Executive Summary: CMS Quality Payment Program 2018 Proposed Rule

Key Financial and Operational Impacts from the Proposed Rule to Implement MACRA

MIPS

1) **Eligible Clinicians**: For payment year 2020, Merit-based incentive payment system (MIPS) applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists billing under the Medicare Physician Fee Schedule. Eligible clinicians may participate in MIPS as individuals or as group practices. A group practice would be identified as a group of two or more clinicians who have reassigned their billing rights to a single tax identification number (TIN).

2) **Virtual Groups**: CMS proposes to allow solo practitioners and/or groups of 10 or fewer clinicians to form virtual groups. All MIPS eligible clinicians within a TIN must participate in the virtual group. Virtual groups must elect to participate in MIPS as a virtual group prior to the beginning of the performance period, and such election cannot be changed once the performance period starts.

   Most, policies that apply to groups would apply to virtual groups with a few exceptions, such as the definition of a non-patient facing MIPS eligible clinician; and small practice, rural area, and Health Professional Shortage Area designations. Virtual groups must use the same data submission mechanisms as groups.

3) **Low Volume Exclusion**: In response to feedback from HFMA and other organizations, CMS proposes increasing the low volume threshold. The proposed rule increased it from Medicare charges of less than or equal to $30k to $90k or the clinician cares for less than 200 Part B beneficiaries (up from 100).

4) **Payment Adjustment and Performance Categories**: In calendar year (CY) 2020 payment year (CY 2018 performance year) clinicians will receive payment adjustments on their Medicare Part B payments of up to +/- 5 percent based on performance on four performance categories. High performing clinicians can qualify for an additional bonus payment capped at 10 percent of their Part B allowable.

Finalized and Proposed Weights by MIPS Performance Category*

Performance Category	Transition Year (Final)	2020 MIPS Payment Year (Proposed)	2021 MIPS Payment Year and Beyond (Final)
Quality	60%	60%	30%
Cost	0%	0%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information**	25%	25%	25%

***** CMS proposes to maintain the same weights from the transition year for the 2020 MIPS payment year for quality and cost (60 percent and zero percent, respectively). ******The weight for advancing care information could decrease (not below 15 percent) starting with the 2021 MIPS payment year if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater.

5) **Performance Range**: CMS proposes that for the 2020 payment year, the MIPS performance threshold be set at **15 points**. This is an increase from 3 points for the 2019 payment year. The additional performance threshold of 70 that was adopted in last year's final rule for purposes of determining the additional MIPS payment adjustment for exceptional performance remains unchanged in the proposed rule. The table below lists the range of performance and potential adjustments:

Points Achieved	Adjustment
0-3.75	Negative 5% – Comprised mostly of practices that don't submit any data.
3.76-14.99	Negative MIPS payment adjustment > negative 5% and < 0% on a linear sliding scale. Based on CMS projections, few practices will fall in this range.
15	0% adjustment
15.1-69.9	Positive MIPS payment adjustment ranging from > 0 percent to 5% × a scaling factor to preserve budget neutrality, on a linear sliding scale.
70.0-100	Positive MIPS payment adjustment of up to 5% AND additional MIPS payment adjustment for exceptional performance. Additional MIPS payment adjustment starting at 0.5% and increasing on a linear sliding scale to 10%, multiplied by a scaling factor).

6) **Satisfying the Performance Threshold**: Below are examples of how the performance threshold could be satisfied. The list below is not intended to be exhaustive:
   a. Submitting the maximum number of improvement activities could result in a score of 15 points (40 out 40 possible points for the improvement activity which is worth 15 percent of the final score).
   b. The performance threshold could also be met by full participation in the quality performance category, where eligible clinicians would earn at least a quality performance category percent score of 30 percent by meeting data completeness for submitting all required measures (3 measure achievement points out of 10 measure points for each required measure) and resulting in a quality performance score of 18 points. (30 percent x 60 percent category weight x 100).
   c. Finally, a MIPS eligible clinician could achieve a final score of 15 points through an Advancing Care Information (ACI) performance category score of 60 percent or higher (60 percent x 25 percent category weight x 100).

   Please see tables I and II for reporting requirements and mechanisms by performance category.

