CMS Issues 2018 Proposed Rule - Year 2 of the Quality Payment Program

[CMS-5522-P] - Medicare Program; CY 2018 Updates to the Quality Payment Program

Background

On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule to continue implementation of the Quality Payment Program (QPP) required by the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). MACRA was bipartisan legislation signed into law in the spring of 2015 to permanently repeal the Sustainable Growth Rate (SGR), streamline quality reporting programs, and provide incentive payments for participation in advanced alternative payment models.

After an initial rulemaking last year, the QPP went into effect January 1, 2017. Based on feedback from stakeholders over the last several months, CMS is proposing some changes to the QPP and its two tracks for Medicare payment in 2018 and beyond: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs).

Some of these changes include:

- Increasing the low volume threshold so more clinicians are exempt from participating in the program
- Offering a new means of participation in MIPS through virtual groups
- Continuing to allow use of the 2014 Edition of Certified Electronic Health Record Technology (CEHRT) without penalty
- Incorporating MIPS performance improvement in scoring quality performance
- Incorporating the option to use facility-based scoring for facility-based clinicians
- Creating a new hardship exception for clinicians in small practices under the Advancing Care Information performance category
- Creating a small practice bonus
- Creating a complex patient bonus

Program Framework

In order to implement MACRA, CMS created the QPP with two tracks for Medicare payment, MIPS and Advanced APMs. CMS intends to refine and improve the QPP each year based on feedback from stakeholders. Through the QPP, CMS aims to improve beneficiary outcomes, reduce burdens on clinicians, increase adoption of advanced APMs, maximize participation, improve data and information sharing, ensure operational excellence in program implementation, and deliver IT systems capabilities that meet needs of users. In rolling out the QPP, CMS named 2017 the "Transition Year" building in flexibilities

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Additional Resources

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CMS Quality Payment Program Website

