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Quality Payment Program Explained: Overview and Analysis of the CY 2018 Proposed Rule

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Introducing the McDermott Team

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Paul brings his experience as a clinician and clinical researcher to his work with professional society and life sciences company stakeholders on MACRA strategy and implementation issues.

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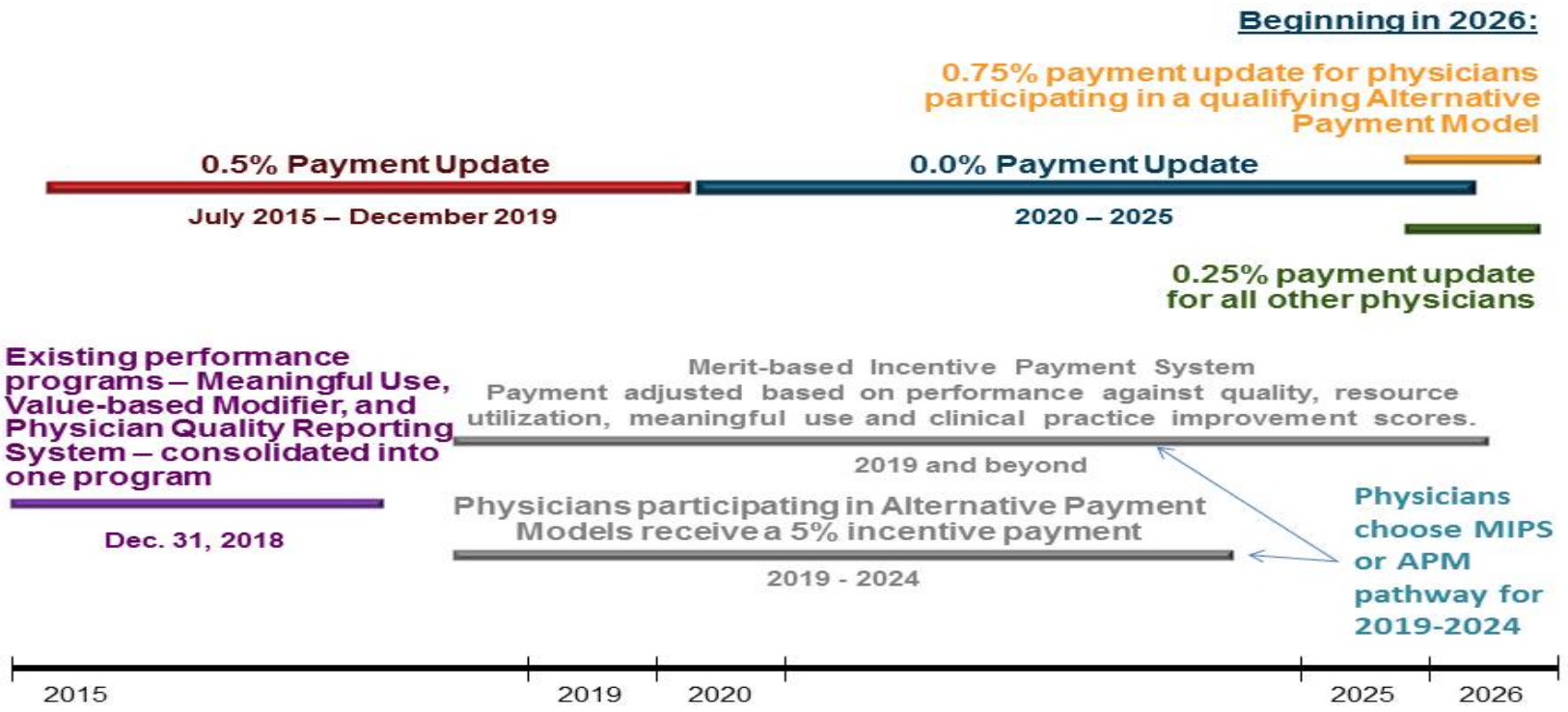
As an attorney with over 15 years of Medicare reimbursement experience and former health care advisor to members of Congress, Piper assists providers and other stakeholders on QPP implementation, analysis and strategy.