7) **Improvement Scoring**: CMS proposes to include improvement scoring for performance in the quality performance category and for the cost performance category beginning with the 2020 MIPS payment year (2018 performance year).

8) **Topped Out Measures**: CMS proposes to cap the score of topped out measures at 6 measure achievement points. CMS is not proposing to apply the topped out measure cap to measures in the CMS web Interface for the Quality Payment Program (QPP).

9) **Facility Based Measurement**: For the 2020 MIPS payment year, CMS proposes to include all the measures adopted for the FY 2019 Hospital Value Based Payment (VBP) Program on the MIPS list of quality measures and cost measures. A clinician is eligible for facility-based measurement if they are determined facility-based as an individual. CMS considers a clinician facility-based if they furnish 75 percent or more of their covered professional services in sites of service identified by place of service codes 21 (inpatient hospital) or 23 (emergency Department) based on claims for a period prior to the performance period as specified by CMS.

   CMS is also proposing that a MIPS eligible clinician is eligible for facility-based measurement if they are determined facility-based as part of a group in which 75 percent or more of the MIPS eligible clinician National Provider Identifier billing under the group's TIN are eligible for facility-based measurement as individuals. Clinicians eligible for and electing to report under facility based measurement would not be required to submit separate cost and quality measures under MIPS.

10) **Complex Patient Bonus**: For payment year 2020 (2018 performance year) only, CMS proposes a complex patient bonus based on the average HCC risk score. The complex patient bonus cannot exceed 3 points. To receive the complex patient bonus, CMS proposes that the MIPS eligible clinician, group, virtual group or Alternative Payment Model (APM) Entity must submit data on at least one measure or activity in a performance category during the performance period.

11) **EHR Certification Criteria for ACI Category**: For the 2018 performance period, CMS extends the use of modified stage two meaningful use requirements by proposing that MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 certification criteria, or a combination of the two.

APMs

1) **Nominal Risk Standard**: The 2017 final QPP rule established two standards for calculating the financial risk a Medicare APM must bear to meet the nominal risk standard. In the final rule, an advanced APM must include in its design that the APM entity meets either the "Revenue" or "Benchmark" standards described below:

   a. <u>*Revenue Standard*</u>: ***8 percent or more*** of the APM Entity's average Parts A and B revenue must be at risk.
      i. Example: *The providers have $1m in Medicare allowable payments. They must be at risk of paying back losses of at least $80k.*

   b. <u>*Benchmark Standard*</u>: ***3 percent or more*** of the expected expenditures for which an APM entity is responsible for. Applies to all performance periods.
      i. Example: *A joint replacement episode target price is $20k. The orthopedic surgeon must be at risk of paying back losses of at least $6k*.

   In the final rule, the revenue standard was only available for performance years 2017 and 2018 (payment years 2019 and 2020). However, the 2018 performance year QPP proposed rule extends the revenue standard to performance years 2019 and 2020 (payment years 2021 and 2022).

Further, the proposed rule adds a revenue-based generally applicable nominal amount standard for the 2019 and 2020 All-Payer qualifying APM participant (QP) performance periods for Other Payer Advanced APMs whose payment arrangements expressly define risk in terms of revenue. Similar to Medicare Advanced APMs, the new standard is met when the model requires an APM Entity to owe or potentially forego 8 percent or more of total combined revenues from the payer of the entity's participating providers and suppliers.

2) **Round 1 CPC Plus Participants**: Beginning with the 2018 Medicare QP performance period, the medical home model revenue-based standard will be restricted for use to medical home APM entities with <50 eligible clinicians in their parent organizations.
    a. CMS exempts from this requirement those entities enrolled in Round 1 of the Comprehensive Primary Care Plus (CPC+) model, since the size requirement was finalized after CPC+ participants signed agreements with CMS.
    b. Future CPC+ participants (e.g., Round 2, now enrolling) would not be exempt.

3) **Medicare Medical Home Risk Progression**: For the following performance periods, progression of the medical home model Advanced APM standard will be adjusted to:
    c. 2 percent for 2018
    d. 3 percent for 2019
    e. 4 percent for 2020
    f. 5 percent for 2020 and later.

    The percentage applies to the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities.

