MIPS/APM Proposed Rule Summary

On Monday, May 9, 2016 the Centers for Medicare and Medicaid Services (CMS) published in the Federal Register the proposed criteria for the Quality Payment Program as prescribed in the Medicare and CHIP Reauthorization Act (MACRA) of 2015. The proposed 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 proposed criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for making comments and recommendations on physician-focused payment models. The deadline for public comments on the proposed rule is Monday, June 27, 2016.

Background

Passed in April 2015, MACRA repealed the sustainable growth rate, creating a new pay-for-performance program for Medicare physician payment and encouraging physician participation in alternative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 takes the place of those programs through the establishment of four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities (CPIA) and Resource Use.

CMS Quality Payment Program Goals:

1. Design a patient centered approach to program development that leads to better, smarter, and healthier care;
2. Develop a program that is meaningful, understandable, and flexible for participating clinicians;
3. Design incentives that drive delivery system reform principles and participation in APMs; and
4. Ensure close attention to CMS’ excellence in implementation, effective communication with stakeholders and operational feasibility.

The following is a summary of the proposed 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 proposes that an eligible professional is defined as a physician, a physician assistant, nurse practitioner and clinical nurse specialist, a certified registered nurse anesthetist and a group that includes such professionals. To participate in the MIPS program an eligible professional must bill $10,000 or more in Medicare business and treat 100 or more Medicare patients per year.
CMS proposes using multiple identifiers for performance and participation that allow MIPS eligible clinicians to be measured as an individual or as part of a group. Eligible clinicians can participate and report performance data for the four performance categories either individually 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.

The first performance period for MIPS will be 2017 and the first payment adjustments under MIPS will begin in 2019. Eligible clinicians with only a partial year’s worth of data will be assessed on the partial period. The percent payment adjustments can be positive or negative and range up to 4 percent for 2019, 5 percent for 2020, 7 percent for 2021, and 9 percent for 2022 and later years. For payment in 2019 through 2024 an additional positive adjustment is provided for exceptional performance.

**MIPS Performance Categories and Measures**

In the proposed rule, CMS proposes standards for the four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities (CPIA), and Resource use. Eligible clinician performance in these categories will determine annual MIPS payment adjustments.

Below is a table reproduced from the *CMS MACRA Quality Payment Program Fact Sheet* that summarizes the key features of the MIPS.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Points Need to Get a Full Score per Performance Category</th>
<th>Maximum Possible Points per Performance Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> 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 and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 Percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 Points</td>
<td>25 Percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 Points</td>
<td>15 Percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all attributed resource measures.</td>
<td>10 percent</td>
</tr>
</tbody>
</table>

1Exemptions or adjustments may apply in some clinicians’ circumstances that change the total category score.

**Quality**
The Agency seeks comment on specialty specific measure sets, specifically whether or not the measures proposed are appropriate for the designated specialty and whether there are additional proposed measures that should be included in a particular specialty-specific measure set.

CMS continues to believe that the National Quality Strategy (NQS) domains are important and the agency encourages MIPS eligible clinicians to provide care that focuses on effective clinical care, communication, efficiency and cost reduction, person and caregiver-centered experience and outcomes, community and population health, and patient safety. Below are the PQRS Oncology Measures Group measures that CMS proposes retaining in the MIPS program categorized by designated NQS Domain:

