Executive Summary: CMS Quality Payment Program 2018 Final Rule

Key Financial and Operational Impacts from the 2018 Final Quality Payment Program (QPP) rule:

A detailed summary will be available on HFMA's Regulatory Resources page shortly.

Merit-based Incentive Payment System (MIPS)

1) **Eligible Clinicians**: For payment year 2020, 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**: The final rule allows for the creation of virtual groups. CMS defines a virtual group as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians that elect to form a virtual group for a performance period for a year. Solo practitioners and the groups would need to exceed the low-volume threshold (discussed below). A solo practitioner or a group that does not exceed the low-volume threshold could not participate in a virtual group, and it is not permissible under the statute to apply the low-volume threshold at the virtual group level.

   Virtual groups are required to make an election to participate in MIPS as a virtual group prior to the start of an applicable performance period. CMS is finalizing a two-stage virtual group election process for the applicable 2018 and 2019 performance periods. The first stage is the optional eligibility stage, but for practices that do not choose to participate in stage 1 of the election process, CMS will make an eligibility determination during stage 2 of the election process. The second stage is the virtual group formation stage. CMS also finalizes that virtual groups must have a formal written agreement among each party of a virtual group. The election deadline will be December 31.

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

4) **Payment Adjustment and Performance Categories**: In CY20 payment year (CY18 performance year) clinicians will receive payment adjustments on their Medicare Part B payments of – 5% up to + 5% times a scaling factor not to exceed 3 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 Weights by MIPS Performance Category

Performance Category	Transition Year (Final)	2020 MIPS Payment Year (Final)	2021 MIPS Payment Year and Beyond (Final)
Quality	60%	50%	30%
Cost	0%	10%	30%

Improvement Activities	15%	15%	15%
Advancing Care Information*	25%	25%	25%

*As described in section II.C.6.f.(5) of this final rule with comment period, 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**: For the 2020 payment year, the MIPS performance threshold will be set at **15 points**. This is an increase from 3 points for the 2019 payment year. The additional performance threshold remains at 70 for purposes of determining the additional MIPS payment adjustment for exceptional performance. 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.
15.00	0% adjustment
15.01-69.99	Positive MIPS payment adjustment ranging from > 0 percent to 5% × a scaling factor not exceeding 3 to preserve budget neutrality, on a linear sliding scale.
70.0-100	Positive MIPS payment adjustment of up to 5% × a scaling factor not exceeding 3 to preserve budget neutrality, on a linear sliding scale 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) **MIPS Measure Performance Categories and Measure Submission Mechanisms**: Please see Tables I and II for details related to measure performance categories and submission mechanisms.

7) **Improvement Scoring**: CMS includes improvement scoring for the quality performance category and for the cost performance category beginning with the 2020 MIPS payment year (2018 performance year). Up to 10 percentage points are available for the quality category and up to 1 percentage point is available in the cost category.

8) **Topped Out Measures**: CMS caps the score of topped out measures at 7 measure achievement points. CMS is not applying the topped-out measure cap to measures in the CMS Web Interface for the QPP. CMS has identified six measures as topped out for the 2018 performance year (2020 payment year).

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second-Generation Cephalosporin. (Quality Measure ID: 21)

- Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)
- Chronic Obstructive Pulmonary Disease (COPD): InhaledBronchodilator Therapy (Quality Measure ID: 52)

9) **Facility Based Measurement**: For the 2021 MIPS payment year, CMS will include a facility based reporting option. The measures will be determined in a future rule making. 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% or more of their covered professional services in sites of service identified by POS codes 21 (inpatient hospital) or 23 (emergency department) based on claims for a period prior to the performance period as specified by CMS.

   A MIPS-eligible clinician can also qualify for facility-based measurement if they are determined facility-based as part of a group in which 75% or more of the MIPS eligible clinician National Provider Identifiers (NPIs) 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 makes a complex patient bonus available based on the average Hierarchical Condition Category risk score, and the number of dually eligible patients treated. The complex patient bonus cannot exceed 5 points. To receive the complex patient bonus, 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) **Electronic Health Record (EHR) Certification Criteria for ACI Category**: For the 2018 performance period, CMS extends the use of modified stage two meaningful use requirements. MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 certification criteria, or a combination of the two. A 10% bonus is available for practices that only use the 2015 Edition Certified EHR Technology (CEHRT) in performance year 2018.

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% 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. *Benchmark Standard*: ***3% or more*** of the expected expenditures for which an APM entity is responsible. 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 final rule extends the revenue standard to performance years 2019 and 2020 (payment years 2021 and 2022).

Further, the 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% or more of total combined revenues from the payer of the entity's participating providers and suppliers if a cost target or benchmark is not met.