4) **Medicaid Medical Home Risk Progression**: The rule proposes to reduce the rate of progression of the nominal risk standard amount for Medicaid Medical Home models. For the All-Payer QP Performance Period, it is reduced from 4 percent to 3 percent of the APM Entity's total revenue under the payer, and for the 2020 period from 5 percent to 4 percent. The risk would remain at 5 percent for the 2021 period and beyond.

Executive Summary: CMS Quality Payment Program 2018 Proposed Rule
Table I:

MIPS Measure Performance Category Details

Performance Category	Category Details	Weighting	Scoring	Maximum Possible Points Per Performance Category
Quality	• Report six self-selected measures that are relevant to the practice during the performance year (CY 2018). • Must report full performance year. • Must include one outcome measure or other high priority measure if an outcome measure isn't available. • Select from individual measures or specialty measure set	60%	• Each measure is scored 1-10 points compared to historical benchmark (if available). • 0 points for a measure that is not reported. • Measures that fail data completeness will receive one point instead of three. • Up to 10 percentage points available based on improvement. • Bonus for reporting outcomes (additional), patient experience, appropriate use, and patient safety measures. • Bonus for end-to-end EHR reporting • Measures are averaged to get a score for the category	60 points
Advancing Care Information	• Base score requires submitting data for each of the objectives below: o Protect patient health information (yes/no – yes required for base score) o E-prescribing (numerator/denominator) o Patient Electronic Access to Health Information (numerator/denominator) o Coordination of Care through Patient Engagement (numerator/ denominator) o Health Information Exchange (numerator/ denominator)	25%	• Base score of 50 points is achieved by reporting at least one use case for each available measure • Performance score provides up to 90 points based on physician/clinician reporting • Expand options beyond the one immunization registry reporting measure for 10% toward the performance score and allow reporting on a combination of other public health registry measures that may be more readily available for 5% each toward the performance score (up to 10%).	100 points

	○ Public Health and Clinical Data Registry Reporting (yes/no – yes required for base score) • Clinicians can choose which of these measures to focus on for their performance score, allowing clinicians to customize their reporting and score.		• For the 5% bonus, must report to a different public health agency or registry than those used to earn the performance score. • Total cap of 100 percentage points available.	
Clinical Practice Improvement Activity (CPIA)*	• Minimum selection of one CPIA from list of 90 possible activities with additional credit given for more activities • Full credit for participation in patient-centered medical home • 50% credit for participating in an APM	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target	40 points
Resource Use	• Only calculated on Medicare Spend Per Beneficiary and Medicare Per Capita Spend. • Calculated based on claims so no additional data submissions are required	0%	• Will not be incorporated into the MIPS performance score for payment year 2020. • However, results for select measures will be provided as feedback. • Improvement scoring will be based on statistically significant changes at the measure level. • Although, CMS proposes an improvement scoring methodology for cost, it would not affect the MIPS final score for the 2020 MIPS payment year. • Will count for 30% of the score in CY 2021 payment year.	Feedback Only in CY 2020

*Clinicians in small practices (15 or fewer professionals, a rural or health professional shortage area, or a non-patient facing professional are only required to report on two CPIAs to receive the full score. Reporting of one CPIA (medium or high weight) would result in 50 percent of the highest potential score (30 points) and reporting of two CPIAs would result in the maximum score of 60 points.

Table II: MIPS Measure Submission Mechanism*

Performance Category	Individual Reporting	Group Reporting
Quality	• Claims • Qualified Clinical Data Registry • Qualified Registry • EHR	• QCDR • Qualified registry EHR • CMS Web Interface (groups of 25 or more) • CMS-approved survey vendor for Consumer Assessment of Healthcare Providers and Systems for MIPS (must be reported in conjunction with another data submission mechanism.) • Administrative claims (for readmission measure –no submission required)
Resource Use	• Administrative Claims	• Administrative Claims
Advancing Care Information	• Attestation • QCDR • Qualified Registry • EHR Vendor	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface*
CPIA	• Attestation • QCDR • Qualified Registry • EHR Vendor	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface*

*In a change from last year's final rule (payment year 2019/performance year 2017), providers can use different reporting mechanisms for both within a reporting category and for different performance categories.