EHR Incentive Program, "all-or-nothing" reporting requirements will not be included. ASTRO urged removing the "all-or-nothing" requirements, particularly for the Advancing Care Information component. In accordance with MACRA, however, failure to report on a required measure or activity will result in zero points for that measure or activity.

- The scoring system will ensure sufficient reliability and validity, by only scoring the measures that meet certain standards (such as required case minimum).

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

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

MIPS Reporting Mechanisms

In the final rule, CMS encourages quality reporting through EHR technologies and Qualified Clinical Data Registries (QCDRs) throughout the proposed rule. CMS finalized its proposal for a March 31 data submission deadline following the close of a performance period. CMS encourages eligible clinicians to use the same reporting mechanism for reporting quality, CPIA, and advancing care information; CMS believes this will reduce the administrative burden associated with reporting information. ASTRO agrees with this improved, less burdensome approach and is working to develop a QCDR to support radiation oncologists' in complying with the reporting requirements.

Alternative Payment Models (APMs)

MACRA mandates that Qualifying APM Participants (QPs) who participate in eligible Advanced APMs or Other Payer Advanced APMs receive incentive payments. The final rule confirms much of the proposed criteria for the incentive payment program and finalizes the definitions, requirements, procedures, and thresholds of participation governing the program. ASTRO remains concerned about the complexity of the APM program, although some changes were made to simplify requirements, and encourage participation among broad ranges of specialties, including radiation oncology. ASTRO will continue to devote significant resources to

support the development and adoption of radiation oncology-focused APM that meets the CMS criteria.

In addition to defining the structure of Advanced APMs and Other Payer Advanced APMs, the rule finalizes the criteria required of MIPS APMs, as well as Physician Focused Payment Models.

Qualifying APM Participants (QPs) and Partial Qualifying APM Participants (Partial QPs)

CMS finalized its proposal that Qualifying APM Participant (QP) and Partial QP determination will be based on whether an entity with a group of individual eligible clinicians participate in an Advanced APM and the eligible clinicians in the Advanced APM Entity collectively meet the threshold requirements as described below:

- QPs must have at least 25 percent of their Part B payments tied to Advanced APMs beginning in 2019. That percentage grows to 50 percent in 2021 and 75 percent in 2023.
- QP patient thresholds start at 20 percent in 2019 and then grow to 50 percent beginning in 2023.

The patient threshold identifies the percentage of patients that must be Medicare enrollees in order to satisfy QP requirements. Satisfying these requirements exempts QPs from MIPS and makes them eligible for the 5 percent Advanced APM incentive payment.

The QP performance period was modified in the final rule. The QP performance period will run from January 1 through August 31 of the calendar year that is two years prior to the payment year. Additionally, during the QP Performance Period, CMS will make QP determinations three times, each of which would be a final determination for eligible clinicians who are determined to be QPs.

The thresholds for Partial QPs are lower. CMS modified its proposed policy that would give Partial QPs the option to choose whether or not to report MIPS data and thereby be subject to a MIPS-related payment adjustment. Following a final determination that eligible clinicians in an Advanced APM Entity group are Partial QPs for a year, the Advanced APM Entity will make an election whether to report to MIPS, thus making all eligible clinicians in the Advanced APM Entity group subject to MIPS reporting requirements and payment adjustments for the year; if the Advanced APM Entity elects not to report, all eligible clinicians in the APM Entity group will be excluded from MIPS adjustments.

Advanced Alternative Payment Models (APMs)

Eligible clinicians who are deemed to be QPs may participate in a CMS-designated Advanced APM. CMS will post notice on the CMS website identifying APMs that are Advanced APMs for a QP period prior to the beginning of the first QP performance period and update the information on a rolling basis. Notification of Advanced APM eligibility/participation will be issued annually before the performance year beginning January 2017. In addition to Advanced APMs, CMS will establish Other Payer Advanced APMs and All Payer Advanced APMs beginning in 2021.

