McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

HIGHLIGHTS: MIPS-RELATED FINAL POLICIES
CY 2018 Final Rule Quality Payment Program (CMS-5522-FC and IFC)
CY 2018 Final Rule Comparison to CY 2017 Final Rule

*Beginning in 2019, eligible clinicians (including most physicians) will be paid for Medicare Part B services under the new Quality Payment Program (QPP), and they will elect to either be subject to payment adjustments based upon performance under the Merit-based Incentive Payment System (MIPS) or to participate in the Advanced Alternative Payment Model track (APM). Eligible clinicians choosing the MIPS pathway will have payments increased, maintained or decreased based on relative performance in four categories: clinical quality, use of information technology, clinical improvement activities and cost. Eligible clinicians choosing the APM pathway will automatically receive a bonus payment once they meet the qualifications for that track. CMS will publish the CY2018 Final Rule for Quality Payment (CMS-5522-FC and IFC) in the Federal Register on November 16, 2017. The Final Rule is available for download **here**. The CMS Fact Sheet is available **here** and the CMS Executive Summary is available **here**.*

MIPS Timeline 2017-2020

<table>
<tr><th>CY 2017</th><th>CY 2018</th><th>CY 2019</th><th>CY 2020</th></tr>
<tr><td rowspan="2">Year 1
Performance Period</td><td rowspan="2">Year 2
Performance Period</td><td>Year 3
Performance Period</td><td>Year 4
Performance Period</td></tr>
<tr><td>Year 1
Payment Year</td><td>Year 2
Payment Year</td></tr>
</table>

Performance Category Weights and Performance Threshold

MIPS participants are scored based on their performance in four categories: Quality, Advancing Care Information (ACI), Improvement Activities and Cost. Weights for these four categories are summarized below. 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). There is an additional $500 million available each year from 2019 to 2024 to award "exceptional performance" bonuses to MIPS providers with the highest composite performance scores. CMS will set an exceptional performance threshold to award these bonuses.

Performance Categories	Payment Year	
	2019	2020
Quality	60%	50%
ACI	25%	25%
Improvement Activities	15%	15%
Cost	0%	10%

Thresholds	Payment Year	
	2019	2020
Performance Threshold	3	15
Exceptional Performance Threshold	70	70

CY 2018 Proposed Rule Quality Payment Program (CMS-5522-FC and IFC)

CY 2018 Final Rule Comparison to CY 2017 Final Rule

Policy	2018 Final	2017 Final
MIPS Timeline	**Performance Period** • Quality and Cost Performance Categories (2020 Payment Year): January 1 - December 31, 2018 • Quality and Cost Performance Categories (2021 Payment Year): January 1 - December 31, 2019 • Improvement Activities and Advancing Care Information (ACI) Performance Categories (2020 Payment Year): minimum of continuous 90 days of data within CY 2018 • Improvement Activities and Advancing Care Information (ACI) Performance Categories (2021 Payment Year): minimum of continuous 90 days of data within CY 2019 **Data Submission Deadline** • March 31, 2019 **Payment Year** • January 1 – December 31, 2020	**Performance Period** • All Performance Categories: CMS will accept a minimum of continuous 90 days of data within CY 2017, although the Agency encourages providers to submit a full year of data **Data Submission Deadline** • March 31, 2018 **Payment Year** • January 1 – December 31, 2019
Payment Adjustments	*MACRA authorized MIPS payment adjustments (to the annual update) of +/- 4 percent beginning in 2019 and going up to +/- 9 percent by 2022. Providers in top 25% of all aggregate MIPS scores receive additional positive adjustment factor (2019 – 2024); bonus capped at 10% per eligible provider.*	
	Payment Adjustment • +/- 5 percent for the 2020 Payment Year	**Payment Adjustment** • +/- 4 percent for the 2019 Payment Year
MIPS Eligible Clinicians	**Definition** • No changes made to the definition or categories of professionals excluded; however • CMS is revising the definition of a low-volume threshold eligible clinician	**Definition** • Identified by a unique billing TIN and NPI combination used to assess performance for the following professionals: 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 • Eligible clinicians who meet the Medicare low-volume exemption criteria • Newly enrolled Medicare eligible clinicians

CY 2018 Proposed Rule Quality Payment Program (CMS-5522-FC and IFC)

