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MEMORANDUM

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

Date: July 5, 2017

Re: Proposed Rule Summary: CY 2018 Updates to the Medicare Quality Payment Program

I. Introduction

On June 20, 2017, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule that updates for 2018 those payment policies, payment rates, and quality provisions for services furnished under the Quality Payment Program ("QPP"), created by the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). This summary covers proposed changes under the two tracks of the QPP, the Merit-based Incentive Payment System ("MIPS") and Advanced Alternative Payment Models ("Advanced APMs"), that may be relevant to AAHKS members' surgical practice, as well as other issues that AAHKS has commented on in the past. CMS will accept stakeholder comments on this proposed rule through August 21, 2017.

II. MIPS – Proposed Changes

CMS states that it is striving to balance the MACRA statutory requirements and programmatic goals with the ease of use, stability, and meaningfulness for MIPS eligible clinicians, while also emphasizing simplicity and scoring that is understandable for MIPS eligible clinicians. This is characterized as an ongoing process by CMS.

a. Low-volume Threshold

For the 2017 performance year, CMS allows providers to be exempt from MIPS if they had less than $30,000 in Medicare Part B revenue or saw fewer than 100 Medicare Part B patients per year. CMS is now proposing that physician practices making less than $90,000 or caring for less than 200 Medicare patients would not have to participate in MIPS.

This change is being proposed because CMS found that their existing threshold was not capturing the volume of small and rural practices that were intended to be exempt from MIPS, as many such providers have higher proportions of costly Medicare patients. CMS estimates that about 134,000 more clinicians (mostly those who work in small practices and those that practice in rural regions and Health Professional Shortage Areas) would be exempt in from participating in the QPP altogether.

b. Virtual groups

There are generally three ways to participate in MIPS: (1) individual- level reporting; (2) group-level reporting; and (3) virtual group-level reporting.

Virtual Groups would be composed of solo practitioners and groups of 10 or fewer eligible clinicians, eligible to participate in MIPS, who come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year. CMS wants to make it possible for Virtual Groups to form no matter where the group members are located or what their medical specialties are. Generally, clinicians in a Virtual Group will report as a Virtual Group across all 4 MIPS performance categories and will need to meet the same measure and performance category requirements as non-virtual MIPS groups. Virtual Groups would need to exceed the low-volume threshold at the group level, regardless of location or specialties.

c. Facility-Based Measures Scoring Option for the Quality and Cost Performance Categories

CMS is proposing to allow facility-based clinicians to voluntarily use their institution's performance rates as a proxy for the clinician's MIPS quality score. This scoring option will use Hospital VBP Program measures, with CMS proposing to use all of the adopted FY 2019 Hospital VBP Program measures for the 2020 MIPS payment year. Clinicians will only be eligible to use facility-based measures if the clinician furnishes 75% or more of their covered professional services in sites of service identified by place of service ("POS") codes as an inpatient hospital (POS code 21) or an emergency room (POS code 23). Because many clinicians provide services at more than one hospital, CMS is proposing allowing clinicians who elect facility-based measurement to receive scores derived from the Hospital VBP score for the facility at which they provided services for the most Medicare beneficiaries during the period of September 1st of the calendar year 2 years preceding the performance period through August 31st of the calendar year preceding the performance period with a 30 day claims run out.

d. New Quality Performance Improvement Score

CMS proposes to add an improvement scoring standard to the MIPS quality and cost performance categories. In developing the proposal, CMS assessed the methodologies for measuring and scoring performance improvement used in existing programs (Hospital VBP Program, the Shared Savings Program, and Medicare Advantage 5-star Ratings Program), considering in particular the ramifications of measure-specific improvement versus improvement in a measure category.