CY 2018 QPP Proposed Rule Released

CY 2018 Updates to the Quality Payment Program (CMS-5522-P)

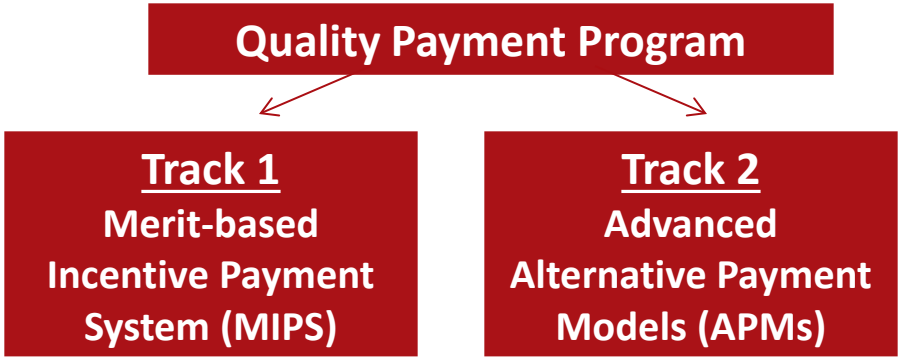
- Proposed Rule Posted: June 20, 2017
- Proposed Rule Published: June 30, 2017 (scheduled)
- Proposed Rule Comment Deadline: August 21, 2017 (www.regulations.gov)
- Effective Date of Final Rule: January 1, 2018

Transition Timeline: 2015 and Beyond



Quality Payment Program Overview

Eligible Clinicians Will Choose a Pathway



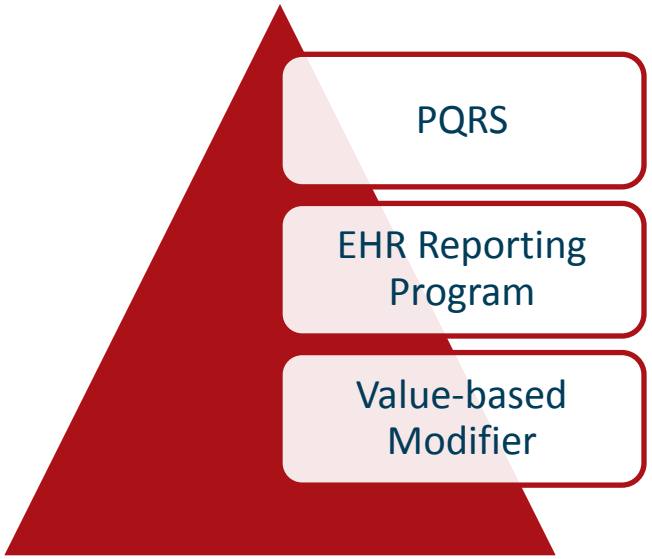
Details	MIPS	Advanced APMs
FFS Adjustments (Adjustment to annual update)	**Yes** (+/- 4% beginning in 2019 Payment Year; goes up to +/- 9% by 2022)	**Not Applicable**
Bonuses and Other Payments	**Bonus to Top 25%** Providers in top 25% of all aggregate MIPS scores receive additional positive adjustment factor (2019 – 2024)	**5% Incentive Payment** (2019-2024)
Annual Update (Beginning in 2026)	**0.25%**	**0.75%**
Criteria for Participation	**MIPS Reporting Requirements in Four Performance Categories**	**Participation Thresholds**

MIPS

MIPS Overview

Pre-MIPS

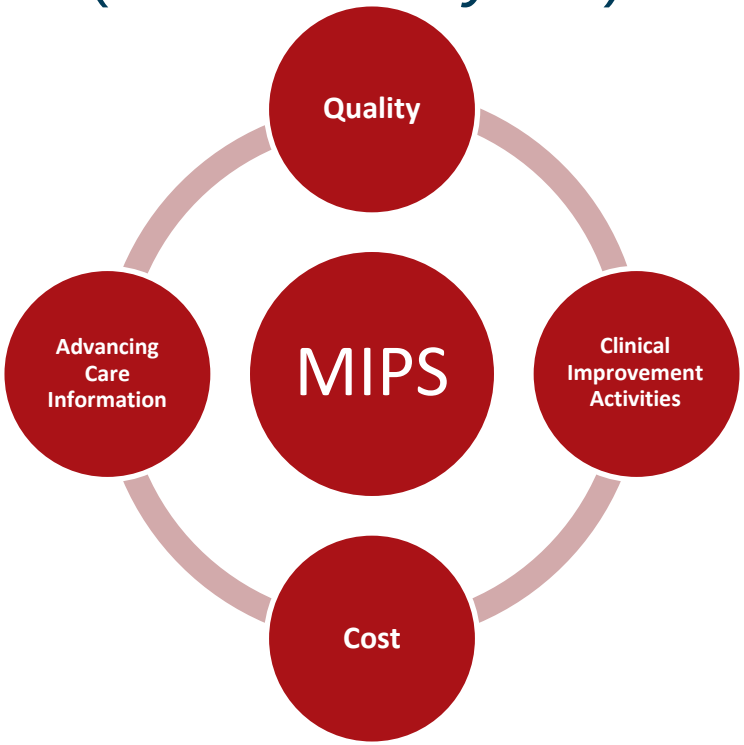
(*Before 2017*)