2) **Round 1 Comprehensive Primary Care Plus (CPC+) 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 less than 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) will not be exempt.

12) **Medicare Medical Home Risk Progression**: For the following performance periods, progression of the medical home model Advanced APM standard will be adjusted to:
    c. 2.5% for 2018 (reduced from 3%)
    d. 3% for 2019 (reduced from 4%)
    e. 4% for 2020 (reduced from 5%)
    f. 5% 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.

13) **Medicaid Medical Home Risk Progression**: The rule reduces the rate of progression of the nominal risk standard amount for Medicaid Medical Home models. For the 2019 All-Payer QP performance period, it is reduced from 4% to 3% of the APM Entity's total revenue under the payer (Medicaid), and for the 2020 period, from 5%to 4%. The risk would remain at 5% for the 2021 period and beyond.

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Table I:
MIPS Measure Performance Category Details

Performance Category	Category Details	Weighting	Scoring	Maximum Possible Points Per Performance Category
Quality	• Report at least six self-selected measures that are relevant to the practice during the performance year (CY18). • Must report full performance year. • Must include one outcome measure or other high priority measure of an outcome measure isn't available. • Select from individual measures or specialty measure set. • If specialty set has less than six measures, it will be considered complete reporting. • 60% data completeness for submission mechanisms, except for web interface and CAHPS.	50%	• Each measure is scored 1-10 points compared to historical benchmark (if available). • 0 points for a measure that is not reported. • Up to 10 percentage points available based on improvement. • 3-point floor for measures scored against a benchmark. • 3 points for measures that don't have a benchmark or don't meet case minimum requirements. • Bonus for additional high priority measures up to 10% of denominator for performance category. • Bonus for end-to-end electronic reporting up to 10% of denominator for performance category. • Measures are averaged to get a score for the category • Measures that don't meet the data completeness criteria will earn 1 point, except for a measure submitted by a small practice, which will earn 3 points.	60 points
Advancing Care Information	• Base score requires submitting data for each of the objectives below:		• Base score of 50 points is achieved by reporting at least one use case for each available measure.	

	○ Protect patient health information (yes/no – yes required for base score) ○ E-prescribing (numerator/denominator) ○ Patient Electronic Access to Health Information (numerator/denominator) ○ Coordination of Care through Patient Engagement (numerator/ denominator) ○ Health Information Exchange (numerator/ denominator) ○ Public Health and Clinical Data Registry Reporting (yes/no – yes required for base score) • Clinicians can choose which of these objectives to focus on for their performance score allowing clinicians to customize their reporting and score.	25%	• Awards performance score points if you submit additional measures (up to 10% each). • For the performance score, you or your group may earn 10% in the performance score for reporting to any single public health agency or clinical data registry. • A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score. • Additional improvement activities are eligible for a 10% Advancing Care Information bonus if you use CEHRT to complete at least 1 of the specified Improvement Activities. • A 10% bonus score for using 2015 edition exclusively. • Total cap of 100 percentage points available.	100 points
Clinical Practice Improvement Activity (CPIA)*	• Minimum selection of one CPIA from list of 112 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 • Small practices, practices in rural areas, geographic health professional shortage areas (HPSAs), and non-patient facing MIPS eligible clinicians don't need more than 2 activities (2 medium or 1 high-weighted activity) to earn the full score.	40 points

			• All other MIPS eligible clinicians don't need more than 4 activities (4 medium or 2 high-weighted activities, or a combination).	
Resource Use	• Only calculated on Medicare spend per beneficiary and Medicare per capita spend for attributed beneficiaries. • Calculated based on claims, so no additional data submissions are required	10%	• Will be incorporated into the MIPS performance score for payment year 2020. • Improvement scoring will be based on statistically significant changes at the measure level. • Will count for 30% of the score in CY21 payment year.	10 points

*Clinicians in small practices (15 or fewer professionals, a rural or HPSA, 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% of the highest potential score (30 points) and reporting of two CPIAs would result in the maximum score of 40 points.

Table II: MIPS Measure Submission Mechanism*

Performance Category	Individual Reporting	Group Reporting
Quality	• Claims • Qualified Clinical Data Registry (QCDR) • Qualified registry • EHR	• QCDR • Qualified Registry • EHR • CMS Web Interface (groups of 25 or more) • CMS-approved survey vendor for CAHPS 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 • CMS Web Interface (groups of 25 or more)*
CPIA	• Attestation • QCDR • Qualified Registry • EHR Vendor	• Attestation • QCDR • Qualified Registry • EHR • CMS Web Interface (groups of 25 or more)*

*For performance year 2018 (payment year 2020), CMS will require the selection of one reporting mechanism for each performance category. Starting in 2019 (2021 payment year) providers may use more than one submission mechanism within each MIPS category.