Starting for the 2020 MIPS payment year, CMS will measure improvement at the performance category level for the quality performance category score. Because clinicians can elect the submission mechanisms and quality measures that are most meaningful to their practice, and these choices can change from year to year, CMS is prioritizing a flexible methodology that allows for improvement scoring even when clinicians change the quality measures used from year to year. CMS considers this particularly important as it encourages clinicians to move away

from topped out measures and toward more outcome measures. It does not want the flexibility that is offered to clinicians in the quality performance category to limit their ability to move towards outcome measures.

The improvement score will be awarded based on the rate of increase in the quality performance percent score of individual clinicians or groups from the current performance period compared to the score in the year immediately prior to the current performance period. CMS will add an explicit regulatory provision that an improvement percent score cannot be negative.

To calculate the quality performance category percent score, the total measures achievement points would be summed with the total measure bonus points and then divided by the total available measure achievement points. The improvement percent score would be added to that calculation. The resulting quality performance category percent score cannot exceed 100 percentage points.

e. Scoring the Cost Performance Improvement

For the cost performance category, improvement will be measured at the measure-specific level as providers do not have year-to-year choices in which cost measures they are being assessed on. Though for 2018, the cost performance improvement category will be weighted at zero and will not impact a clinician's ultimate score. CMS invites public comment on these proposals for scoring improvement for the quality and cost performance categories.

CMS will calculate a cost improvement score only when data sufficient to measure improvement is available, that is when a clinician participates in MIPS using the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods.

f. Accounting for Transition Year in Performance Improvement

CMS invites comment on its proposal to measure improvement only if the clinician's 2018 quality performance category achievement percent score exceeds 30 percent. CMS wants to award improvement for net increases in performance and not just improved participation in MIPS and therefore proposes to measure improvement above a floor for the 2018 performance period. CMS intends this approach to appropriately recognize the participation of clinicians who participated in a transition year during 2017 and accounts for clinicians who participated minimally and may otherwise be awarded for an increase in participation rather than an increase in achievement performance.

g. Data Completeness Standards

To better encourage complete reporting, CMS proposes that in the 2020 MIPS payment year, measures that do not meet data completeness standards will receive 1 point instead of the 3 points that were awarded in the 2019 MIPS payment year. An exception will be made for small practices that would continue to receive 3 points for measure even if the data is not complete.

h. Incentives to Use CEHRT to Support Quality Performance Category Submissions

CMS is proposing no changes to the awarding of bonus points for using CEHRT for end-to-end reporting. However, CMS is seeking comment in general on the use of health IT in quality measurement and how HHS can further encourage the use of certified EHR technology in quality measurement. CMS's specific questions include:

- What other incentives could be leveraged to incentivize more clinicians to report electronically?
- What format should these incentives take? For example, should clinicians who report all of their quality performance category data in an end-to-end manner receive additional bonus points than those who report only partial electronic data?
- Are there other ways that HHS should incentivize providers to report electronic quality data beyond what is currently employed?

i. Topped Out Quality Measures

A measure may be considered topped out if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. Topped out measures could have a disproportionate impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians. CMS proposes a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through comment and rulemaking for the 4th year. Therefore, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period.

CMS requests comments on its proposal to score topped out measures differently by applying a 6-point cap, provided it is the second consecutive year the measure is identified as topped out. Feedback is sought on whether 6 points is the appropriate cap or whether CMS should consider another value. Comment is also sought on other possible options for scoring topped out measures that would meet CMS's goal of encourage clinicians to begin to submit measures that are not topped out while also providing stability for MIPS eligible clinicians.

The measures identified by CMS as topped out include:

- Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin

- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

j. Changes to Quality Measures

Please see the Appendix at the end of this document for a description of substantial changes to the TKA and THA patient experience measures as well as the revised Orthopedic Surgery Specialty Measure Set.

k. Accounting for Risk Factors

The MACRA statute requires the Secretary and CMS to assess, on an ongoing basis, appropriate adjustments to quality measures, cost measures, and other measures to account for health status and other risk factors, and to implement as appropriate adjustments to payments, category scores and final scores in MIPS. CMS is aware that stakeholders are particularly interested in risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors). CMS has stated an interest in ensuring the quality of care furnished by providers and suppliers is assessed as fairly as possible, while simultaneously ensuring against masking potential disparities or minimizing incentives to improve the outcomes for disadvantaged populations.