Clinicians participated in multiple quality programs, each with their own penalty/bonus schedule.

MIPS

(*2017 and beyond*)



Clinicians receive a single score based on measures and activities reported in four performance categories.

MIPS Timeline: 2017 - 2020

CY 2018
Year 2 Performance Period

CY 2017	CY 2018	CY 2019	CY 2020
Year 1 Performance Period	**Year 2** Performance Period	**Year 3** Performance Period	**Year 4** Performance Period
		Year 1 Payment Year	**Year 2** Payment Year

MIPS 2018: Transition Principles Continued

If 2017, the first year of MIPS, was about helping clinicians ease into the new quality program, the emphasis of 2018 is acknowledging the heterogeneity among clinician practices in general; as well as more specifically in their experience with quality-based payments.

2017	2018
• Implementation of "Pick Your Pace" (flexible participation options)	• Gradual transition continues but with increased participation requirements
• Reporting period reduced from 1 year (2017 Proposed Rule) to continuous 90 days	• Reporting period increased to 1 year for 2 of the 4 performance categories
• Cost Performance Category weighted at 0%	• Cost Performance Category still weighted at 0%
• Reduced MIPS reporting requirements	• Various provisions of MACRA implemented to help reduce clinician burden and offer flexibility (*e.g.* virtual group option; increased low-volume threshold exception; bonus points for caring for complex patients or to small practices)

Key Features: 2018 versus 2017

Policy	2018 Proposed	2017 Final
MIPS Timeline	**Performance Period** • **Quality and Cost Performance Categories**: CY 2018 • **Improvement Activities and Advancing Care Information (ACI) Performance Categories**: No change from 2017 (continuous 90 days) **Data Submission Deadline** • March 31, 2019 **Payment Year** • January 1 – December 31, 2019	**Performance Period** • **All Performance Categories:** CMS will accept a minimum of continuous 90 days of data within CY 2017 **Data Submission Deadline** • March 31, 2018 **Payment Year** • January 1 – December 31, 2018
Payment Adjustment	***MACRA authorized MIPS payment adjustments of +/- 4% beginning in 2019 which goes up to +/- 9% by 2022. Providers in the top 25% of all aggregate MIPS scores receive additional positive adjustment factor (2019 – 2024).***	
	Payment Adjustment • +/- 5% for the 2020 Payment Adjustment Year	**Payment Adjustment** • +/- 4% for the 2019 Payment Adjustment Year
MIPS Eligible Clinicians	**No change proposed for 2018 from the 2017 policy for the definition or categories of professionals excluded**; although CMS is proposing to revise the definition of a low-volume threshold eligible clinician.	**Definition** • Identified by a unique billing TIN and NPI combination; physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and a group, and a group that includes such clinicians **Categories of Professionals Excluded** • Advanced APM Qualified Participants (QPs) • Partial QPs who choose not to participate in MIPS • Low-volume threshold eligible clinicians

Key Features: 2018 versus 2017 cont.

Policy	2018 Proposed	2017 Final
Low-Volume Threshold Exception	***The MACRA statute allows CMS to exempt from MIPS payment adjustments eligible clinicians with low Medicare volume. CMS defined the criteria for the low-volume threshold exemption in the QPP regulations.***	
	Criteria • ≤ $90,000 in Part B allowed charges, OR • ≤ 200 Part B beneficiaries **Additional Proposals** • CMS is also considering establishing an additional criterion for the low-volume threshold exception that would be based on the number of items and services a MIPS-eligible clinician provides to Part B beneficiaries • CMS is also soliciting comments on a process for clinicians that meet the low-volume threshold criteria to voluntarily opt-in to MIPS	**Criteria** • ≤ $30,000 in Part B allowed charges, OR • ≤ 100 Part B beneficiaries
Individual versus Group Participation	**No change proposed for 2018 from the 2017 policy**	**Definition** • Individual: A single National Provider Identification (NPI) tied to a Tax Identification Number (TIN) • Group: A set of clinicians (minimum 2 identified by their NPIs) sharing a common TIN, no matter the specialty or practice site; group-level data is sent in for each of the MIPS categories through the CMS web interface or a third-party data-submission service such as a certified electronic health record, registry, or a qualified clinical data registry; of all clinicians in the group must participate as a group