<table>
<thead>
<tr>
<th>Efficiency and Cost Reduction</th>
<th>Measure Title and Description</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:</strong> 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, OT cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.</td>
<td>Registry or EHR</td>
<td>Process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective Clinical Care</th>
<th>Measure Title and Description</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer:</strong> Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist).</td>
<td>Registry</td>
<td>Process</td>
</tr>
<tr>
<td></td>
<td><strong>Proportion with more than one emergency room visit in the last 30 days of life:</strong> Percentage of patients who died from cancer with more than one emergency room visit in the last 30 days of life.</td>
<td>Registry</td>
<td>Outcome</td>
</tr>
<tr>
<td></td>
<td><strong>Proportion admitted to the ICU in the last 30 days of life:</strong> Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.</td>
<td>Registry</td>
<td>Outcome</td>
</tr>
<tr>
<td></td>
<td><strong>Proportion not admitted to hospice:</strong> Percentage of patients who died from cancer not admitted to hospice.</td>
<td>Registry</td>
<td>Process</td>
</tr>
<tr>
<td></td>
<td><strong>Proportion admitted to hospice for less than 3 days:</strong> Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there.</td>
<td>Registry</td>
<td>Outcome</td>
</tr>
</tbody>
</table>
### Person and Caregiver-Centered Experience and Outcomes

<table>
<thead>
<tr>
<th>Measure Title and Description</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oncology: Medical and Radiation – Pain Intensity Qualified:</strong> 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.</td>
<td>Registry, EHR</td>
<td>Process</td>
</tr>
<tr>
<td><strong>Oncology: Medical and Radiation – Plan of Care for Pain:</strong> 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.</td>
<td>Registry</td>
<td>Process</td>
</tr>
</tbody>
</table>

### Patient Safety

<table>
<thead>
<tr>
<th>Measure Title and Description</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oncology: Radiation Dose Limits to Normal Tissues:</strong> 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.</td>
<td>Claims or Registry</td>
<td>Process</td>
</tr>
<tr>
<td><strong>Documentation of Current Medications in the Medical Record:</strong> Percentage of visits for patients aged 18 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.</td>
<td>Claims, Registry or EHR</td>
<td>Process</td>
</tr>
</tbody>
</table>

### Community/Population Health

<table>
<thead>
<tr>
<th>Measure Title and Description</th>
<th>Data Submission Method</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention:</strong> 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.</td>
<td>Claims, Web Interface, Registry, or EHR</td>
<td>Process</td>
</tr>
</tbody>
</table>

CMS proposes to retain the majority of the existing measures within the PQRS Oncology Measures Group in the Individual Quality Measures list. However, the Agency proposes to remove the following two measures:

- **Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone (ER/PR) Positive Breast Cancer:** Percentage of female patients aged 18 years and older
with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period.

- **Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients:** Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.

CMS proposes to remove these measures as they are similar to core measures established by the Core Measure Collaborative. As such, the clinical performance identified with these measures can be addressed by measures within the core measures set.

Additionally, CMS proposes to omit **Measure 110 - Preventative Care and Screening: Influenza Immunization** as cross cutting measure beginning in 2017.

CMS estimates that 1,281 of Radiation Oncologists representing $308 million in allowed charges (2 percent of total allowed charges) will submit quality performance category data to MIPS but will not receive scores in quality or resource use because their measures will not meet the minimum case sizes for measures in these two categories. Additionally, CMS estimates that, of the 4,239 Radiation Oncologists able to participate in the program, just over half (56 percent) will experience a positive rate adjustment and the remaining 44 percent will receive a negative rate adjustment as a result of MIPS participation.

**Advancing Care Information**

For this category, CMS proposes that eligible clinicians will choose to report customizable measures that reflect how they use technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. According to CMS, this allows for more flexibility and unlike the existing reporting program, this category would not require all-or-nothing EHR measurement or redundant quality reporting.

CMS proposes that eligible clinicians, EPs, eligible hospitals, and CAHs would be required to attest that they have cooperated in good faith with the surveillance and ONC direct review of their health IT certified under the ONC Health IT Certification Program, to the extent that such technology meets (or can be used to meet) the definition of CEHRT. Cooperation includes responding in a timely manner and in good faith to requests for information about CEHRT performance and capabilities that are in use by the provider and accommodating requests for access to the provider’s CEHRT for the purposes of direct surveillance and direct review to the extent that doing so would not compromise patient care or cause undue burden on the eligible clinician.