CMS continues to seek comment on whether MIPS should account for social risk factors, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include:

- adjustment of MIPS eligible clinician scores (for example, stratifying the scores of MIPS eligible clinicians based on the proportion of their patients who are dual eligible);
- confidential reporting of stratified measure rates to MIPS eligible clinicians;
- public reporting of stratified measure results;
- risk adjustment of a particular measure as appropriate based on data and evidence; and
- redesigning payment incentives (for instance, rewarding improvement for clinicians caring for patients with social risk factors or incentivizing clinicians to achieve health equity).

CMS is also seeking comment on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to the following: dual eligibility/low-income subsidy; race and ethnicity; and geographic area of residence.

l. Complex Patient Bonus

While work on risk adjustment for social factors is ongoing, CMS proposes an interim adjustment for patients with numerous, complex factors that impact health outcomes. CMS will calculate the average Hierarchical Conditions Category ("HCC") risk score for a clinician or group by averaging the HCC risk scores for beneficiaries cared for by the clinician or group. Clinicians will then be awarded 1 to 3 bonus points if their patient population is deemed particularly complex. CMS seeks comment on any alternative complex patient methodologies, under which a bonus would be applied based on the ratio of dual eligible patients.

m. Small Practice Bonus

CMS proposes to add a 5 point bonus for clinicians, group practices, virtual groups, or APM Entities that consist of 15 or fewer clinicians that participate in MIPS by submitting data on at least one performance category in the 2018 performance period. This is intended to be a short-term, transition strategy for the 2018 MIPS performance period only, though CMS will assess on an annual basis whether to continue the bonus and how the bonus should be structured.

n. Final Score – Category Weights

For the 2020 MIPS Payment Year, CMS is proposing in the CY2018 proposed rule to weigh the quality performance category as 60% of the final score (50% was originally proposed in the CY2017 final rule). CMS is also proposing to change the weight of the cost performance category to 0% from the 10% weight CMS previously called for in the CY2017 final rule. The advancing care information performance category will continue to have a 25% weight while the improvement activities performance category will continue to have a 15% weight.

CMS is also proposing reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances at the MIPS eligible clinician's request. This is analogous to the reweighting CMS finalized in the CY2017 final rule of the advancing care information performance category, and would only be eligible in the rare circumstances where clinicians are unable to collect and report information (such as a fire or natural disaster, but not in circumstances like the inability to renew a lease or being found noncompliant with state licensure requirements).

III. Advanced APM Policies

CMS continues to encourage clinician participation in Advanced APMs, and estimates that the number of eligible clinicians who are determined to be Qualifying APM Participants ("QPs") will increase in performance year 2018. This increase is due to new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus (1+) Model, and the reopening of the application process to new participants for some current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus Model.

a. Advanced APM Determinations: Nominal Risk Standard

To be considered an Advanced APM, an APM must:

(1) require participants to use CEHRT;
(2) provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS and;
(3) either require that participating APM Entities bear risk for monetary losses of a more than nominal amount under the APM, or be a Medical Home Model expanded under section 1115A(c) of the Social Security Act.

Currently, the total potential risk that APM Entities must bear must be equal to at least: either 8% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the Medicare QP Performance Periods (from January 1 to August 31) in 2017 and 2018 (the ***revenue-based standard***), OR 3% of the expected expenditures that an APM Entity is responsible for under the APM for all performance years (the ***benchmark-based standard***).

If total risk under the APM is not expressly defined in terms of revenue, CMS proposes to calculate the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity. CMS would then calculate an average of all the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity, and if that average estimated total Medicare Parts A and B revenue at risk for all APM Entities was equal to or greater than 8%, the APM would satisfy the generally applicable revenue-based nominal amount standard.