Performance Categories: 2018 versus 2017

Eligible Clinicians are measured based on their performance in four Performance Categories: Quality, Advancing Care Information (ACI), Improvement Activities (IA) and Cost.

	2018 Proposed	2017 Final
Quality	• **# of Measures**: No change • **Data Completeness**: No changes proposed; but proposes to increase it to 60% for 2019 • **Topped Out Measures**: Proposal to identify topped out measures, and after 3 years to consider removal from the program through rulemaking in the 4th year	• **# of Measures**: 6 quality measures (including outcome measure) or 1 measure set (if no outcome measures are available in the measure set, report another high priority measure) • **Data Completeness**: 50% • **Topped Out Measures**: No policy
ACI	• **Measures**: A number of changes related to the measures (*e.g.* allows use of either 2014 or 2015 Edition CEHRT) • **Small Practice Hardship Exception**: Hardship exception for small practices • **Ambulatory Surgical Center-based (ASC) Physicians**: Implementation of 21st Century Cures Act that ASC-based physicians (75%) will be automatically reweighted to 0%	• **Measures**: 5 required measures
IA	• **Activities**: Additional activities and changes to existing activities proposed • **Small Practices in Rural Areas**: Reduced reporting	• **Measures**: 4 medium-weighted activities OR 2 high-weighted activities
Cost	• **Weight:** No change, CMS seeks comments on alternative approach of weighting at 10%	• **Weight**: 0%

Weights: 2018 versus 2017

CMS Proposes No Changes to Weights in 2018

	2018 Proposed	2018 Proposed (ACI exemption)	2018 Proposed (ACI exemption) ALTERNATIVE PROPOSAL	2017 Final	2017 Final (ACI exemption)
Quality	60%	85%	75%	60%	85%
ACI	25%	0%	0%	25%	0%
IA	15%	15%	25%	15%	15%
Cost	0%	0%	0%	0%	0%

Potential Implications of Not Implementing the Cost Performance Category in 2018

- *The MACRA statute requires a 30% weight for the Cost Performance Category by the 2021 Payment Year that cannot be waived by the agency; maintaining the 0% weight for Cost for the 2018 Performance Period is expected to result in a sharp increase in the Cost Performance Category to 30% in Performance Period 2019 (2021 Payment Year).*

- *In order to avoid such a large change, CMS also seeks comments on an alternative approach of weighting the Cost Performance Category at 10% for 2018.*

Facility-based Measures: 2018 versus 2017

Policy	2018 Proposed	2017 Final
Facility-based Measures	***MACRA authorized CMS to use measures from other payment systems (e.g., inpatient hospitals) for the Quality and Cost performance categories for "hospital-based" MIPS eligible clinicians but excluded measures from hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.***	
	• **Proposal**: CMS proposes to implement a voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program • **Criteria**: This option would be available only for facility-based clinicians who have 75% of their covered professional services supplied in the inpatient hospital or emergency department setting • **Scoring:** The facility-based measure option converts a hospital Total Performance Score into a MIPS Quality Performance Category and Cost Performance Category score	**CMS did not implement in 2017**

Scoring: 2018 versus 2017

Policy	2018 Proposed	2017 Final
Performance Threshold	***Under the MIPS scoring system, a participant's MIPS score ranges from 0-100 points, and the payment adjustment applied is based upon that score. The "performance threshold" represents the score that is needed to receive a neutral to positive payment adjustment for the year. A score below the performance threshold will result in a negative payment adjustment; while a score above the payment threshold will result in a positive payment adjustment (a score at the payment threshold will result in a neutral payment adjustment).***	
	• **15 points**, which can be achieved in multiple pathways (*e.g.* full performance with Quality and submission of maximum number of Improvement Activities)	• **3 points**, which can be earned by submitting a single Quality measure or attesting to performing one Improvement Activity for 90 days
Improvement Scoring	***The MACRA statute allows CMS to implement improvement scoring. Improvement scoring rewards improvement in performance for an individual MIPS eligible clinician or group for a current performance period compared to the prior performance period.***	
	CMS proposes to apply this policy to the Quality and Cost Performance Categories • **Quality:** The improvement scoring will be based on the rate of improvement and will be measured at the Quality Performance Category level; up to 10 percentage points will be available • **Cost:** Improvement scoring will be based on statistically significant changes at the measure level; it will not impact the 2020 MIPS payment year if the Cost Performance Category is weighted at 0 for the 2018 Performance Period	**CMS did not implement in 2017**

