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MEMORANDUM

To: American Society of Transplant Surgeons MACRA Task Force

From: Diane Millman
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Subject: MIPS/APM Proposed Rule: Summary and Impact on Transplant Surgeons

Date: May 16, 2016

CMS has released its **proposed rule** implementing the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs). These new payment systems, now being referred to by CMS as the "Quality Payment Program," are required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the same law that repealed the sustainable growth rate (SGR) methodology. The proposed rule is almost 1,000 pages, but there is a shorter summary available on the CMS **website**. **Comments are due on June 27, 2016.**

This memorandum is our initial take on the proposal. It focuses on those aspects of the proposed rule which may impact transplant surgeons. This is a complex rule and this memorandum does not purport to address every possible issue. If you have questions that are not addressed below, please let us know and we will attempt to provide answers.

I. MIPS

A. Financial Impact

Unless a clinician[1] is excluded from MIPS (see discussion below), s/he will receive a MIPS composite score that will determine whether s/he will receive an incentive payment or a negative adjustment. By law, the program must be budget neutral, so reductions in payment for those who score poorly will fund the incentives of those who score highly. During the first year, the maximum downward adjustment is 4%, rising to 9% by 2022. MIPS payment adjustments begin in 2019 based on performance during 2017. A clinician can receive an individual score or a group score.

CMS estimates that 54.1% of clinicians will receive a positive adjustment during the first year and 45.4% will receive a negative adjustment.

B. Impact on Transplant Surgeons

The CMS impact tables do not address transplant surgeons specifically but do include projected impact data for general surgery and a number of surgical subspecialties. For example, CMS estimates that the impact of the proposal on general surgeons will be in line with the impact on clinicians generally: Of the 20,387 general surgeons expected to participate in MIPS, an estimated 54.2% are projected to receive

[1] Clinician is the term used by CMS in the proposed rule to refer to both physicians and non-physician practitioners subject to MIPS.

positive adjustments and an estimated 45.5% are projected to receive negative adjustments. The aggregate negative payment adjustment is projected at -$24 million and the aggregate positive payment adjustment is projected to reach +$35 million. These estimates are based on the specialty's historic participation in PQRS, Maintenance of Certification, Meaningful Use, and the Value Modifier program.

Obviously, the fewer Medicare patients a transplant surgeon has, the less the impact. However, even if the financial impact were insignificant, MIPS scores will be posted on the Physician Compare website which could be a cause for concern for those with poor MIPS scores.

C. Exclusion from MIPS

CMS estimates that about 5090 general surgeons will be excluded from MIPS. Clinicians with fewer than $10,000 in Medicare Allowed Claims and fewer than 100 Medicare patients for a given year are not subject to MIPS. Medicare Advantage patients do not count toward these thresholds. Another basis for exclusion is successful participation in an advanced alternative payment model (AAPM).

D. MIPS Quality Component

The most significant of the four MIPS components is "quality" which will account for 50% of the composite score in 2019. Quality is measured through reporting of MIPS quality measures. Since this MIPS category counts the most, it is important to make sure that there are sufficient measures for transplant surgeons to report.

It should be helpful that CMS is proposing to decrease the number of measures required to be reported from the current PQRS requirement of nine measures to six. The measures set forth at Attachment A may be of particular interest to transplant surgeons; however, we would suggest that the complete measure set be reviewed to determine whether there are additional quality measures that transplant surgeons may be in a position to report.

E. MIPS Advancing Care Information (Meaningful Use of EHR) Component

This component counts for 25% of the MIPS score. The proposed rule purports to ease the MU requirements (now referred to as Advancing Care Information) by eliminating the all or nothing provision that caused many to be unable to attest; however, in order to get any credit under this category, a physician would have to meet a certain core set of requirements, which may continue to make it difficult for smaller practices to score well. A more detailed summary of this aspect of MIPS can be found on the CMS **website**. It is significant in this regard that CMS is proposing to exempt "hospital-based MIPS eligible clinician(s)" from the Advancing Care Information requirements. Under the proposal, this term is defined as any clinical who furnishes 90 percent or more of his or her covered professional services in sites of service identified in the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the performance period (ie 2016, for the 2019 MIPS payment year). It is possible, if not likely, that many ASTS members may qualify for an exemption from this MIPS component as "hospital-based MIPS eligible clinician(s)."