CMS proposes to extend the 8% revenue-based standard for the Medicare QP Performance Periods in 2019 and 2020. CMS seeks comment on whether it should consider a lower or higher revenue-based nominal amount standard for the 2019 and 2020 Medicare QP Performance Periods, and on the amount and structure of the revenue-based nominal amount standard for Medicare QP Performance Periods 2021 and later. CMS also seeks comment on whether a different, potentially lower, revenue-based nominal amount standard should apply to small practices and those in rural areas that are not participating in a Medical Home Model for the 2019 and 2020 Medicare QP Performance Periods.

b. QP and Partial QP Determinations

Eligible clinicians participating in an Advanced APM are categorized as QPs if they meet the established thresholds for a certain percentage of their patients or payments being through an Advanced APM. Eligible clinicians who participate in Advanced APMs but do not meet the QP or Partial QP thresholds are subject to MIPS reporting requirements and payment adjustments.

CMS proposes than an Advanced APM must be actively tested for a minimum of ***60 continuous days*** during the Medicare QP Performance Period (from January 1 to August 31) in order for the payment amount or patient count data to be considered for purposes of QP determinations for the year. For Advanced APMs that start or end during the Medicare QP Performance Period and operate continuously for a minimum of 60 continuous days during the Medicare QP Performance Period for the year, CMS proposes to make QP determinations using payment or patient data only for the dates that APM Entities were able to participate in active testing of the Advanced APM, and not for the full Medicare QP Performance Period. Note that this policy for QP determinations does not apply to the CEHRT Track 1 of the Comprehensive Care for Joint Replacement Model ("CJR"). CMS has determined that ***Track 1 of CJR is an Advanced APM*** for the 2017 QP Performance Period, and therefore, CMS will include episodes ending on or after January 1, 2017 in QP determinations.

For eligible clinicians who participate in ***multiple Advanced APMs***, QP and Partial QP determinations would be made using the full Medicare QP Performance Period, even if the eligible clinician participates in one or more Advanced APMs that start or end during the Medicare QP Performance Period (including Advanced APMs that are in active testing for less than 60 continuous days). Further, if an eligible clinician is determined to be a QP based on participation in multiple Advanced APMs, but any of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP.

c. All-Payer Combination Option

i. Payment Arrangement Requirements

To be an Other Payer Advanced APM, a payment arrangement with a payer (for example, a Medicare Advantage or Medicaid Managed Care plan) must meet the ***same three criteria that are applicable to Medicare Advanced APMs*** (i.e., use of CEHRT by at least 50% of participating eligible clinicians, payment arrangements based on MIPS-comparable quality measures (including one outcome measure if there is an applicable outcome measure on the MIPS quality measure list), and nominal financial risk).

In general, ***financial risk*** means that if an APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period, the payer must withhold payment of services to the APM Entity and/or the APM Entity's eligible clinicians; reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians; or require direct payments by the APM Entity to the payer. With respect to the ***nominal risk standard***, CMS previously established that an Other Payer Advanced APM must have marginal risk of at least 30%; a minimum loss rate of no more than 4%; and total risk of at least 3% of the expected expenditures that the APM Entity is responsible for under the payment arrangement. CMS proposes to add a ***revenue-based nominal amount standard*** of 8%, as an alternative to the benchmark-based nominal amount standard. This revenue-based standard would be applicable only to payment arrangements in which risk is expressly defined in terms of revenue. CMS seeks comment on whether it should consider a lower or higher revenue-based nominal amount standard, and whether it should consider a different, potentially lower, revenue-based nominal amount standard only for small practices and those in rural.

ii. Identification of Other Payer Advanced APMs

Other Payer Advanced APMs will be identified based on information submitted to CMS by clinicians, APM Entities, and in some cases by payers, including Medicare Advantage plans and states operating Medicaid Managed Care Plans. CMS proposes to adopt a Payer-Initiated Other Payer Advanced APM Determination Process ("Payer-Initiated Process"), as well as an Eligible Clinician-Initiated Process.