Advanced APMs must meet all of the following criteria established under MACRA:

- Adoption of certified EHR technology (CEHRT) - Provides for payment for covered professional services based on quality measures comparable to measures under the quality performance category under MIPS
- Either requires its participating Advanced APM Entities to bear financial risk for monetary losses that are in excess of a nominal amount or is a Medical Home Model

Advanced APM – Certified Electronic Health Records Technology (CEHRT)

CEHRT must be used by eligible practitioners to meet the Meaningful Use objectives and measures in specific years. In the final rule, CMS recognizes the need for MIPS eligible clinicians and Advanced APM participants to use the same EHR systems. As such, the Agency finalized its decision to use the same definition of CEHRT under the Advanced APM CEHRT use criterion as the MIPS definition as found in Section 414.1305 of MACRA which follows:

> *For any calendar year before 2018, EHR technology (which would include multiple technologies) certified under the ONC Health IT Certification Program that meets one of the following: 1) The 2014 Edition Base EHR definition (as defined at 45 CFR 170.102) and that has been certified to the certification criteria that are necessary to report on applicable objectives and measures specified for the MIPS advancing care information performance category, including the applicable measure calculation criterion at 45 CFR 170.314(g)(1) or (2) for all certification criteria that support an objective with a percentage-based measure.*

The CEHRT use requirements still differ due to the distinct regulatory requirements for MIPS versus APMs. The Agency will further consider whether to include the care plan and other new or advanced certified health IT modules in future rulemaking.

CMS finalized its proposal to require CEHRT adoption requirement by 50 percent of eligible clinician participating in Advanced APMs. The Agency did not finalize its proposal to increase that threshold to 75 percent beginning in 2018, but rather decided to retain the 50 percent requirement in future years, in accordance with ASTRO's recommendation to maintain the threshold at 50 percent.

Advanced APM - Quality Measures "Comparable" to MIPS Measures

In the final rule, CMS recognized that for Advanced APM measures to be comparable to MIPS measures, the measures should have evidence-based focus and, as appropriate, target the same priorities (for example, clinical outcomes, use and overuse).

Advanced APMs must include at least one of the following types of measures provided that they 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 (Include at least one outcome measure if an appropriate measure exists);

- Quality measures that are endorsed by a consensus-based entity;
- Quality measures developed under the CMS Quality Measures Development Plan;
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- Any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid.

In accordance with an ASTRO suggestion, CMS also clarified that MIPS-comparable quality measures can include QCDR measures provided that QCDR measures used by an Advanced APM for payment have an evidence-based focus and are reliable and valid. In the final rule, CMS establishes an internal Innovation Center quality measure review process for measures that are not NQF-endorsed or on the final MIPS measure list in order to assess whether the measures meet the evidence-based focus and are reliable and valid criteria.

Advanced APM – Nominal Financial Risk

CMS finalized its financial risk standard as proposed. To be an Advanced APM, an APM must provide that, if actual expenditures for which an APM entity is responsible under the APM exceed expected expenditures during a specified performance period, CMS can withhold payment for services to the APM Entity or the APM Entity's eligible clinicians; reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians; or require the APM Entity to reimburse CMS.

CMS' proposed nominal financial risk construct was revised in the final rule. The Agency omitted the use of marginal risk and a minimum loss rate in exchange for a more straightforward approach based on total cost of care benchmarks. CMS will assess financial risk that is under an Advanced APM, specifically those risk arrangements that are part of the terms and conditions of the APM itself, not the underlying payment system or systems that the APM may modify, but rather the potential losses in relation to the target price for episode payment models.

CMS finalized two pathways for an APM to meet the Advanced APM nominal amount standard, 1) for QP Performance Periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities (the "revenue-based standard); or 2) for all QP Performance Periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM. For episode payment models, expected expenditures means the target price for an episode. These are the total amounts that an APM Entity potentially owes CMS or foregoes under an Advanced APM.

CMS is only finalizing the amount of revenue-based nominal amount standard for the first two QP Performance Periods at this time. However, the Agency intends to increase the revenue-based nominal amount standard for the third and subsequent QP performance periods. CMS seeks comment on the amount and structure of the revenue-based nominal amount standard for QP Performance Periods in 2019 and later. Specifically, the Agency is seeking comment on 1) setting the revenue-based standard for 2019 and later at up to 15 percent of revenue; or 2) setting

the revenue-based standard at 10 percent so long as risk is at least equal to 1.5 percent of expected expenditures for which an APM Entity is responsible under an APM.