Explore Quality Payment Program Measures

AMA Resources

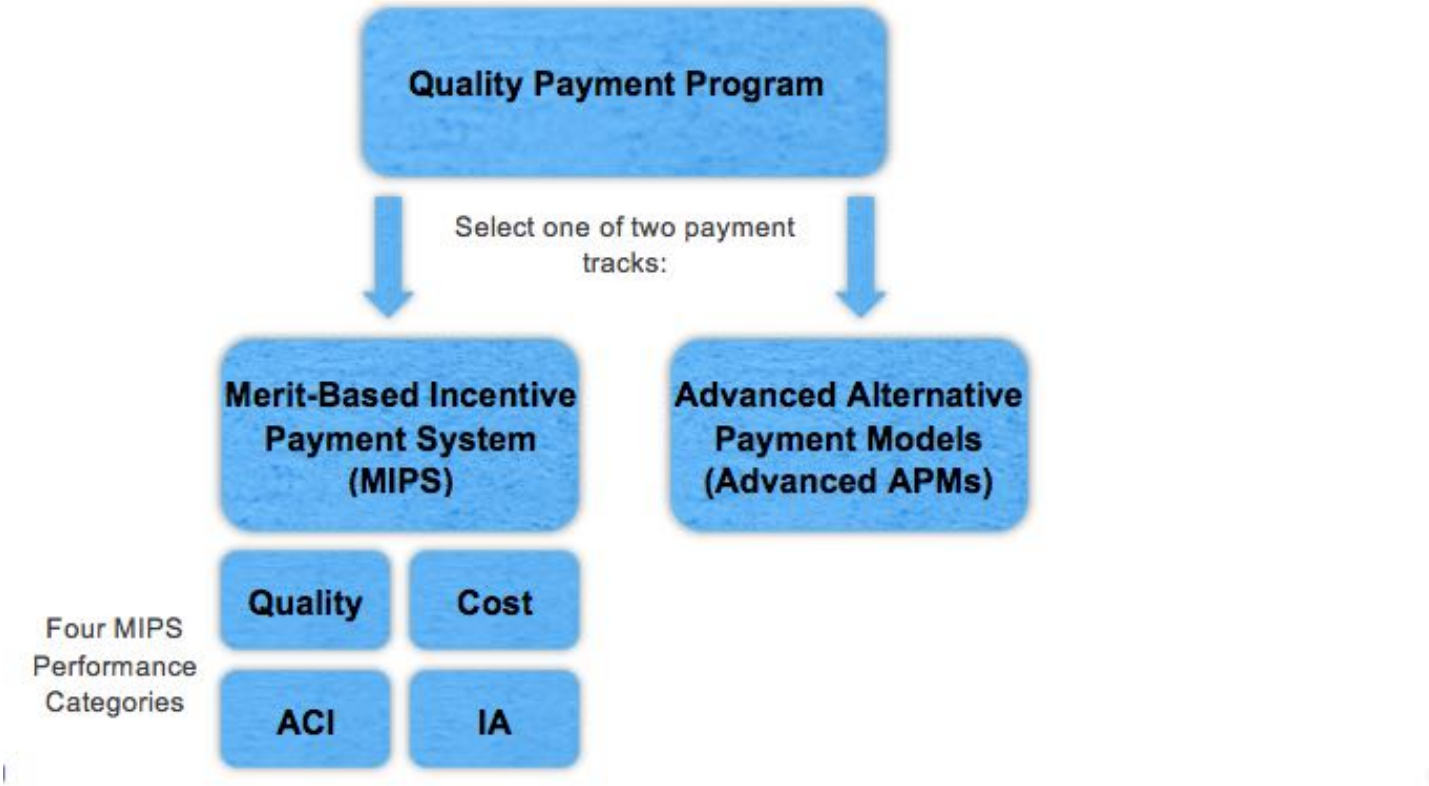
AMA Payment Model Evaluation Tool

ISASS Resources

Center for Healthcare Quality and Payment Reform

A Guide to Physician-Focused Alternative Payment Models

designed to encourage participation in the program. In 2018, we start to see a gradual ramping up of the performance threshold and potential for payment adjustments along with additional flexibilities in reporting options and more opportunities for bonus points.



Merit-Based Incentive Payment System (MIPS)

Participation in MIPS constitutes one of two payment paths under the QPP. MIPS retains the traditional fee-for-service payment model and streamlines the current physician reporting programs: Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Meaningful Use Incentive Program.

Who participates in MIPS?

"MIPS eligible clinicians" include physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who bill under Medicare Part B in excess of $90,000 per year **AND** provide care for more than 200 Medicare patients a year.

Who is excluded from MIPS?

- Clinicians newly enrolled in Medicare Part B (these clinicians are excluded for the first year of participation in the Medicare program)
- Clinicians that meet or exceed the "low volume threshold" (Medicare Part B billing is less than or equal to $90,000 **OR** the clinician provides care to 200 or fewer Medicare patients in one year). CMS is proposing to increase the low volume threshold in 2018 to $90,000/200 patients (from $30,000/100 patients in 2017) so that fewer clinicians are required to participate in the program.
- Certain clinicians participating in Advanced APMs (must receive 25 percent of Medicare payments OR see 20 percent of Medicare patients through an Advanced APM)

Facility-Based Measurement

In 2018, CMS will implement an optional voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. This option is only available for facility-based clinicians who have at least 75% of their covered professional services supplied in the hospital inpatient setting. Scoring of clinicians is based on a hospital total performance score.