CY 2018 Final Rule Comparison to CY 2017 Final Rule

Policy	2018 Final	2017 Final
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
Low-Volume Threshold	*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 **Request for comments** • 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
MIPS Performance Categories, Criteria and Weight	*Eligible Clinicians are measured on their performance in four weighted performance categories.*	
	Quality Performance Category (50% of Final MIPS Score) • Reporting criteria: No change • Measures: Tables A-D list available measures and measure sets and list removed measures, and measures with substantive changes finalized for use for the 2018 Performance Period and future years • Data completeness: Requires data completeness level of 60% for Payment Years 2020 and 2021 • Topped out measures: A measure may be considered topped out if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made; CMS finalized a proposal to implement a 4-year timeline to identify topped-out measures (after 3 years of topped out), after which they may propose to remove the measures through rule-making (in Year 4)	**Quality Performance Category (60% of Final MIPS Score)** • Reporting criteria: 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); or alternatively report one specialty measure set and will be required to report one outcome measure or, if no outcome measures are available in the measure set, the MIPS eligible clinician will report another high priority measure* • Data completeness: Requires data completeness level of 50% • Topped out measures: No policy established for topped out measures * Note the CMS Web Interface submission mechanism (which is open to groups of 25 or larger) has slightly different criteria

Policy	2018 Final	2017 Final
	ACI Performance Category (25% of Final MIPS Score) • Measures and Objectives: CMS is finalizing proposed modifications to the ACI measures and objectives in addition to an additional modification to the description of the Syndromic Surveillance Reporting Measure • Certification: CMS will allow use of either 2014 or 2015 Edition CEHRT or a combination of both editions. CMS will provide a 10 point bonus for using only 2015 Edition CEHRT • Scoring: A MIPS eligible clinician may earn 10 percentage points in the performance score for reporting to any single public health agency or clinical data registry to meet any of the measures associated with the Public Health and Clinical Data Registry Reporting Objective • Bonus: For CY 2017, a bonus was available for the ACI Performance Activities if certain Improvement Activities were completed using CEHRT; for the 2018 Performance Period, CMS is expanding this list of improvement activities (Table 6) • Small practice hardship exception: New category of hardship exception for small practices (15 or fewer clinicians) • Ambulatory Surgical Center-based (ASC) physicians: Implementation of 21st Century Cures Act that ASC-based physicians (defined as furnishing 75 percent of their services in an ASC setting) will be automatically reweighted to zero **Improvement Activities (15% of Final MIPS Score)** • Activities: Table F lists new activities and Table G lists changes to existing activities • Group Reporting: CMS clarified that if any MIPS eligible clinician in a group completed an improvement activity, the entire group (TIN) would receive credit for the activity • Annual Call for Activities: CMS established a formal Annual Call for Activities; activities submitted by March 1 will be for inclusion in the performance period in the occurring in the following calendar year	**Advanced Care Information (ACI) Performance Category (25% of Final MIPS Score)** • Measures: Five required measures **Improvement Activities (IA) Performance Category (15% of Final MIPS Score)** • Reporting Criteria: Four medium-weighted activities OR two high-weighted activities (general); one high-weighted or two medium-weighted activities (small practices, rural practices or geographic HPSAs) **Cost Performance Category (0% of Final MIPS Score)** • Not implemented in 2017

<table>
<tr><th>Policy</th><th>2018 Final</th><th colspan="3">2017 Final</th></tr>
<tr><td></td><td><u>Cost Performance Category (10% of Final MIPS Score)</u>
<u>Reporting criteria</u>: CMS will calculate measures based on administrative claims data; no additional data will need to be reported
<u>Measures</u>: CMS will use the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures in the Cost Performance Category for the 2018 Performance Period
<u>Report on Burden of Measure Reporting</u>
CMS is finalizing a number of modifications to this study including: modifying the name of the study to “CMS Study on Burdens Associated with Reporting Quality Measures,” increasing the sample size for CY 2018 and beyond and other technical changes</td><td colspan="3"></td></tr>
<tr><td rowspan="5">MIPS Submission Mechanisms</td><td rowspan="5"><u>Number of Mechanisms</u>
For the 2018 Performance Period, individual MIPS eligible clinicians and groups are allowed to submit measures and activities through multiple submission mechanisms but they may only use one submission mechanism per Performance Category
Beginning in the 2019 Performance Period, individual MIPS eligible clinicians, groups and virtual groups may submit data on measures and activities, via multiple data submission mechanisms for a single performance category
<u>No change for 2018 from the 2017 policy for types of submission mechanisms</u></td><td></td><td><u>Individual</u></td><td><u>Group</u></td></tr>
<tr><td colspan="3">Only one submission mechanism allowed per Performance Category.</td></tr>
<tr><td><u>Quality</u></td><td>Qualified Clinical Data Registry (QCDR)
Qualified Registry
EHR
Claims</td><td>QCDR
Qualified Registry
EHR
Administrative Claims
CMS Web Interface
CAHPS for MIPS</td></tr>
<tr><td><u>ACI</u></td><td>QCDR
Qualified Registry
EHR
Attestation</td><td>QCDR
Qualified Registry
EHR
Attestation
CMS Web Interface</td></tr>
<tr><td><u>IA</u></td><td>QCDR
Qualified Registry
EHR
Attestation</td><td>QCDR
Qualified Registry
EHR
CMS Web Interface
Attestation</td></tr>
<tr><td><u>Cost</u></td><td>Administrative claims</td><td>Administrative claims</td></tr>
</table>