1. Payer-Initiated Process

Prior to the start of the 2019 All-Payer QP Performance Period, and each year thereafter, certain payers (including Medicare Advantage plans, Medicare-Medicaid plans, 1876 and 1833 cost plans, and Programs of All Inclusive Care for the Elderly ("PACE") plans, and payers with payment arrangements in CMS Multi-Payer Models (including the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model), may request that CMS determine whether their payment arrangements are Other Payer Advanced APMs. This option would be offered to other payer types, including commercial and other private payers, starting in 2019 prior to the 2020 All-Payer QP Performance Period, and each year thereafter.

If a payer requests that CMS determine whether a payment arrangement is one of the authorized categories, and the payer uses the same payment arrangement in other commercial lines of business, CMS proposes to allow the payer to concurrently request that CMS determine whether those other payer arrangements are Other Payer Advanced APMs as well. CMS proposes that all Other Payer Advanced APM determinations would be in effect for only one year at a time. Payers would need to submit payment arrangement information each year in order for CMS to make an Other Payer Advanced APM determination in each year.

2. Eligible Clinician-Initiated Process

If an Other Payer Advanced APM determination has not already been made through the Payer-Initiated process, APM Entities or clinicians may submit information regarding their payment arrangements to CMS for such a determination. CMS proposes to require the APM Entity or clinician to submit information for each other payer arrangement, including:

- Arrangement name;
- Brief description of the nature of the arrangement;
- Term of the arrangement (anticipated start and end dates);
- Locations (nationwide, state, or county) where this other payer arrangement will be available;
- Evidence that the CEHRT criterion is satisfied;
    - Note that CMS proposes that it would presume that an other payer arrangement would satisfy the 50% CEHRT use criterion if CMS receives information and documentation from the eligible clinician through the Eligible Clinician-Initiated Process showing that the other payer arrangement requires the requesting eligible clinician(s) to use CEHRT to document and communicate clinician information.
- Evidence that the quality measure criterion is satisfied, including an outcome measure;
- Evidence that the financial risk criterion is satisfied; and
- Other documentation as may be necessary for CMS to determine whether the other payer arrangement is an Other Payer Advanced APM.

CMS proposes to eliminate the requirement that payers must attest that the information submitted by clinicians is accurate. Instead, CMS proposes to require payers to certify the

information that they submit directly to CMS and APM Entities or clinicians to certify the information that they submit. CMS also proposes that the information a payer submits to CMS through the Payer-Initiated Process and the information an APM Entity or a clinician submits to CMS through the Eligible Clinician-Initiated Process would be kept confidential to the extent permitted by federal law, in order to avoid dissemination of potentially sensitive contractual information or trade secrets.

iii. QP Determinations and Threshold Scores

Beginning in performance year 2019, a clinician may qualify as a QP through the All-Payer Combination Option. To become a QP through the All-Payer Combination Option, a clinician ***must participate in an Advanced APM with CMS, as well as an Other Payer Advanced APM***. For a eligible clinician, CMS will conduct QP determinations sequentially, so that CMS first looks at a clinician's participation in a Medicare Advanced APM (the ***Medicare Option***), and then the clinician's participation in both a Medicare Advanced APM and an Other Payer Advanced APM (the ***All-Payer Combination Option***).

CMS will calculate Threshold Scores under the Medicare Option through both the payment amount and patient count methods (based on Medicare Part B covered professional services furnished through Advanced APMs), compare each Threshold Score to the relevant QP and Partial QP thresholds, and use the most advantageous score to make QP determinations. If necessary, then the same approach would be used for the All-Payer Combination Option (based on a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through Other Payer Advanced APMs).