MIPS Performance Categories

- MIPS has four weighted performance categories:
    1. Quality - 60 percent of overall score in 2018
        - Clinicians must report data on six selected quality measures
        - The data completeness threshold stays at 50% for 2018, but quality measures that do not meet data completeness requirements will get one point instead of three points, except "small practices" will continue to get three points.
        - Use this tool to browse, review, and identify MIPS Quality measures applicable to your practice.
            - In 2018, CMS proposes to add x new quality measures related to spine surgery:
                - Average Change in Back Pain Following Lumbar Discectomy / Laminotomy - Measures 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
                - Average Change in Back Pain Following Lumbar Fusion – Measures the average change (preoperativeto one year postoperative) in back pain for patients 18 years of age or older who had lumbar spine fusion surgery
                - Average Change in Leg Pain Following Lumbar Discectomy / Laminotomy - The average change (preoperativeto three months postoperative) in leg pain for patients 18 years of age or older who had lumbar discectomy laminotomy procedure

    2. Cost - Zero percent of overall score in 2018
        - There are no reporting requirements for clinicians as CMS calculates this category based on claims.
        - CMS will not count cost scores in 2018 as episode-based cost measures are still under development and will not be ready in time for use in the 2018 performance period.

    3. Improvement Activities - 15 percent of overall score in 2018
        - Clinicians attest to participation in selected activities that improve clinical practice
        - Clinicians must attest to two 20-point high weighted activities, four 10-point medium-weighted activities, or another combination of high and medium weighted activities equaling 40 points or more to achieve full credit in the Improvement Activities category
        - A lower reporting threshold of two medium-weighted or one high-weighted improvement activities are required for small, rural, health professional shortage areas and non-patient facing clinicians to receive full credit.
        - Use this tool to browse, review, and identify MIPS Improvement Activities applicable to your practice.

    4. Advancing Care Information - 25 percent of overall score in 2018
        - Clinicians report on measures and objectives that focus on the secure exchange of health information and the use of certified electronic health record technology (CEHRT).
        - In 2018, CMS will allow clinicians to use either the 2014 or 2015 Edition CEHRT and will grant a bonus for using only 2015 edition CEHRT.

- CMS will permit clinicians to continue to report on Modified Stage 2 measures in 2018 instead of new Stage 3 measures.
- CMS is creating a decertification exception for clinicians whose EHR was decertified.
- CMS is creating a hardship exception to reweight this performance category to zero and reallocate the weight to the Quality performance category for small practices of 15 or fewer clinicians.
- CMS is changing the deadline for hardship exceptions to December 31 of the performance year.
- ASC-based clinicians will automatically have this performance category reweighted to zero.
- Use this tool to browse, review, and identify MIPS Advancing Care Information measures applicable to your practice.

Improvement Scoring for Quality and Cost

In 2018, CMS will begin rewarding improvement in the Quality and Cost performance categories for a current performance period compared to the prior performance period. CMS will add improvement percentage points to the Quality and Cost performance category scores not to exceed 100%.

Complex Patient Bonus

In 2018, CMS will apply an adjustment of up to three bonus points by adding the average Hierarchical Conditions Category risk score to the final score. This will award between one and three points to clinicians based on the medical complexity of the patients they see.

Small Practice Bonus

In 2018, CMS will adjust the final score of all clinicians or groups in a small practice (15 or fewer clinicians) by adding five bonus points to the final score as long as the clinician or group submits data on at least one performance category during the performance period.

MIPS Final Score

- The four performance categories are used to calculate a final MIPS score (0-100 points)
    - Scoring method accounts for:
        - weights of each performance category
        - exceptional performance factors
        - availability and applicability of measures for different categories of clinicians
        - group performance
        - special circumstances including small practices, rural practices, etc.
        - bonus points
    - To calculate the final score, CMS uses the following formula: (Quality performance category score x Quality performance category weight) + (Cost performance category score x Cost performance category weight) + Improvement Activities category score x Improvement Activities category weight) + Advancing Care Information performance category score x Advancing Care Information category weight) x 100 + bonus points
    - 2018 Final Score greater than or equal to 70 points = positive payment adjustment and eligible for exceptional performance bonus (minimum of additional 0.5 percent)
    - 2018 Final Score from 16-69 points = positive payment adjustment, but not eligible for exceptional performance bonus
    - 2018 Final Score of 15 points = neutral payment adjustment

    - 2018 Final Score of 0-14 points = negative payment adjustment (0 points means the clinician did not submit any data or attempt to participate in MIPS)
- The payment adjustment is applied to the amount Medicare paid for Part B claims.

