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CMS Proposes Changes to Quality Payment Program

OVERVIEW

On June 20th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would implement changes to Quality Payment Program (QPP). As required by the Medicare Access and CHIP Reauthorization Act (MACRA), base payment rates for services under the Physician Fee Schedule will remain at 2019 levels through 2025, but beginning in 2019, the amounts paid to eligible providers will be adjusted according to the provider's participation for one of two QPP tracks:

- The Merit-based Incentive Payment System (MIPS); and
- Advanced Alternative Payment Models (APMs).

CYs 2017 and 2018 are intended to serve as "transition years" to encourage the participation, planning, and education of eligible clinicians in MIPS or Advanced APMs. The first payment year is scheduled to begin in 2019. The proposed rule would continue to implement the QPP, but would generally ease requirements and extend transition timelines for providers, especially those in small and rural practices. This document summarizes major provisions of the proposed rule.

CMS will accept comments on the proposed rule through August 18th. The rule is available here.

ELIGIBLE PROVIDERS

Providers that are required to participate in QPP include: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists who meet certain Medicare revenue and beneficiary threshold requirements. The rule does not modify the list of eligible clinicians.

For 2017, providers or groups with less than $30,000 in Medicare-allowable charges or less 100 Medicare beneficiaries per year are excluded from participating in MIPS. The rule proposes to increase this low-volume threshold. Beginning in 2018, providers or groups with less than $90,000 in Medicare-allowable charges or less 200 Medicare beneficiaries would be excluded from participating in MIPS. However, low-volume threshold providers would be able to opt-in to MIPS if they exceed the Medicare revenue or beneficiary threshold.

CMS estimates that the proposed low-volume threshold would exclude an additional 134,000 providers, on top of approximately 700,000 that would be excluded based on 2017 standards.

MIPS

Under MIPS, providers have their payments adjusted according to their composite score in four performance categories. For 2017, the performance categories are weighted as follows: Quality (60%), Advancing Care information (25%), Improvement Activities (15%), and Cost (0%). The proposed rule would continue 2017 performance category weights for 2018, but would modify future weight adjustments, measures, and requirements.

- *Quality* – Providers must report on a minimum of six CMS-approved measures that are relevant to their specialty. The rule also proposes that providers whose quality scores improve from year-to-year may be eligible for a bonus of up to 10%.

Under current law, the weight of this category is scheduled to decrease in stages from 60% in 2017 to 30% in 2021. The rule proposes that the weight remain at 60% until it decreases to 30% in 2021.

- *Advancing Care Information* – Providers are required to report five measures that reflect how they use technology and exchange information. Providers that report on additional measures are eligible receive a higher score. The proposed rule would allow providers to continue to use the 2014 Edition of Certified Electronic Health Record Technology (CEHRT), but providers that use the 2015 Edition would be eligible for a 10% bonus. The proposed rule would also allow small practices (15 or fewer clinicians) and ambulatory surgical center-based clinicians to be exempt from this category and would allow providers claim an exemption from reporting e-Prescribing and Health Information Exchange measures.

  The rule does not propose a weight adjustment for this category. It would remain at 25% for 2018.

- *Improvement Activities* – To receive a perfect score in this performance category, most providers are required: to implement four medium-weighted or two high-weighted improvement activities; or be certified as Patient-Centered Medical Home. Small practices and those located in rural or health professional shortage areas only need to implement two medium-weighted or one high-weighted activity to receive a full score. CMS is not proposing to change the number of improvement activities necessary to receive a full score, but would offer additional activities for providers to choose from.

  The weight of this category would remain at 15% under the proposed rule.

- *Cost* – Providers are currently scored based on the following measures: Medicare Spending per Beneficiary (MSPB), total per capita cost, and 10 episode-based cost measures. The rule proposes that only the MSPB and total per capita cost measures be used to calculate this performance category for 2018. Beginning in 2021, providers who demonstrate statistically significant improvement in cost would be eligible for a bonus.

  Under current law, the weight of this category is scheduled to increase from 0% to 10% in 2020 and to 30% in 2021. The proposed rule would maintain the weight at 0% until it increases to 30% in 2021.

In addition to these performance categories, providers would be eligible for the following bonuses:

- *Complex Patients* – Providers would be eligible to receive up to a 3% bonus based on their Hierarchical Conditions Category risk score.
- *Small Practice* – Any provider who is in a small practice would be eligible for a 5% bonus.

Under the proposed rule, CMS estimates that 572,000, or 37%, of Part B providers would participate in MIPS in 2018.

Virtual Groups

To encourage MIPS participation among providers in small practices and rural or health professional shortage areas, the rule proposes a Virtual Groups Participation option in 2018. Single providers or groups of up to 10 providers would be able to form a Virtual Group with at least one other provider or a group or providers to participate in MIPS. Single practitioners that wish to join a Virtual Group must meet all MIPS eligibility criteria, but a provider group that is a part of a Virtual Group may include clinicians who do not meet MIPS eligibility criteria so long as the group qualifies as a whole. The formation of a Virtual Group would not be limited to specific geographies or specialties.

ADVANCED APMS

Under QPP, providers that participate in an Advanced APM and meet specified Medicare revenue and beneficiary thresholds are excluded from MIPS requirements and qualify to receive a 5% incentive payment. The incentive payment will be in addition to payment for covered services. Eligible providers, who are referred to as Qualifying APM Participants (QPs), are scheduled to begin receiving the incentive payments in 2019, based on 2017 performance.

For an entity to qualify as an Advanced APM, the APM must meet three criteria:

- Require participants to use CEHRT;
- Provide payments based on quality measure that are similar to those in MIPS; and
- Require that participants satisfy one of two risk standards:
  - *Generally Applicable Standard* - For 2017 and 2018, the total potential risk for the APM is at least: 8% of the average Part A and B revenue of participating entities or 3% of the expected expenditures of the Advanced APM. The proposed rule would maintain the revenue-based nominal amount standard at 8% for 2019 and 2020.
  - *Medical Home Model Standard* – For a Medical Home Model to be an Advanced APM it must take on the total potential risk of at least 2.5% of the average Part A and B revenue of participating entities in 2017. The risk level is scheduled to gradually increase to 5% by 2020. The proposed rule would decrease the risk standard to 2% for 2018 and have it gradually increase to 5% by 2021.

For 2018, Advanced APMs will include:

- Next Generation Accountable Care Organizations (ACOs);
- Comprehensive Primary Care Plus Models;
- Comprehensive ESRD Care Models;
- Episode Payment Models;
- The Vermont All-Payer ACO Model;
- Comprehensive Care for Joint Replacement Model (CEHRT Track);
- Oncology Care Model (Two-Sided Risk Arrangement);
- ACO Track 1+ Model; and
- Medicare Shared Savings Program (Tracks 2 and 3).

QPs

QPs are providers who are eligible to receive the 5% APM Incentive Payment based on their participation in an Advanced APM and the ability to meet certain Medicare payment and beneficiary volume threshold requirements. Eligible providers who participate in an Advanced APM, but do not meet QP or Partial QP thresholds are subject to MIPS reporting and payment adjustments. For 2017, providers qualified as a QP if they:

- Received at least 25% of their Part B payments through an Advanced APM; or
- Delivered Part B services to at least 20% of their Medicare beneficiaries through an Advanced APM.

The proposed rule would maintain these threshold requirements for 2018.

CMS estimates that between 180,000 and 245,000 providers will become QPs in 2018, compared to an estimated 110,000 providers that will become QPs in 2017.

Partial QPs

Providers that participate in an Advanced APM, but do not qualify as a QP at the individual-level may meet the slightly lower threshold requirements to become a Partial QP. Partial QPs may elect to participate in MIPS and receive MIPS payment adjustments. For 2018, the proposed rule would define Partial QPs as providers who:

- Receive at least 20%, but less than 25% of their Part B payments through an Advanced APM; or
- Deliver Part B services to at least 10%, but less than 20%, of their Medicare beneficiaries through an Advanced APM.

CMS estimates that in 2018, approximately 17 Advanced APMs would include Partial QPs that elect to participate in MIPS.

MIPS APMS

Under current law, an Advanced APM can exclude a participating provider from its scoring by leaving that provider off its Participation List, which is submitted three times per year. The proposed rule would require that Advanced APMs submit four participation assessments per year.

If a provider is not included in at least one Advanced APM Participation List per year, the provider will have to adhere to MIPS reporting requirements and have their payment adjusted according to scoring for MIPS-eligible providers in MIPS APMs. The proposed rule makes minor changes to the performance category weights for MIPS-eligible providers in MIPS APMs.

All-Payer Combination Option

Beginning in 2019, providers may be become a QP based on their participation in a Medicare Advanced APM and Other Payer Advanced APM. Similar to Advanced APM criteria, Other Payer Advanced APMs must:

- Require participants to use CEHRT;
- Provide payments based on quality measure that are similar to those in MIPS; and
- Require that participants satisfy one of two risk standards:
    - *Generally Applicable Standard* - Under current law, All-Payer QPs would be required to take on a total risk of at least 3% of expected expenditures in 2019. To adhere to the Medicare Advanced APM standard, the proposed rule would also allow providers to satisfy the total risk standard with a revenue-based amount of 8% for 2019 and 2020.
    - *Medicaid Medical Home Model* – Currently, the nominal amount of risk for Medicaid Medical Home Models is slated to be 4% in 2019 and 5% in 2020. The proposed rule would reduce the nominal amount of risk to 3% of the APMs total Medicaid revenue in 2019. This would gradually increase to 4% in 2020 and 5% in 2021.

The rule proposes that QP determinations under the All-Payer Combination Option be made at the provider-level. To be considered, providers must submit payment arrangement information to CMS. Currently a request for an Other Payer Advanced APM determination must be accompanied by an attestation from the payer, but the proposed rule would waive this requirement.

The rule proposes that certain payers interested in participating in an Other Payer Advanced APM may request a CMS determination in 2018, prior to the 2019 All-Payer QP Performance Period. Eligible payers include, but may not be limited to payers with payment arrangements authorized under: Medicaid, Medicare Advantage, Medicare-Medicaid plans, 1876 and 1833 Cost Plans, Programs for All-Inclusive Care for the Elderly (PACE), and payers with payment arrangements in CMS-Multi-Payer Models. Other payers, including commercial and private payers, would be able to request determinations in 2019, prior to the 2020 All-Payer QP Performance Period. Payers may submit applications for multiple payment arrangements across various lines of business.

The first payment year for the All-Payer Combination Option would be in 2021, based on 2019 performance.