MACRA requires that to be a meaningful EHR user, an eligible clinician must satisfy an attestation requirement, which includes the following parameters:

- EP did not knowingly and willfully take action to limit or restrict the compatibility or interoperability of certified EHR technology
EP attests that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure that the certified EHR technology was, at all relevant times: connected in accordance with applicable law; compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170.

EP attests that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information including from patients, healthcare providers, and other persons, regardless of the requestor’s affiliation or technology vendor.

Satisfies advancing care performance category under MIPS and APMs.

CMS seeks comments on this proposal, including whether these statements could provide the Secretary with adequate assurances that providers have complied with the statutory requirements for information exchange.

Clinical Practice Improvement Activities

CMS proposes that this category will reward clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety. 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). It is ASTRO’s opinion that participation in RO-ILS: Radiation Oncology Incident Learning System®, which is part of Clarity PSO, a federally listed patient safety organization, satisfies the CPIA PSO requirement.

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. CMS proposes that the highest potential score will be 60 points for the CY 2017 performance period. CMS seeks comment on this multi-tiered approach.

Cost

For this category, the score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use 40 episode-based measures to account for cost differences among specialties. Of the episode-based measures proposed for the 2017 MIPS performance period, two are cancer specific:

- Mastectomy for Breast Cancer – Mastectomy for a breast cancer episode is triggered by a patient’s claim with any of the interventions assigned as Mastectomy trigger codes. Mastectomy can be triggered by either an ICD procedure code, or CPT codes in any setting (e.g. hospital, surgical center).
- Prostatectomy for Prostate Cancer – Definitive Prostatectomy for a prostate cancer episode is a distinguished procedure from transurethral resection (TURP) and other procedures for on neoplastic disease of the prostate. This episode is triggered by an
inpatient hospital claim with any of the interventions assigned as episode trigger codes. Episodes can be triggered by either an ICD procedure code, or CPT codes in any setting.

**MIPS Composite Score Methodology**

CMS proposes a 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 proposes and seeks comment on the following characteristics for the unified scoring system:

- For the quality and resource use performance categories, all measures would 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 would 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 would generally not be included. In accordance with MACRA, however, failure to report on a required measure or activity would result in zero points for that measure or activity.

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

- The scoring proposals would 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 would receive points towards the performance category scores.

**MIPS Reporting Mechanisms**

CMS encourages quality reporting through EHR technologies and Qualified Clinical Data Registries (QCDRs) throughout the proposed rule. CMS proposes 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 would reduce the administrative burden associated with reporting information. CMS states it is concerned, however, that not all third party entities will be able to implement the necessary changes to support reporting on all
categories in the first year. CMS seeks comments on whether it should propose requiring health IT vendors, QCDRs and qualified registries to have the capability to submit data for all MIPS performance categories.

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 proposed rule addresses the criteria of the incentive payment program and proposes the definitions, requirements, procedures, and thresholds of participation governing the program.

In addition to defining the structure of Advanced APMs and Other Payer Advanced APMs, the proposed rule introduces the concept of a MIPS APM and provides criteria for the establishment of a process for the Physician Focused Payment Model Technical Advisory Committee (PTAC) to evaluate Physician Focused Payment Models.

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

CMS proposes that Qualifying APM Participant (QP) and Partial QP determination will be based on whether an entity with a group of individual eligible clinicians participates 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% of their Part B payments tied to Advanced APMs beginning in 2019. That percentage grows to 50% in 2021 and 75% in 2023.
- QP patient thresholds start at 20% in 2019 and then grow to 50% beginning in 2023.

The CMS proposed 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 aligns with the MIPS performance period, thus the first performance year will be 2017 for 2019 payment.

The thresholds for Partial QPs are lower. Additionally, Partial QPs have the option to choose whether or not to report MIPS data and thereby be subject to a MIPS-related payment adjustment. CMS seeks comment on the proposed Medicare Part B payment and patient count thresholds.