Scoring: 2018 versus 2017 cont.

Policy	2018 Proposed	2017 Final
Bonus Points	• **Complex Patient Bonus**: Apply an adjustment of up to 3 bonus points by adding the average Hierarchical Conditions Category (HCC) risk score to the final score; CMS also asks for comments on the option of including dual eligibility as a method of adjusting scores as an alternative to the HCC risk score or in addition to the risk score • **Small Practice Bonus**: Adjust the final score of any eligible clinician or group who is in a small practice (defined in the regulations as 15 or fewer clinicians) by adding 5 points to the final score as long as the eligible clinician or group submits data on at least 1 performance category; CMS also asks for comments on whether the small practice bonus should be given to those who practice in rural areas as well	**CMS did not implement the complex patient bonus or small practice bonus in 2017**

Scoring: 2018 versus 2017

MIPS Final Score

Payment adjustment ⇧ if score is above performance threshold

Performance Threshold
- 2018 = 15 points
- 2017 = 3 points

Payment adjustment ⇩ if score is below performance threshold

MIPS Scores Range from 0-100 Points*

Maximum Points By Performance Category
Quality (60 points); ACI (25 points); and IA (15 points)

2018 Performance Period		2017 Performance Period	
Points	**Adjustment**	**Points**	**Adjustment**
0.0 - 3.75	**Negative** • - 5%	**0.0 – 0.75**	**Negative** • - 4%
3.76- 14.99	**Negative** • Greater than -5% to less than 0% on linear sliding scale	**0.76 – 2.99**	**Negative** • Greater than -4% to less than 0% on linear sliding scale
15.00	**Neutral** • 0%	**3.00**	**Neutral** • 0%
15.01 – 69.99	**Positive** • Greater than 0% to 5%, on linear sliding scale	**3.01 – 69.99**	**Positive** • Greater than 0% to 5%, on linear sliding scale
70.00 - 100	**Positive** • Greater than 0% to 5%, on linear sliding scale • Exceptional performance adjustment	**70.00 - 100**	**Positive** • Greater than 0% to 5%, on linear sliding scale • Exceptional performance adjustment

**Adjustment factor can be applied to score to ensure budget neutrality.*

Special Accommodations: 2018 versus 2017

Policy	2018 Proposed	2017 Final
Virtual Groups	***The MACRA statute allows CMS to establish "virtual groups" for purposes of reporting and measuring performance under MIPS as a collective entity. Virtual groups can be composed of solo practitioners and small group practices.***	
	• **Description:** CMS proposes to allow solo practitioners and groups of 10 or fewer eligible clinicians to come together "virtually" with at least one other solo practitioner or group to participate in MIPS • **Assessment:** They virtual group assessed collectively, but only the NPIs that meet the definition of a MIPS-eligible clinician would be subject to a MIPS payment adjustment	**CMS did not implement in 2017**
Non-patient Facing Eligible Clinicians	**No change proposed for 2018 from the 2017 policy for the definition and special MIPS scoring adjustments** • **Virtual Groups**: CMS is proposing the same definition for virtual groups; virtual groups with more than 75 percent of NPIs within a virtual group during a performance period are labeled as non-patient facing.	• **Individual**: Individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters during the non-patient facing determination period • **Group**: A group where more than 75% of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period • **Special MIPS Scoring Adjustments**: Exempt from reporting ACI (assigned a weight of 0 %) and reduced reporting requirements for IA

Special Accommodations: 2018 versus 2017

Policy	2018 Proposed	2017 Final
Hospital-based Eligible Clinicians	**No substantive change proposed for 2018 from the 2017 policy for special scoring adjustment for hospital-based eligible clinicians** • **Definition**: CMS is proposing to modify the definition by including covered professional services furnished by MIPS eligible clinicians in an off-campus outpatient hospital (POS 19) to the definition	• **Definition**: MIPS eligible clinician who furnishes 75% or more of covered professional services in an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22) or emergency room setting (POS 23) in the year preceding the performance period • **Special MIPS Scoring Adjustment:** Exempt from reporting ACI (assigned a weight of 0%)

What does this all mean?