Note that the all payer portion of the Threshold Score calculations under the All-Payer Combination Option is based on the sum of payments for Medicare Part B covered professional services furnished by the clinician and, with certain exceptions, all other payments regardless of payer. Categories of payments that are excluded include payments made to the eligible clinician from Tricare; from VA facilities; and from a standard Medicaid fee-for-service program (in which no Medicaid Medical Home Model or APM is available under the state plan). The exclusion of Medicaid payments means that Medicaid patients will be excluded from the all-payer calculation under the All-Payer Combination Option, unless: (1) a state has in operation (at the county level) at least one Medicaid APM or Medicaid Medical Home Model that is determined to be an Other Payer Advanced APM; and (2) the relevant APM Entity is eligible to participate in at least one of such Other Payer Advanced APMs during the QP Performance Period, regardless of whether the APM Entity actually participates in such Other Payer Advanced APMs. In order for CMS to make determinations about the exclusion of certain Medicaid payments, CMS will have to determine if a clinician practices under one of the specialty codes eligible to participate in a Medicaid APM or Medicaid Medical Home Model and the clinician will have to identify and certify the county where they saw the most patients during the relevant All-Payer QP Performance Period.

With respect to QP determinations using the All-Payer Combination Option, CMS proposes to conduct all QP determinations under the All-Payer Combination Option at the ***individual clinician level***. If the Medicare Threshold Score for an eligible clinician is higher

when calculated for the APM Entity group than when calculated for the individual eligible clinician, CMS proposes to make the QP determination under the All-Payer Combination Option using a ***weighted Medicare Threshold Score*** (to reflect the individual eligible clinician's Medicare volume) that will be factored into an All-Payer Combination Option Threshold Score calculated at the individual clinician level.

CMS proposes that the All-Payer QP Performance Period will be from ***January 1 through June 30***. Accordingly, QP determinations under the All-Payer Combination Option will be made based on two periods: January 1 to March 31 or January 1 to June 30. This is different from the Medicare QP Determination Period, which is based on data available through March 31, June 30, and August 31. Alternatively, CMS seeks comment on establishing the All-Payer QP Performance Period from January 1 through March 31, and making QP determinations based on only that time period. CMS notes that it needs to collect information on eligible clinicians' payments and patients with all other payers by ***December 1*** of the QP performance year in order to provide eligible clinicians with timely QP determinations and allow them to make their own timely decisions regarding MIPS reporting based on their QP status for the year.

IV. Physician-Focused Payment Models Technical Advisory Committee ("PTAC")

The PTAC is an 11-member federal advisory committee that is charged with reviewing stakeholders' proposed Physician-Focused Payment Models ("PFPMs"), and making comments and recommendations to the Secretary regarding whether they meet the PFPM criteria established by the Secretary through rulemaking in the CY 2017 Quality Payment Program final rule.

CMS seeks comment on whether to broaden the definition of PFPM subject to review by the PTAC to include payment arrangements that involve Medicaid or the Children's Health Insurance Program ("CHIP") as a payer, even if Medicare is not included as a payer in the arrangement. A PFPM could then include Medicaid, CHIP, or Medicare (or some combination of these) as a payer. A PFPM might still include other payers in addition to Medicaid, CHIP, or Medicare; however, an other payer arrangement or Other Payer Advanced APM that includes only private payers would not be a PFPM. Note that Medicare Advantage and other private plans paid to act as insurers on the Medicare program's behalf are considered to be private payers.