Policy	2018 Final	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; 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	• **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.*	
	Final Policy • CMS will implement it for the 2018 Performance Year • For Quality, CMS will measure improvement at the performance category level, and 10 percentage points will be available • For Cost, CMS will base improvement scoring on statistically significant changes at the measure level; up to one percentage point is available in the Cost Performance Category • Improvement scoring will only apply if there is two years (or performance periods) of data available	**CMS did not implement in 2017**
Bonus Points	**Final Policy** • In 2018, CMS is implementing a complex patient bonus and small practice bonus. • For the complex patient bonus, CMS will apply an adjustment of up to 5 bonus points for the treatment of complex patients (based on the combination of the Hierarchical Conditions Category (HCC) risk score and the number of dually eligible patients treated). • For the small practice bonus, CMS will add 5 points to any MIPS eligible clinician or small group who is in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS eligible clinician or group submits data on at least one performance category in an applicable performance period	**CMS did not implement in 2017**
Hospital-based Eligible Clinicians	**No substantive change for 2018 from the 2017 policy for special scoring adjustment for hospital-based eligible clinicians**	**Definition** • MIPS eligible clinician who furnishes 75 percent or more of covered professional services in an inpatient hospital (POS 21), on-campus outpatient

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	Definition • CMS is modifying the definition by including covered professional services furnished by MIPS eligible clinicians in an off-campus outpatient hospital (POS 19) to the definition	hospital (POS 22) or emergency room setting (POS 23) in the year preceding the performance period **Special MIPS Scoring Adjustments** • Exempt from reporting ACI (assigned a weight of 0 percent)
Non-Patient Facing Eligible Clinicians	*The MACRA statute allows for flexibility in the application of measures and activities required by "non-patient facing" 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 as groups • Virtual groups with more than 75 percent of NPIs within a virtual group during a performance period are labeled as non-patient facing	**Definition** • Individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services) during the non-patient facing determination period • 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 clinicians during the non-patient facing determination period **Special MIPS Scoring Adjustments** • Exempt from reporting ACI (assigned a weight of 0 percent) • Reduced reporting requirements for Improvement Activities (2 medium-weighted activities or 1 high-weighted activity)
Virtual Groups	*The MACRA statute allows CMS to establish "virtual groups" for purposes of reporting and measuring performance under MIPS. Virtual groups can be composed of solo practitioners and small group practices that join together to report on MIPS requirements as a collective entity, and the members of a virtual group share the same financial adjustments as the result of that reporting. The statutes envisioned virtual groups as a way for smaller practices to pool resources and achieve efficiencies.*	
	Final Policy • Definition: Solo practitioners and groups of 10 or fewer eligible clinicians can come together "virtually" with at least one other solo practitioner or group to participate in MIPS; CMS notes that all NPIs billing under the TIN joining the virtual group must participate • Payment Adjustment: Each MIPS eligible clinician in a group (not participating in a MIPS APM or Advanced APM) will receive a MIPS payment adjustment based on the virtual group's combined performance assessment; adjustment will be applied at the TIN/NPI level • Advanced APM Participants: If there is a portion of the TIN participating in a MIPS APM or Advanced APM they will receive a MIPS adjustment based on	**CMS did not implement in 2017**

Policy	2018 Final	2017 Final
	that standard; participants may be excluded from MIPS if they achieve QP or Partial QP status • Additional Classifications: CMS is not establishing additional classifications (such as by geographic area or by specialty) regarding virtual group composition or a limit on the number of TINS that may form a virtual group • Election Deadline: For the CY 2018 Performance Period, the deadline to elect to be in a virtual group is December 31, 2017	
Facility-based Measures	*MACRA authorized the 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.*	
	Final Policy • In Payment Year 2021, a MIPS eligible clinician or group may elect to be scored in the Quality or Cost Performance Categories using facility-based measures; this option would be available only for facility-based clinicians who have 75 percent of their covered professional services supplied in the inpatient hospital or emergency department setting • CMS will implement a voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program; the facility-based measure option converts a hospital Total Performance Score into MIPS Quality and Cost scores	**CMS did not implement in 2017**