For the 2018 Performance Period…

- Reduced Number of MIPS Participants: Some providers that participate in 2017, may not have to participate in 2018 (*e.g*. Low-volume threshold exception).

- Increased Reporting to Avoid Penalty: To avoid a penalty or earn a bonus, eligible clinicians will have to do more in 2018 (*e.g.* successfully complete in one performance category) than they did in 2017 (*e.g.* submit one measure).

- Expanded Reporting Accommodations: Certain categories (*e.g*. facility-based, ASC-based) of eligible clinicians may have opportunities for reduced reporting.

For the 2019 Performance Period…

- Steep Increase in Weight of Cost Performance Category in Performance Period 2019: If CMS finalizes proposal to maintain a weight of 0% for Cost in 2018; in 2019 the weight of Cost will increase from 0% of the MIPS score to 30% of the score.

- Pegging Performance Threshold to Mean or Median May Impact Bar to Avoid Penalty: By statute CMS must peg the MIPS performance threshold at the median or mean, potentially increasing the bar to avoid a penalty in 2019.

Advanced APMs

Advanced APM Track Overview

For Payment Years 2019 and 2020, clinicians qualify for the Advanced APM track through their participation in Medicare models designated by CMS as Advanced APMS

Beginning in 2021, clinicians can qualify based upon their participation in both Medicare and other payer models designated by CMS

To qualify for the Advanced APM track in 2020, an APM entity must have sufficient payment or patient volume in Medicare models meeting three specified criteria for Advanced APMs:

1. Certified electronic health record technology (CEHRT) use requirements
2. Quality reporting and/or performance requirements
3. Financial and nominal risk requirements

APM Participant Threshold Overview

The MACRA statute sets the threshold amounts for qualifying as a QP or Partial QP in the Advanced APM Track. The Medicare Only Option is currently available, and the All Payer Combination Option that includes participation in both Medicare and Other Payer Advanced APMs begins for PY 2021.

Status	Threshold	2019 – 2020	2021 – 2022	2023 & Beyond
Qualifying Participant	***Medicare Only Option***			
	Payment Threshold	25%	50%	75%
	Patient Threshold	20%	35%	50%
	All Payer Combination Option			
	Other Payment Threshold	N/A	50%	75%
	Medicare Payment Minimum	N/A	25%	25%
	Other Patient Threshold	N/A	35%	50%
	Medicare Patient Minimum	N/A	20%	20%
Partial Qualifying Participant	***Medicare Only Option***			
	Payment Threshold	20%	40%	50%
	Patient Threshold	10%	25%	35%
	All Payer Combination Option			
	Other Payment Threshold	N/A	40%	50%
	Medicare Payment Minimum	N/A	20%	20%
	Other Patient Threshold	N/A	25%	35%
	Medicare Patient Minimum	N/A	10%	10%

Minor Modifications to Advanced APM Criteria

Requirement	Payment Year 2019	Payment Year 2020
EHR	Model requires at least 50% of the eligible clinicians within an APM entity or group to use CEHRT in 2018	No change; maintain consistency with MIPS
Quality	Payment under model based on reporting on quality measures that are evidenced-based, reliable and valid • Requires at least one reported outcome measure unless CMS determines that no such measure is available in the appropriate area of practice.	No change; maintain consistency with MIPS
Nominal Risk	Entity participating in model is required to repay or forego at least: • 8% of the average estimated total Medicare Parts A and B revenue for the entity; or • 3% of the expected expenditures for which the entity is responsible under the APM	Entity participating in model is required to repay or forego at least: • 8% of the average estimated total Medicare Parts A and B revenue for the entity* * Rule proposes to use this standard through Performance Year 2020

Additional Advanced APM Guidance

Medical Home Standard Modified to Reflect Practice Dynamics

APM entity must be at risk to either repay or forego a minimum amount equal to 2% of estimate average total Medicare Parts A and B revenue in PP 2018, 3% in 2019, 4% in 2020 and 5% in 2021 and beyond.