CMS clarifies that the CMS Innovation Center will review proposals submitted to, and recommended by, the PTAC, along with any comments from the PTAC. This review does not require the submission of a second proposal to CMS. If a PFPM project is recommended by the PTAC and selected by CMS for further evaluation or testing, CMS may work with the individual stakeholders who submitted their proposals to consider design elements for testing the PFPM and make changes as necessary. CMS seeks comment on the finalized criteria for the PTAC's evaluation of PFPM proposals, including, but not limited to, whether the criteria are appropriate for evaluating PFPM proposals and are clearly articulated. CMS also seeks comment on stakeholders' needs in developing PFPM proposals that meet these evaluation criteria (i.e., is there sufficient guidance available on what constitutes a PFPM; the relationship between PFPMs,

APMs, and Advanced APMs; and on how to access data, or how to gather supporting evidence for a PFPM proposal).

APPENDIX A
Measures with Substantive Changes Proposed for MIPS Reporting in 2018

Category	Description
NQF #:	N/A
Quality #:	375
CMS E-Measure ID:	66v6
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients 18 years of age and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported functional status assessments
Proposed Substantive Change:	Aligning the initial population more closely with the measurement period. The overall duration of period remains the same. Changes to the measure description: Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Patient Experience)
Rationale:	The American Association of Hip and Knee Surgeons have recommended that the general/mental health survey be completed prior to surgery (during the preoperative visit) and after surgery (during the post-operative visit). The guidance calls for revised alignment with the measurement period.

Category	Description
NQF #:	N/A
Quality #:	376
CMS E-Measure ID:	56v6
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients 18 years of age and older with primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported functional status assessments
Proposed Substantive Change:	Revise timing to identify initial population, to align more closely with the measurement period. The overall duration of period remains the same. Changes to the measure descriptions: Percentage of patients 18 years of age and older with who received an elective primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Patient Experience)
Rationale:	The American Association of Hip and Knee Surgeons have recommended that the general/mental health survey be completed prior to surgery (during the preoperative visit) and after surgery (during the post-operative visit). The guidance calls for revised alignment with the measurement period.

APPENDIX B
Specialty Measure Sets

CMS has proposed to modify the Orthopedic Surgery specialty measure based upon review of updates made to existing quality measure specifications, the proposal of adding new measures for inclusion in MIPS, and the feedback provided by specialty societies. Existing measures with proposed substantive changes are noted with an asterisk (*), core measures as agreed upon by Core Quality Measure Collaborative (CQMC) are noted with the symbol (§), high priority measures are noted with an exclamation point (!), and high priority measures that are appropriate use measures are noted with a double exclamation point (!!) in the column.

B.11. Orthopedic Surgery

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!!	0268	021	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis.	American Society of Plastic Surgeons
!	0239	023	N/A	Claims, Registry	Process	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxi to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	American Society of Plastic Surgeons
!	0045	024	N/A	Claims, Registry	Process	Communication and Care Coordination	**Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	National Committee for Quality Assurance

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
§ !	0097	046	N/A	Claims, Web Interface, Registry	Process	Communication and Care Coordination	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older.	National Committee for Quality Assurance
	0326	047	N/A	Claims, Registry	Process	Communication and Care Coordination	**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 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.	National Committee for Quality Assurance

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	109	N/A	Claims, Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.	American Academy of Orthopedic Surgeons
* §	0421	128	69v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.	Centers for Medicare & Medicaid Services

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	0419	130	68v7	Claims, Registry, EHR	Process	Patient Safety	**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.	Centers for Medicare & Medicaid Services
!	0420	131	N/A	Claims, Registry	Process	Communication and Care Coordination	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Centers for Medicare & Medicaid Services
	0418	134	2v7	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Centers for Medicare & Medicaid Services
!	0101	154	N/A	Claims, Registry	Process	Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.	National Committee for Quality Assurance
!	0101	155	N/A	Claims, Registry	Process	Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.	National Committee for Quality Assurance
	N/A	178	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Functional Status Assessment:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.	American College of Rheumatology

