Highlights from the MACRA Quality Payment Program (QPP) Proposed Rule

Comments due by August 21, 2017

On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule[1] outlining changes to the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[2] The Proposed Rule is largely a continuation of current policies and does not represent a sea change for providers. The Administration has, however, proposed adjustments that would make QPP participation less burdensome for providers, especially for solo and small practices, by continuing certain CY 2017 "transition year" policies and adding new exemptions. At the same time, the Proposed Rule continues the move to value-based payment for physician services.

The Proposed Rule features policies for CY 2018 (the second performance year of the QPP), which impacts payment in CY 2020, as a well as a few that retroactively impact CY 2017 performance.

As you know, eligible clinicians must participate in one of two tracks of the QPP in order to fulfill the requirements of MACRA:

> (1) Participate in an Advanced Alternative Payment Model (APM), which provides a 5 percent incentive payment on allowable Part B charges in lieu of a Merit-based Incentive Payment System (MIPS) payment adjustment; or,
>
> (2) Be subject to MIPS, which provides positive or negative payment adjustments on allowable Part B charges.

CMS clarifies in the Proposed Rule that to the extent the agency can associate Part B drugs and other items with an individual clinician, such charges will be subject to MIPS payment adjustments, with few exceptions, starting in CY 2019.[3] Stakeholders are seeking clarity on whether APM incentive payments will *also* apply to drugs.

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[1] Medicare Program; CY 2018 Updates to the Quality Payment Program Proposed Rule (CMS-5522-P), 82 Fed. Reg. 30,010 (June 30, 2017), available at https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf [hereinafter "Proposed Rule"].

[2] The Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 101, 129 Stat. 87 (2015) [hereinafter "MACRA"].

[3] Proposed Rule at 30,019.

Highlighted changes to each track are outlined in this document. Key takeaways include:

- Proposed adjustments to the MIPS scoring methodology that would gradually make it harder for clinicians to achieve the minimum score necessary to avoid a payment penalty and/or achieve positive payment adjustments;
- New bonus points in MIPS scoring for clinicians in small groups or who treat complex patients;
- Proposed increases to the low-volume exclusion to clinicians who bill $90,000 (up from $30,000) or less or see 200 or fewer Medicare Part B patients annually (up from 100 patients).

MIPS

Payment adjustments under MIPS are based on scores that clinicians receive across four different performance categories. For CY 2018, the agency proposes to retain the current weight of each performance category:[4]

Performance Category	***Payment Adjustment Weighting***
Cost (Resource Use)	0 percent—i.e., will not impact CY 2018 score/2020 payments
Quality	60 percent—i.e., largest impact on CY 2018 score/2020 payments
Improvement Activities	15 percent
Advancing Care Information	25 percent

To avoid a payment reduction, MIPS eligible clinicians must receive a score above a certain threshold. **In CY 2017, CMS allows clinicians to "pick their pace."[5] For CY 2018, CMS continues some level of flexibility, but proposes changes that would make it marginally more difficult to achieve the score necessary to avoid a payment reduction.** In particular, CMS proposes to

[4] Proposed Rule at 30,037, 30,052, 30,058.

[5] Proposed Rule at 30,012-13.

raise the threshold score required to avoid a negative adjustment from 3 to 15 points.[6] Therefore, clinicians who focused on meeting the bare minimum "testing" requirements in 2017 will need to increase their performance in one or more categories in order to continue avoiding a payment reduction.

In addition, CMS explains how it proposes to measure and reward **improvement** in performance, in addition to achievement, as a factor in scoring the Quality and Cost performance categories.[7]

Key takeaways within each performance category are described below.

Cost Performance Category

Top line takeaway: Continued de-emphasis on Cost performance category for CY 2018

- **No mention of whether CMS will incorporate Part D costs.** The agency previously considered counting Part D costs when measuring the total cost of care,[8] but makes no further mention of this concept in the Proposed Rule. Including Part B ***and*** Part D drug costs would reduce any potential incentive to prescribe Part D drugs over Part B drugs out of a concern for performing worse on cost measures.

- **Cost performance for CY 2018 would not impact 2020 payments.** In CY 2017, cost is not a factor in the MIPS payment adjustment methodology. CMS proposes that Medicare spending will not count for or against clinicians for CY 2018,[9] but is unlikely to delay the category in 2019. However, the agency would continue to collect cost data in CY 2018 for clinicians on two Medicare spending measures.

[6] Proposed rule at 30,016-17.

[7] Proposed Rule at 30,115-17.

[8] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77,008, 77,064 (Nov. 4, 2016) (final rule).

[9] Proposed Rule at 30,015.