Contrary to ASTRO and other physician group's recommendations, CMS did not include business risk or the investments necessary to establish an APM in its consideration of "nominal financial risk". CMS recognizes this is a valid issue but expressed concern that these costs will vary significantly by APM, as such it would be difficult to quantify.

APM Base Rate and Incentive Payment

CMS finalized its proposal to omit MIPS adjustments included in the base period payment from the incentive payment calculation. CMS also notes that MACRA explicitly states that the 5 percent incentive payment will not be included in determining actual expenditures under an APM or for determining or rebasing benchmarks under the APM.

CMS finalized its proposal to make the incentive payment to the TIN associated with the APM entity. CMS justifies this decision stating that the Agency has traditionally used the TIN as the billing unit, as such any incentive payments earned would then be paid to the TIN. Currently, the Physician Quality Reporting System incentive payments are handled in this manner. The agency does not provide any guidance on how APM incentive payments are to be distributed to QPs within the TIN.

MIPS Eligible APM Entities (MIPS/APMs)

Eligible clinicians, who are not QPs, may choose to participate in an APM formed under an agreement with CMS. CMS proposes MIPS-eligible APM entities must:

- Participate in the APM under an agreement with CMS
- Include one or more MIPS eligible clinicians on a Participation List; and
- Base payment on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

CMS finalized its proposal to establish a scoring standard for MIPS eligible clinicians participating in APMs that will reduce participant reporting burden by eliminating the need for these APM-eligible clinicians to submit data for both MIPS and their respective APMs. CMS will use the APM scoring standard for MIPS-eligible clinicians in APM entity groups that are identified as MIPS APMs. A Composite Performance Score (CPS) will be issued for each MIPS-eligible clinician within the APM Entity Group. A separate APM Entity Group CPS score will be used to evaluate the APM.

The APM scoring standard for MIPS APMs contains several key features not available to eligible clinicians outside the MIPS APM program. CMS proposes to reduce the MIPS quality and resource use category weight to zero for all MIPS-eligible APM entities. The first year, the APM Entity group will submit quality measures to CMS that are required by the APM to serve as measures in future years. The resource use category is reduced to zero due to the fact that

MIPS APMs are already subject to cost and utilization performance standards. As a result of these two changes, the CPIA category weight will increase from 15 percent to 25 percent and for the first performance period only, eligible clinicians who submit either individual or group level MIPS data may earn a minimum score of 50 percent of the highest potential CPIA performance category. Additionally, the Advancing Care Information category weight will increase to 75 percent.

Physician Focused Payment Model (PFPM)

The final rule confirms the criteria for evaluating Physician Focused Payment Models (PFPM). The Physician Focused Payment Model Technical Advisory Committee (PTAC) is expected to review, comment on and provide recommendations to the Secretary of HHS regarding PFPM presented by specialty societies and other stakeholder groups. In the final rule, CMS states that while the PTAC serves an important advisory role in the implementation of PFPMs, there are additional considerations that must be made by the Secretary beyond what is provided by PTAC, such as competing priorities and available resources. Additionally, the decision to test a model recommended by the PTAC would not require submission of a second separate proposal to CMS.

CMS also confirmed that stakeholders can propose PFPMs as either Advanced APMs or other APMs that lead to better care for patients, better health for communities and lower health care spending.

CMS finalized the following PFPM criteria:

Promote payment incentives for higher value care
PFPMs should promote value over volume and provide incentives for physicians to deliver high-quality health care. A PFPM's payment methodology must be different from current payment methodology. Submissions should describe the type and degree of financial performance risk assumed by the PFPM. They should also include details on how Medicare and other payers will pay APM entities.

CMS finalized the PFPM scope criterion to require that PFPMs 1) directly address an issue in payment policy that broadens and expands the APM portfolio or 2) include APM Entities whose opportunities to participate in APMs have been limited. However, the Agency modified the criteria to state that PFPMs should aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM Entities whose opportunities to participate in APMS have been limited. The Agency believes that this addresses concerns expressed by ASTRO and other stakeholders that the criteria was vague and potentially limited the inclusion of PFPMs for episodes of care already covered under existing APMs, such as the Oncology Care Model.

