McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

MIPS-Related Proposals
CY 2018 Proposed Rule Quality Payment Program (CMS-5522-P)
CY 2018 Proposed 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), under which they will select whether to have payments adjusted under the Merit-based Incentive Payment System (MIPS) or to participate in Advanced Alternative Payment Models (APMs). Eligible clinicians choosing the MIPS pathway will have payments increased, maintained or decreased based on relative performance in four categories. Eligible clinicians choosing the APM pathway will receive incentive payments for their participation. CMS published the CY2018 Proposed Rule for Quality Payment (CMS-5522-P) in the Federal Register on June 30, 2017 and comments are due on August 21, 2017. The Proposed Rule is available to download **here**. The fact sheet is available **here**:*

MIPS Timeline 2017-2020

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-Related Proposals

Policy	2018 Proposed	2017 Final
MIPS Timeline	**Performance Period** • Quality and Cost Performance Categories: January 1 - December 31, 2018 • Improvement Activities and Advancing Care Information (ACI) Performance Categories: minimum of continuous 90 days of data within CY 2018 • **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

Policy	2018 Proposed	2017 Final
MIPS Eligible Clinicians	**No change proposed for 2018 from the 2017 policy for the definition or categories of professionals excluded**; however, CMS is proposing to revise 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
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 **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 considering defining items and services by using the number of patient encounters or procedures associated with a clinician	**Criteria** • ≤ $30,000 in Part B allowed charges, OR • ≤ 100 Part B beneficiaries

Policy	2018 Proposed	2017 Final
	• CMS is also soliciting comments on a process for clinicians that meet the low-volume threshold criteria to voluntarily opt-in to MIPS	
MIPS Performance Categories, Criteria and Weight	*Eligible Clinicians are measured on their performance in four weighted performance categories.*	
	Weights • CMS is not proposing any changes to the weights for the different performance categories **Changes in Measures** • Proposed changes in measures for all performance categories for the 2018 Performance Period are summarized in Tables A-H of the proposed rule **Quality Performance Category** • Data completeness: CMS proposes no changes for the data completeness level but proposes to increase the data completeness threshold to 60 percent for the 2019 Performance Period • Topped out measures: CMS proposes to identify topped out measures, and after three years to consider removal from the program through rulemaking in the 4th year **ACI Performance Category** • Measures: CMS proposes a number of changes to the measures (*e.g.* allows use of either 2014 or 2015 Edition CEHRT, bonus for using only 2015 Edition CEHRT, changes related to reporting on registries, and a decertification exception) • 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 (75 percent) will be automatically reweighted to zero **Cost Performance Category** • CMS proposes to maintain a 0 percent weight on the Cost Performance	**Quality Performance Category (60% of Final MIPS Score)** • 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: Requires data completeness level of 50% • Topped out measures: No policy established for topped out measures **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)** • Measures: Four medium-weighted activities OR two high-weighted activities **Cost Performance Category (0% of Final MIPS Score)** • Not implemented in 2017

<table>
<tr><th>Policy</th><th>2018 Proposed</th><th>2017 Final</th></tr>
<tr><td></td><td>Category; the agency continues to believe that more time is necessary to allow clinicians to better understand the methodology and impact of the cost measure, and to allow CMS time to develop measures that will be used in this category in future years
• The MACRA statute requires a 30 percent weight for the Cost Performance category by 2021 that cannot be waived by the agency; maintaining the zero percent weight for Cost for the 2018 Performance Period is expected to result in a sharp increase in the Cost Performance Category to 30 percent in Performance Period 2019
• In order to avoid such a large change, CMS also seeks comments on an alternative approach of weighing the Cost Performance Category at 10 percent for 2018</td><td></td></tr>
<tr><td>Reweighting ACI to Quality</td><td><u>No change proposed for 2018 from the 2017 policy for reweighting ACI to Quality</u>

<u>Alternative Policy</u>
• CMS is proposing an alternative option for reweighting the ACI Performance Category if the Cost Performance Category is weighted to zero percent
<table>
<tr><th>Performance Category</th><th>Weighting for the 2020 MIPS Payment Year</th><th>2017 Final and 2018 Proposed Reweighting Policy if ACI Zeroed Out</th><th>Alternative Reweighting Proposal if ACI Zeroed Out</th></tr>
<tr><td>Quality</td><td>60 percent</td><td>85 percent</td><td>75 percent</td></tr>
<tr><td>Cost</td><td>0 percent</td><td>0 percent</td><td>0 percent</td></tr>
<tr><td>Improvement Activities</td><td>15 percent</td><td>15 percent</td><td>25 percent</td></tr>
<tr><td>Advancing Care Information</td><td>25 percent</td><td>0 percent</td><td>0 percent</td></tr>
</table></td><td><u>Reweighting Policy</u>
• When ACI is zeroed out, CMS will redistribute the weight of the ACI Performance Category to the Quality Performance Category
• This results in the following weights for the MIPS final score: Quality (85 percent); IA (15 percent); ACI (0 percent); and Cost (0 percent)</td></tr>
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<table>
<tr><th>Policy</th><th>2018 Proposed</th><th colspan="3">2017 Final</th></tr>
<tr><td rowspan="6">MIPS Submission Mechanisms</td><td rowspan="6"><u>Number of Mechanisms</u>
• Proposes to allow individual MIPS eligible clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category as available and applicable

<u>No change proposed 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><u>Number of Mechanisms</u></td><td colspan="2">MIPS Eligible clinicians required to use only one submission mechanism 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 Survey</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>
<tr><td>Performance Threshold</td><td colspan="4">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).</td></tr>
<tr><td></td><td colspan="2">• <u>15 points</u>, which can be achieved in multiple pathways (e.g. full performance with Quality and submission of maximum number of Improvement activities)</td><td colspan="2">• <u>3 points</u>, which can be earned by submitting a single Quality measure or attesting to performing one Improvement Activity for 90 days</td></tr>
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Policy	2018 Proposed	2017 Final
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.*	
	Proposal • 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 zero for the 2018 Performance Period	**CMS did not implement in 2017**
Bonus Points	**Proposal** • 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 in 2017**
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 percent 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 Adjustments** • Exempt from reporting ACI (assigned a weight of 0 percent)

Policy	2018 Proposed	2017 Final
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 • 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.*	
	Proposal • 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; CMS notes that all NPIs billing under the TIN joining the virtual group must participate • They are assessed collectively as a virtual group, but only the NPIs that meet the definition of a MIPS-eligible clinician would be subject to a MIPS payment adjustment; virtual groups may submit data through any of the mechanisms available to groups under the broader program requirements, such as a registry • While CMS did consider limiting the size of virtual groups, it does not propose to put any limits on the number of TINs that may form a virtual group. Because of the lead time needed to form a virtual group, CMS estimates that the number of virtual groups will be very small in 2018 but will grow over time	**CMS did not implement in 2017**

Policy	2018 Proposed	2017 Final
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.*	
	Proposal • CMS proposes to implement a voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program • 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 • The facility-based measure option converts a hospital Total Performance Score into MIPS Quality and Cost scores	**CMS did not implement in 2017**