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	179	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months.	American College of Rheumatology
	N/A	180	N/A	Registry	Process	Effective Clinical Care	**Rheumatoid Arthritis (RA): Glucocorticoid Management** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.	American College of Rheumatology
* §	0028	226	138v6	Claims, Web Interface, Registry, EHR	Process	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco 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.	Physician Consortium for Performance Improvement Foundation (PCPI®)
	N/A	317	22v6	Claims, Registry, EHR	Process	Community/ Population Health	**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.	Centers for Medicare & Medicaid Services
	0101	318	139v6	EHR, Web Interface	Process	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	National Committee for Quality Assurance

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
!	N/A	350	N/A	Registry	Process	Communication and Care Coordination	**Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy:** Percentage of patients regardless of age undergoing a total knee replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g. nonsteroidal anti-inflammatory drugs (NSAIDs), analgesics, weight loss, exercise, injections) prior to the procedure.	American Association of Hip and Knee Surgeons
!	N/A	351	N/A	Registry	Process	Patient Safety	**Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation:** Percentage of patients regardless of age undergoing a total knee replacement who are evaluated for the presence or absence of venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), Myocardial Infarction (MI), Arrhythmia and Stroke).	American Association of Hip and Knee Surgeons
!	N/A	352	N/A	Registry	Process	Patient Safety	**Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet:** Percentage of patients regardless of age undergoing a total knee replacement who had the prophylactic antibiotic completely infused prior to the inflation of the proximal tourniquet.	American Association of Hip and Knee Surgeons
!	N/A	353	N/A	Registry	Process	Patient Safety	**Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report:** Percentage of patients regardless of age undergoing a total knee replacement whose operative report identifies the prosthetic implant specifications including the prosthetic implant manufacturer, the brand name of the prosthetic implant and the size of each prosthetic implant.	American Association of Hip and Knee Surgeons
!	N/A	358	N/A	Registry	Process	Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	American Association of Hip and Knee Surgeons

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
* !	N/A	374	50v6	Registry, EHR	Process	Communication and Care Coordination	**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.	Centers for Medicare & Medicaid Services
* !	N/A	375	66v6	EHR	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Total Knee Replacement:** Changes to the measure description: Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	Centers for Medicare & Medicaid Services
!	N/A	376	56v6	EHR	Process	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Total Hip Replacement:** Percentage of patients 18 years of age and older with who received an elective primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.	Centers for Medicare & Medicaid Services
	N/A	402	N/A	Registry	Process	Community/ Population Health	**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.	National Committe e for Quality Assurance
	N/A	408	N/A	Registry	Process	Effective Clinical Care	**Opioid Therapy Follow-up Evaluation:** All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	American Academy of Neurology
	N/A	412	N/A	Registry	Process	Effective Clinical Care	**Documentation of Signed Opioid Treatment Agreement:** All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	American Academy of Neurology

B.11. Orthopedic Surgery (continued)

Indicator	NQF #	Quality #	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description	Measure Steward
	N/A	414	N/A	Registry	Process	Effective Clinical Care	**Evaluation or Interview for Risk of Opioid Misuse:** All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record	American Academy of Neurology
	0053	418	N/A	Claims, Registry	Process	Effective Clinical Care	**Osteoporosis Management in Women Who Had a Fracture:** The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture	National Committee for Quality Assurance
	N/A	TBD	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Back Pain Following Lumbar Discectomy / Laminotomy:** The average change (preoperative to three months postoperative) in back pain for patients 18 years of age or older who had lumbar discectomy /laminotomy procedure	MN Community Measurement
	N/A	TBD	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Back Pain Following Lumbar Fusion:** The average change (preoperative to one year postoperative) in back pain for patients 18 years of age or older who had lumbar spine fusion surgery	MN Community Measurement
	N/A	TBD	N/A	Registry	Outcome	Person and Caregiver-Centered Experience and Outcomes	**Average Change in Leg Pain Following Lumbar Discectomy / Laminotomy:** The average change (preoperative to three months postoperative) in leg pain for patients 18 years of age or older who had lumbar discectomy / laminotomy procedure	MN Community Measurement