Advanced Alternative Payment Models (APMs)

Eligible clinicians who are deemed to be QPs may participate in a CMS-designated Advanced APM. CMS proposes to 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. The requirements, incentive and participation notification timeline are the same as those described below for the Advanced APM.

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

- Adoption of certified EHR technology (CEHRT) - CMS proposes to phase in the CHERT adoption requirement by setting a goal of 50 percent of eligible clinician participation by 2017 and 75 percent of eligible clinical participation by 2018.
- 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 - Quality Measures “Comparable” to MIPS Measures

CMS recognizes 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). However, as each APM Entity is different, there needs to be the flexibility to determine which measures are most appropriate for use in their respective APM for the purpose of linking those measures to payment under the model.

CMS proposes that Advanced APMs 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 (CMS is proposing that an Advanced APM 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.

Advanced APM – Nominal Financial Risk

CMS proposes that the amount of nominal financial risk that providers must meet be at least 4 percent of the spending target. Additionally, the Agency proposes to include a marginal risk level that must be at least 30 percent of the maximum amount at risk and a minimum loss rate that cannot exceed 4 percent. The minimum loss rate is the amount the eligible clinician’s spending can exceed the benchmark before they become responsible for financial losses. CMS seeks comment on the risk construct, particularly whether it should be applied to the Advanced APM benchmark or to actual revenues. Additionally, CMS is seeking feedback on whether the risk construct could be successful without the minimum loss rate.
CMS proposes that if actual expenditures under the APM exceed expected expenditures during the 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 did not propose including 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. CMS welcomes recommendations on ways to appropriately account for the business risk and other investments clinicians will have to make in their practices in order to successfully achieve Advanced APM status. In addition to not recognizing business risk, CMS also neglected to recognize the savings achieved by changes in practice patterns that some APMs will naturally create as a result of payment modification.

Advanced APM - Role of Existing CMMI Models and Medical Homes

CMS proposes that several existing CMMI models, including the two sided risk track for the Oncology Care Model, are already considered Advanced APMs. Additionally, CMS is proposing that a Medical Home will not be recognized as Advanced APMs unless they include primary care practitioners (PCPs, GPs, Geriatrics, etc...).

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 proposes 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 proposes to 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 would 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 requires by the APMS 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 proposed rule provides Physician Focused Alternative Payment Model Technical Advisory Committee (PTAC) with criteria for evaluating Physician Focused Payment Models (PFPM). The 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. CMS proposes that PFPMs will not automatically receive recognition as Advanced APMs but that PFPM can be a pathway for attaining Advanced APM status in the future.

CMS proposes PFPM criteria in the following key areas:

**Promote payment incentives for higher value care**

CMS proposes that 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 proposes that models must address an issue not already part of the CMS APM portfolio. The Agency proposes that a PFPM must either 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. A model should either address a new issue or include a new specialty; a PFPM that includes multiple specialties would meet this criterion if at least one of the specialties is not currently addressed by another APM. Additionally, PFPMs should contain methods for evaluation of their effectiveness.

**Care Delivery Improvement**

CMS proposes that 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, CMS proposes that PFPMs should encourage the use of Healthcare Information Technology to inform care decisions.

**PFPM PTAC Review Criteria**
In addition to describing the proposed PFPM criteria, CMS also proposed PTAC review criteria for use in the evaluation of proposed PFPMs. CMS proposes that the review should consider the following evaluation criteria:

- Anticipated size and scope of a proposed PFPM, including eligible physicians, beneficiaries, and services.
- Description of the burden of disease, illness or disability on the target patient population
- Assessment of the financial opportunity for APM entities, including a business case for how their participation in the model could be more beneficial to them than participation in FFS
- Information about whether the submitter believes the model is sufficient to meet the standards for an Advanced APM
- Geographic location(s) included in the model
- Performance period
- Defined episode of care
- Number and quality of services affected by the model

CMS seeks comments on the criteria for both the formulation of PFPMs, as well as for the proposed evaluation criteria to be used by PTAC.