F. Clinical Practice Improvement Component

Clinical Practice Improvement counts for 15% of the MIPS component score in 2019; however, its weight will increase over time. Clinicians must choose from among 90 "clinical practice improvement activities" (CPIAs) activities in areas of care coordination, population management, health equity, beneficiary engagement, patient safety, and others. Participation in a patient centered medical home gives a physician full credit in this category, as does participation in an "advanced alternative payment model" ("AAPM") discussed below.

Clinicians in groups of over 15 would have to perform two high-weighted CPIAs or three medium weighted CPIAs to achieve a score of 100%, and it is anticipated that most ASTS members will fall into this category. Because the law requires CMS to give special consideration to the circumstances of small practices in establishing MIPS requirements, small practices could achieve a score of 100% by engaging in two CPIAs that are medium or high weighted. A number of the clinical practice improvement activities that may be relevant to ASTS members is included at Attachment B; in addition, it may be appropriate for the Task Force to review the list of proposed CPIAs to determine whether others are also relevant.

G. **Cost/Resource Use Component**

This component is worth 10% of the composite score and attempts to measure efficiency and cost of care based on 40 episode-specific measures, a total per capita cost measure (a measure that takes into account all Part A and Part B costs of assigned beneficiaries) and the Medicare Spending Per Beneficiary (MSPB) measure (a measure taking into account the costs of inpatient admissions and a designates post-discharge period for certain hospitalizations). Significantly, however, to receive a score on a cost measure, at least 20 cases/patients must be attributed to the clinician for that measure, and it is anticipated that many physicians will not receive a score for the resource use component of MIPS. There are no transplant-specific episodes listed in the proposed rule, and the MSPB measure likewise does not focus on transplant admissions. For this reason, it is likely that this measure will not be applicable to transplant surgeons who participate in MIPS individually. For those that do not meet the threshold, CMS will reweight the category to zero and adjust the other three MIPS performance scores.

II. AAPMs

Significant participation in an AAPM will allow clinicians to be exempt from MIPS and to receive an automatic 5% bonus payment from Medicare through 2024 and, beginning in 2026, these physicians will receive a higher fee schedule update every year compared to those who do not qualify. However, CMS has established extremely tight proposed criteria for AAPMs, such that many of the demonstrations that CMS itself has designed would not qualify; in fact, the provisions defining AAPM requirements are among the most controversial in the proposed rule. Basically, only clinicians associated with fully capitated Medicare Shared Savings Programs and "Next Generation" ACOs will even potentially qualify.

It is of interest, however, that CMS is proposing that End Stage Renal Disease Comprehensive Care Organizations' (ESCOs) that take on down side risk (i.e. those operated by large dialysis organizations) would qualify as AAPMs under the proposed rule. These ESCOs have a strong incentive not to refer relatively healthy dialysis patients for transplantation, and to refer only those who consume relatively high health care resources (e.g. those who undergo frequent hospitalization). While there are only a handful of ESCOs that take on down side risk now, the proposed rule's designation of these entities as potential AAPMs suggests that the agency is planning to expand the demonstration program and provide strong

financial incentives for dialysis facilities, renal physicians and others caring for ESRD patients to participate. Broad participation may pose a significant threat to transplantation.

IV. Physician Compare Website

By law, CMS is required to post individual MIPS eligible clinician and group performance information, including the clinician's score under each MIPS performance category. It is also required to report clinicians in AAPMs and the names of the AAPMS and their performance. Clinicians will have a 30-day period to preview data before it is posted on the website.