Care Delivery Improvement

PFPMs should involve integration and care coordination among practitioners. Additionally, models should encourage greater attention to the health of the population served, while also supporting the unique needs and preferences of patients and improve patient safety.

Information Enhancements

Finally, PFPMs should encourage the use of Healthcare Information Technology to inform care decisions.

QPP Resources

CMS has a number of resources available for eligible clinicians to review in anticipation of participating in the MIPS and APM programs.

CMS' Official QPP Website - https://qpp.cms.gov

QPP Fact Sheet - https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

Final Rule Executive Summary - https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf

Final Rule - https://qpp.cms.gov/docs/CMS-5517-FC.pdf

Appendix A

Oncology Measures

MEASURE NAME	MEASURE DESCRIPTION	NQF	QUAL. ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE
Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	326	47	Communication and Care Coordination	Process	Yes
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	389	102	Efficiency and Cost Reduction	Process	Yes
Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	419	130	Patient Safety	Process	Yes

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	28	226	Community/Population Health	Process	No
Radical Prostatectomy Pathology Reporting	Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status	1853	250	Effective Clinical Care	Process	No
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated	N/A	317	Community/Population Health	Process	No
Closing the Referral Loop: Receipt of Specialist Report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	N/A	374	Communication and Care Coordination	Process	Yes
Tobacco Use and Help with Quitting Among Adolescents	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user	N/A	402	Community/Population Health	Process	No
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	2152	431	Community/Population Health	Process	No

HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	Proportion of female patients (aged 18 years and older) with breast cancer who are human epidermal growth factor receptor 2 (HER2)/neu negative who are not administered HER2-targeted therapies	1857	449	Efficiency and Cost Reduction	Process	Yes
Trastuzumab Received By Patients With AJCC Stage I (T1c) - III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy	Proportion of female patients (aged 18 years and older) with AJCC stage I (T1c) - III, human epidermal growth factor receptor 2 (HER2) positive breast cancer receiving adjuvant chemotherapy who are also receiving trastuzumab	1858	450	Efficiency and Cost Reduction	Process	Yes
KRAS Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy	Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy for whom KRAS gene mutation testing was performed	1859	451	Effective Clinical Care	Process	No

Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies	Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-EGFR monoclonal antibodies	1860	452	Patient Safety	Process	Yes
Proportion Receiving Chemotherapy in the Last 14 Days of Life	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life	210	453	Effective Clinical Care	Process	Yes
Proportion of Patients who Died from Cancer with more than One Emergency Department Visit in the Last 30 Days of Life	Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life	211	454	Effective Clinical Care	Outcome	Yes
Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life	Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life	213	455	Effective Clinical Care	Outcome	Yes
Proportion Admitted to Hospice for less than 3 days	Proportion of patients who died from cancer, and admitted to hospice and spent less than 3 days there	216	457	Effective Clinical Care	Outcome	Yes

Proportion Not Admitted To Hospice	Proportion of patients who died from cancer not admitted to hospice	215	456	Effective Clinical Care	Process	Yes

Appendix B

Option 1: Advancing Care Information Objectives and Measures

Advancing Care Information Measure	Required/Not Required
Security Risk Analysis	Required
e-Prescribing	Required
Provide Patient Access	Required
Send a Summary of Care	Required
Request/Accept Summary of Care	Required
Patient-Specific Education	Not Required
View, Download, or Transmit	Not Required
Secure Messaging	Not Required
Patient-Generated Health Data	Not Required
Clinical Information Reconciliation	Not Required
Immunization Registry Reporting	Not Required
Syndromic Surveillance	Not Required
Electronic Case Reporting	Not Required
Public Health Registry Reporting	Not Required
Clinical Data Registry Reporting	Not Required

Option 2: 2017 Advancing Care Information Transition Objectives and Measures

Advancing Care Information Measure	Required/Not Required
Security Risk Analysis	Required
e-Prescribing	Required
Provide Patient Access	Required
Health Information Exchange	Required
View, Download or Transmit (VDT)	Not Required
Patient-Specific Education	Not Required
Secure Messaging	Not Required
Medication Reconciliation	Not Required
Immunization Registry Reporting	Not Required
Syndromic Surveillance	Not Required
Specialized Registry Reporting	Not Required