How to participate in MIPS?

- Clinician can participate as an individual (use individual unique Tax Identification Number (TIN) and National Provider Identifier (NPI))
- Clinician can participate as part of a group (use a single TIN with two or more NPIs that have assigned billing to the TIN or as an APM entity)
- Starting in 2018, clinicians can participate as part of a Virtual Group. Virtual groups are comprised of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" with at least one other such solo practitioner or group to participate in MIPS for the year performance period, regardless of geographic location or specialty. CMS is proposing components of a written agreement between each member of the virtual group.

How to submit data to CMS for MIPS?

- Data submission depends on whether the clinician is reporting as an individual or as a group
- Data can be submitted via claims, QCDR, Qualified Registry, EHR Vendors, CMS Web Interface, and CAHPS
- Starting in 2018, CMS will allow individual clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category.

MIPS Performance Cycle

- Performance is evaluated on an annual basis from January 1-December 31. During this "performance period," the Quality and Cost performance categories are evaluated and scored based on performance in all twelve months, but the Advancing Care Information and Improvement Activities performance categories are evaluated and scored based on a 90-day performance period.
- Performance in 2018
- Data collection in 2019
- Payment adjustments in 2020

MIPS Payment Adjustments

- Payment adjustment of up to +/- 4 percent in 2019 for performance year 2017
- **Payment adjustment of up to +/- 5 percent in 2020 for performance year 2018**
- Payment adjustment of up to +/- 7 percent in 2021 for performance year 2019
- Payment adjustment of up to +/- 9 percent in 2022 and beyond for performance years 2020 and beyond

Advanced Alternative Payment Models (Advanced APMs)

Only participants in **Advanced** APMs at MACRA thresholds qualify for 5 percent lump sum payments. The rule lays our two types of Advanced APMS: Advanced Medicare APMs and Other Payer Advanced APMs.

Advanced APMs must meet the following criteria:

1. Participation in use of certified EHR technology;

2. Payment based on quality measures comparable to those in the Quality performance category under MIPS; and

3. Either requires APM entities to be a Medical Home Model expanded under CMMI authority OR bear more than nominal financial risk for monetary losses. "More than nominal financial risk" is defined as 8% of the average estimated Part A and B revenue of the participating APM entities for the performance period OR 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Other Payer Advanced APMs must meet the following criteria:

1. Requires at least 50% of eligible clinicians to use certified EHR technology to document and communicate clinical care information;

2. Payment based on quality measures comparable to those in the Quality performance category under MIPS; and

3. Either requires APM entities to be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under CMMI authority OR bear more than nominal financial risk for monetary losses if actual aggregate expenditures exceed expected aggregate expenditures

All-Payer Combination Option

Beginning in 2019, CMS will allow clinicians to become qualified Advanced APM participants through an All-Payer Combination Option, which counts participation in a combination of both Advanced Medicare APMs and Other Payer Advanced APMs in Medicaid, Medicare Advantage, and CMMI multi-payer models. CMS expects to add remaining payer types in future years.

How do I become a Qualifying Advanced APM participant?

- In order to qualify, clinicians must have a certain percentage of patients (20 percent in 2018) or payments (25 percent in 2018) through an Advanced APM
- Qualifying APM participants will be excluded from MIPS AND receive a 5 percent lump sum bonus in 2020-2024 and higher fee schedule updates starting in 2026

MIPS APMs

- MIPS APM participants can improve their MIPS scores in APMs that do not meet criteria to be Advanced APMs or do not meet the revenue or patient thresholds to qualify for bonuses.
- MIPS APMs are not Advanced APMs and as such, participants in MIPS APMs will be subject to MIPS reporting requirements and the MIPS payment adjustment and will not be eligible for the 5 percent lump sum bonus for Advanced APM participation.

- MIPS eligible clinicians who participate in MIPS APMs will be scored using the APM scoring standard instead of the generally applicable MIPS scoring standard.
- APM must base payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality

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