V. Summary and Bottom Line

Virtually all ASTS members will be paid under MIPS in 2019, based on 2017 performance. Only those members associated with ACOs that take capitation are carry substantial "down side" financial risk will have the potential to qualify for the APM "track" and obtain the promised 5% bonus.

MIPS will take the place of a number of the current "carrot and stick" CMS programs (PQRS, Value-Based Modifier, and Meaningful Use of Electronic Health Records), and the MIPS requirements will be less stringent than those currently imposed under these programs insofar as the only six (as opposed to the current PQRS requirement of nine) quality measures will be required under MIPS. Participation in quality reporting will be the single most important factor in transplant surgeons' score under MIPS. It appears likely that many transplant surgeons may qualify for "hospital-based" exemption from the "Advancing Care Information" (currently MU requirements) under MIPS, and it is unclear whether and to what extent transplant surgeons will receive a score under the Cost/Resource component of the program, since transplant episodes are not currently on the list of episodes that CMS plans to track for the purposes of this cost measure. It appears that due to the significant quality and cost coordination activities that transplant surgeon routinely engage in, transplant surgeons likely will not have significant difficulty in getting a relatively high score under the "Clinical Practice Improvement Activity" component of MIPS.

We would suggest that the Task Force review the quality measures set forth in the Proposed Rule and the Clinical Practice Improvement Activities to determine with greater specificity which of these are likely to be relevant for transplant surgeons. We hope that this memorandum provides a basis for further discussion and analysis.

Attachment A: Quality Measures of Potential Interest

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description¥	Measure Steward
!!	0268/021	N/A	Patient Safety	Claims, Registry	Process	**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 Medical Association-Physician Consortium for Performance Improvement/ National Committee for Quality Assurance
* § !	0097/046	N/A	Communication and Care Coordination	Claims, Web Interface, Registry	Process	**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 / American Medical Association-Physician Consortium for Performance Improvement
§	0409/205	N/A	Effective Clinical Care	Registry	Process	**HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection.	National Committee for Quality Assurance/ American Medical Association-Physician Consortium for Performance Improvement

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description¥	Measure Steward
* !	0419/130	68v 5	Patient Safety	Claims, Registry, EHR	Process	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible clinician 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/ Mathematica / Quality Insights of Pennsylvania
* !	N/A/355	N/A	Patient Safety	Registry	Outcome	**Unplanned Reoperation within the 30 Day Postoperative Period:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period.	American College of Surgeons
* !	N/A/356	N/A	Effective Clinical Care	Registry	Outcome	**Unplanned Hospital Readmission within 30 Days of Principal Procedure:** Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.	American College of Surgeons
* !	N/A/357	N/A	Effective Clinical Care	Registry	Outcome	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI).	American College of Surgeons
!	N/A/358	N/A	Person and Caregiver-Centered Experienc e and Outcomes	Registry	Process	**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 College of Surgeons

Attachment B: Potentially Relevant Clinical Practice Improvement Activities

Patient Safety and Practice Assessment	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator.	Medium
Patient Safety and Practice Assessment	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following: Train all staff in quality improvement methods; Integrate practice change/quality improvement into staff duties; Engage all staff in identifying and testing practices changes; Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	Medium
Patient Safety and Practice Assessment	Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: Make responsibility for guidance of practice change a component of clinical and administrative leadership roles; Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	Medium

Patient Safety and Practice Assessment	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator.	Medium
Patient Safety and Practice Assessment	Participation in Maintenance of Certification Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.	Medium
Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	High
Care Coordination	Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).	Medium
Care Coordination	Establish standard operations to manage transitions of care that could include one or more of the following: Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or Partner with community or hospital-based transitional care services.	Medium
Care Coordination	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium

Subcategory	Activity	Weighting
Population Management	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium
Population Management	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or Conduct periodic, structured medication reviews.	Medium
Population Management	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium