spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Final Rule to Implement the Quality Payment Program (QPP)

OVERVIEW

On November 2nd, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will implement changes to the 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 in one of two QPP tracks:

- The Merit-based Incentive Payment System (MIPS); or
- 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, based on 2017 performance. The final rule will continue to implement the QPP, but will generally ease requirements and extend transition timelines for providers, especially those in small and rural practices. This document summarizes major provisions of the final rule.

The rule will go into effect on January 1, 2018. The rule is available here.

ELIGIBLE PROVIDERS

The following providers are required to participate in QPP if they meet certain Medicare revenue and beneficiary threshold requirements: physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

For 2017, providers or groups with less than $30,000 in Part B-allowable charges or less than 100 Part B-beneficiaries per year were excluded from participating in MIPS. Under the final rule, providers or groups with less than $90,000 in Part B-allowable charges or less than 200 Part B beneficiaries will be excluded from participating in MIPS in 2018.

CMS estimates that the new low-volume threshold will exclude an additional 123,000 providers from MIPS in 2018, which is 11,000 less than CMS' estimate from the proposed rule. The final rule is estimated to reduce the total number of eligible clinicians to 622,000 in 2018.

MIPS

Under MIPS, providers have their payments adjusted according to their composite score in four performance categories. The maximum MIPS adjustment in 2018 is five percent of claims payments for an eligible provider, with an additional $500 million incentive pool available for exceptional performance. For 2017, the performance categories were weighted as follows: Quality (60%), Advancing Care Information (25%), Improvement Activities (15%), and Cost (0%). Under the final rule, performance category weights will be modified as follows for 2018: Quality (50%), Advancing Care Information (25%), Improvement Activities (15%), and Cost (10%).

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For 2017, the performance period for each category was a minimum of 90 days in the calendar year. For 2018, CMS will extend the Quality performance period to 12 months. The rule also makes the following changes to performance category requirements:

- *Quality* – Providers are generally required to report on a minimum of six CMS-approved measures that are relevant to their specialty. The rule clarifies that specialists who report from a specialty measure set with fewer than six measures will only be required to report on those measures. Providers may receive up to a 10% bonus for reporting high priority measures or electronic reporting, and up to a 10% bonus for improvements in their Quality performance.

- *Advancing Care Information* – Providers are required to report measures that reflect how they use technology and exchange information. Providers will be eligible for bonuses ranging from 5-10% for submitting data to public health agencies or clinical data registries. The final rule will allow providers to continue to use the 2014 Edition of Certified Electronic Health Record Technology (CEHRT), but providers that use the 2015 Edition will be eligible for a 10% bonus. Providers who use CEHRT for at least one of the Improvement Activities will also be eligible for a 10% bonus. As required by the 21st Century Cures Act and finalized by this rule, the Advancing Care Information category will account for 0% of the final score for Ambulatory Surgical Center-based clinicians.

- *Improvement Activities* – To receive a perfect score in this category, most providers are required: to implement four medium-weighted or two high-weighted improvement activities; or be designated as a Patient-Centered Medical Home or a comparable specialty practice. Small practices (with 15 or fewer eligible clinicians) 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. The rule does not change the number of improvement activities necessary to receive a full score, but will increase the number of activities from 92 in 2017 to 112 in 2018.

- *Cost* – For 2017, providers were scored based on: Medicare Spending per Beneficiary (MSPB), total per capita cost, and 10 episode-based cost measures. CMS finalized its proposal to only use the MSPB and total per capita cost measures to calculate Cost performance in 2018. CMS will propose new episode-based cost measures in future rule making and is requesting stakeholder feedback on what these measures should be.

A new option within the quality and cost performance categories that allows facility-based clinicians to be scored according to their facility's performance will start in the 2019 measurement year, rather than in 2018 as in the proposed rule. CMS will promote operational readiness for facility-based reporting in 2018.

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

- *Complex Patients* – Providers will be eligible to receive up to a 5% bonus based on their Hierarchical Conditions Category risk score and dual eligibility ratio.
- *Small Practices* – Any provider who is in a small practice (defined as 15 or fewer eligible clinicians) will be eligible for a 5% bonus as long as the MIPS eligible clinician or group submits data on at least one performance category in an applicable performance period.

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Virtual Groups

To encourage MIPS participation among providers in small practices and rural or health professional shortage areas, CMS will implement a Virtual Groups Participation option in 2018. A single provider, who is not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS, as well as a group of up to 10 (including at least one MIPS eligible clinician) will be able to form a Virtual Group with at least one other provider meeting the virtual group criteria. Single practitioners and small physician groups must meet the MIPS low-volume threshold criteria independently. The formation of a Virtual Group will 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, referred to as QPs, are scheduled to begin receiving incentive payments in 2019, based on 2017 performance.

For 2018, the following models will be eligible to qualify as an Advanced APM:

- Next Generation Accountable Care Organization (ACO);
- Comprehensive Primary Care Plus;
- Comprehensive End-Stage Renal Disease Care Models (Two-Sided Risk Arrangement);
- Vermont All-Payer ACO Model;
- Comprehensive Care for Joint Replacement Model (CEHRT Track);
- Oncology Care Model (Two-Sided Risk Arrangement);
- ACO Track 1+; and
- Medicare Shared Savings Program (Tracks 2 and 3).

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

1. Require participants to use CEHRT;
2. Provide payments based on quality measures that are similar to those in MIPS; and
3. Require that participants satisfy one of the following risk standards:
    - *Generally Applicable Standard* – Currently, the total potential risk for the APM must be at least: 8% of the average Part A and B revenue of participating entities for performance years 2017 and 2018; or 3% of the expected expenditures of the Advanced APM for all performance years. The final rule will extend the 8% revenue-based standard for performance years 2019 and 2020.
    - *Medical Home Model Standard* – For a Medical Home Model to be an Advanced APM, it must take on the potential risk of at least 2.5% of the average Part A and B revenue of participating entities in 2017. Under the final rule, the risk level will stay at 2.5% for 2018 and gradually increase to 5% by 2021. Beginning in 2018, entities that are owned and operated by organizations with more than 50 eligible clinicians (excluding CPC+ clinicians) will not be able to qualify under the Medical Home Model Standard.

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QPs

In order to be designated as a QP and receive a 5% APM Incentive Payment, providers must participate in an Advanced APM and meet certain Medicare payment and beneficiary volume threshold requirements. Providers who participate in an Advanced APM, but do not meet threshold requirements are subject to MIPS reporting and payment requirements. For 2018, CMS will continue to define QPs as providers who:

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

Each year, the QP performance period is from January 1st through August 31st and determinations are made based on three snapshot dates: March 31st, June 30th, and August 31st. CMS estimates that between 185,000 to 250,000 providers will become QPs in 2018. Over 100,000 providers are estimated to have qualified as QPs in the initial 2017 performance period.

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, instead of the APM incentive payment. For 2018, CMS will define Partial QPs as providers who:

- Receive at least 20%, but less than 25%, of their payments for Part B services 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 will 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 final rule will require that Advanced APMs must 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 the MIPS reporting requirements and have their payments adjusted according to their composite score in the four MIPS performance categories. MIPS APM performance categories are weighted slightly differently than regular MIPS performance categories: Quality (50%), Advancing Care Information (30%), Improvement Activities (20%), and Cost (0%).

ALL-PAYER COMBINATION OPTION

Beginning in 2019, providers may become a QP based on their participation in a Medicare fee-for-service Advanced APM and an Other Payer Advanced APM, collectively known as an All-Payer Advanced APM. The

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first payment year for the All-Payer Combination Option will be in 2021, based on 2019 performance. Each year, the All-Payer QP performance period will be from January 1st through August 31st.

Under the final rule, Other Payer Advanced APMs must require 50% of participants to use CEHRT, tie provider payments to quality measures that are similar to those in MIPS, and satisfy the following risk standards:

- *Generally Applicable Standard* – Currently, Other Payer Advanced APMs will be required to take on a total risk of at least 3% of expected expenditures in 2019 (including a marginal risk of 30% and a minimum loss rate of no more than 4% before penalties are triggered). The final rule will also allow providers to satisfy the Generally Applicable 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 final rule will reduce the nominal amount of risk to 3% of the APMs total estimated revenue in 2019. This will gradually increase to 4% in 2020 and 5% in 2021.

CMS finalized its proposal that Other Payer Advanced APM determinations are only effective for one year, but is seeking comment on multi-year arrangements that may be addressed in future rulemaking. Other Payer Advanced APM determinations may be initiated through the Eligible Clinician-Initiated Process or Payer-Initiated Process.

Eligible Clinician-Initiated Process

CMS finalized its proposal to allow APMs and eligible clinicians participating in other payer arrangements to request that CMS determine whether those payment arrangements are Other Payer Advanced APMs. Eligible clinicians and APMs may request an Other Payer Advanced APM determination for multiple payment arrangements, but will be required to file an Eligible Clinician Initiated Submission Form for each payer arrangement.

In general, eligible clinicians and APMs may request Other Payer Advanced APM determinations from August 1st through December 1st of the current performance year. However, CMS will accept submissions from eligible clinicians and APMs for Medicaid arrangements from September 1, 2018 through November 1, 2018 and make determinations for the 2019 performance period in December 2018.

Payer-Initiated Process

Beginning in 2018, certain payers may request that CMS make an Other Payer Advanced APM determination prior to the 2019 performance period. Eligible payment arrangements include those that are aligned with: Medicaid; CMS-Multi Payer Models; and Medicare Health Plans, including Medicare Advantage (MA). CMS finalized the following schedule for 2019 performance period determinations:

Determination Process	Medicaid	CMS-Multi Payer	Medicare Health Plans
Submission Period Opens	January 2018	January 2018	April 2018
Submission Period Closes	April 2018	June 2018	June 2018
CMS Determinations Made	September 2018	September 2018	September 2018

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Other payers, including commercial and private payers, will be able to request determinations in 2019, prior to the 2020 performance period.

CMS estimates that 300 Other Payer arrangements will be submitted in 2018, including 150 MA, 100 Multi-Payer, and 50 Medicaid.

All-Payer QP Determinations

Under the proposed rule, providers would have had to request QP determination at the individual-level, but the final rule will allow providers to qualify as a QP at the APM-level. To request an All-Payer QP determination, the provider or APM must submit: the amount of revenue for services furnished through the payment arrangement, total revenue received from payers, the number of patients furnished services through the payment arrangement, and the number of patients furnished any services. For the 2019 performance year, providers or APMs will have to meet the following payment and patient volume thresholds to qualify as QP or Partial QP:

Designation	Payment Amount		Patient Volume	
	Medicare	Total	Medicare	Total
QP	25%	50%	20%	35%
Partial QP	20%	40%	10%	25%

MA DEMONSTRATION

In the final rule, CMS notes its intent to implement an MA Advanced APM demonstration. The demonstration may allow providers to become QPs based on their participation in MA arrangements that qualify as Advanced APMs in 2018 through 2024.