- APM entities that can count medical home model participation in the APM track are limited to organizations with fewer than 50 eligible clinicians (including the employees of the parent organization in addition to the APM entity itself)
  - Exception for Round 1 CPC+ model participants because they signed up for program before the 50 clinician limit was announced

Full Capitation Models Count As Advanced APMs; Medicare Advantage Plan Models Still Do Not Qualify Automatically as Advanced APMs

- APMs that include a full capitation risk arrangement can qualify as Advanced APMs; partial capitation models will be evaluated on an individual basis based upon the nominal risk criteria
- Payments made under the Medicare Advantage program do not count automatically as Advanced APMs under Medicare Option but rule seeks comment on additional pilots or demonstrations that could qualify MA arrangements differently

Further All Payer Option Guidance

- Establishes Payer or Clinician-Initiated Determination Process
  - Replaces the previous clinician attestation requirement with voluntary processes where a payer or eligible clinician can submit information about a payment arrangement to CMS to make a determination of whether the model qualifies as an other payer advanced APM
    - This option is available to payers with payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payers with payment arrangements in CMS Multi-Payer Models beginning in 2018 and will extend to additional payers in subsequent year
- Minor Modification to Nominal Risk Requirement
  - In order to meet the requirement under the All Payer Option, the APM must include:
    - Marginal risk of at least 30%
    - Minimum loss ratio of no more than 4%; AND
    - Total risk of at least 3% of expected expenditures an entity is responsible for under the model OR at least 8% of the total combined revenue from the payer of providers and suppliers in participating APM entities
- Defines the All Payer Determination Period for QPs
  - Establishes January 1- June 30 as the unique All Payer QP Determination period, which is shorter than the Medicare Option Determination Period because of data considerations
- Limits QP Determinations in All Payer Combination Option to Individual Eligible Clinician Level

Expected Advanced APM Options in 2018

Comprehensive ESRD Care Model (LDO and non-LDO)	Comprehensive Primary Care Plus (CPC+)	Medicare Shared Savings Program Tracks 1+, 2 and 3
Oncology Care Model (Two-Sided Risk)	Next Generation ACO Model	CJR/AMI/CABG/SHFFT (Track One)
Vermont All Payer ACO Model	Medicare-Medicaid ACO Model (MSSP Tracks 2 &3)	New Models To Come in 2017?

Physician-Focused Technical Advisory Committee (PTAC)

- MACRA established the PTAC to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee
- Ongoing submission and evaluation process began in late 2016 and is currently underway
- Proposed Rule seeks comment on expanding PTAC review to include potential Medicaid models as well

Key Takeaways & Themes

Themes from the QPP 2018 Proposed Rule

- Priority on easing clinician burden and providing regulatory relief
  - Increase small and low-volume thresholds to $90K in Part B revenues or ≤ 200 patients in 2018 performance year
  - Allow solo practitioners and small practices to form virtual groups for MIPS
  - Payer-initiated determination Advanced APMs
- Maintain slow ramp-up to full implementation
  - Continue the gradual pace for Performance Year for 2018
  - Use of 2014 Edition of CEHRT, and bonus points for using 2015 Edition
  - Continue last year's decision to weight the cost component at 0%
  - Maintain nominal risk at 8% of revenue for 2 years for Advanced APMs
- Multiple pathways to score well
  - Bonus points for clinicians in small practices
  - Bonus points for greater share of complex patients using HCC scores

Themes: Implications

- One year's experience under our belt, the new Administration has continued to heed concerns among clinicians to avoid major disruption, rather, opt for slow transition
  - However, first and second years are likely not representative years, potentially creating a "cliff" for Performance Period 2019
- Proposed Rule reflects a continued commitment to MACRA's intent to move from volume-based to value-based reimbursement
- The Administration needs to address several issues in the 2018 Final Rule:
  - Whether or not Part B drugs are accounted for in MIPS adjustment
  - What will be the weight of the Cost Performance Category
  - What adjustments will be made to Quality measures
- Is MACRA/QPP truly game changing?
  - How different these reporting mechanisms are from prior experiences
  - Concerns about the large number of clinicians that are exempt from MIPS

Questions?

- Thank you for your time. If you have any additional questions, wish to speak with one of our consultants or want to join our MACRA listserv for updates delivered directly to your inbox – contact Jennifer Randles at jrandles@mcdermottplus.com

- For additional resources or to view an archive of this presentation, visit our MACRA Resource Center at: http://www.mcdermottplus.com/news/macra-resource-center