- **Discard existing episode-based cost measures.** CMS proposes to discard all ten of the episode-based cost measures finalized for the current performance year, and instead, work with stakeholders to develop replacement episode-based cost measures.[10]

Quality Performance Category

Top line takeaway: Encourages shift to outcomes measures and ratchets up expectations for performance

- **Performance on quality measures is becoming more important for avoiding a negative payment adjustment, or achieving a positive one.** CMS proposes to *lower* the minimum number of points most clinician can receive for any given quality measure from 3 to 1 point, thus making it necessary to report additional measures to achieve a higher score.[11]

- **Raise the data completeness standard, over time.** Currently, CMS requires clinicians to report quality measures for at least 50 percent of patient encounters in order to meet "data completeness standards." CMS proposes to increase the standard to 60 percent for CY 2019, and raise it higher in future years.[12]

- **Identify quality measures that should be phased out, and ultimately remove them from the program.** As part of a broader push toward outcomes-driven quality assessment, CMS proposes to phase out certain measures, the majority of which are process-based.[13]

Improvement Activities Performance Category

Top line takeaway: Preserves the status quo

- **Additional options for reporting improvement activities.** CMS does not propose major structural or methodological changes to the Improvement Activities performance

[10] Proposed Rule at 30,016.

[11] Proposed Rule at 30,042.

[12] Proposed Rule at 30,041.

[13] Proposed Rule at 30,046, 30,105.

category. However, the agency proposes to add or modify activities which can be reported.[14]

Advancing Care Information Performance Category

Top line takeaway: Adds new exemptions, accommodations, and bonus points for using current electronic health records (EHRs)

- **Allow clinicians to continue using EHR technology certified to 2014 Edition for CY 2018.** However, CMS proposes to provide bonus points to physicians that do adopt 2015 Edition certified EHR technology (CEHRT).[15]

- **New exemptions from Advancing Care Information.** CMS proposes new exemptions from the performance category for solo practitioners and those in practices of 15 or fewer clinicians, ambulatory surgery center (ASC)-based clinicians, and others with specific hardships.[16]

Advanced APM Participants

Allow APMs at financial risk for at least 8 percent of Medicare Parts A and B revenue to qualify as Advanced APMs in CYs 2018 to 2020, rather than increasing the required risk amount. The required nominal risk amount was set to increase after 2018 in last year's final rule, but the proposed approach will potentially allow more clinicians to qualify.[17]

Develop an all-payer combination option for future years of the program.[18]

Allow several additional Medicare models, including the ACO Track 1+, 2, and 3 models to qualify as Advanced APMs, thus expanding the number of options available to clinicians.[19]

[14] Proposed Rule at 30,015.

[15] Proposed Rule at 30,065.

[16] Proposed Rule at 30,076-78.

[17] Final Rule at 77,471-72.

[18] Proposed Rule at 30,234.

[19] See Alternative Payment Models in the Quality Payment Program, October 14, 2016, available at https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.

Easing Burden on Providers

Expand the low-volume exclusion. CMS proposes to expand the CY 2018 criteria for the exclusion of low-volume practices from MIPs.[20]

Low Volume Exclusion Criteria for CY 2018	***Current Policy***	***Proposed***
Allowable Annual Part B Charges	≤ $30,000; OR	≤ $90,0000; OR
Part B Visits	≤ 100 patients	≤ 200 patients

Offer new bonus points for clinicians who are part of a practice with 15 or fewer clinicians, or who care for complex patients.[21]

Allow groups of 10 or fewer clinicians to "combine" with other small groups and solo practitioners to aggregate performance across the four MIPS performance categories.[22] These "virtual groups" may span any location or specialty, so long as each clinician is independently eligible for MIPS.

Implement an optional facility-based scoring mechanism using the Hospital Value-Based Purchasing (VBP) program for hospital-based clinicians who provide 75 percent or more of their services in the emergency room or inpatient hospital settings.[23]

Allow for multiple types of data reporting mechanisms within a single performance category, rather than restricting clinicians to a particular method of reporting, as current policy requires.[24]

[20] Proposed Rule at 30,234.

[21] Proposed Rule at 30,140.

[22] Proposed Rule at 30,030.

[23] Proposed Rule at 30,243.

[24] Proposed Rule at 30,036.

Appendix: Anticipated Impact

The vast majority of clinicians are projected to receive a neutral or positive adjustment under MIPS.[25] These figures, estimated by CMS for selected specialties, are summarized below:

Physician Specialty	***Projected Percent Subject to Neutral or Positive Payment Adjustment***
11,000 gastroenterologists	~96 percent
8,500 urologists	~96 percent
3,300 rheumatologists	~97 percent
>700 surgical oncologists	~99 percent
>3,000 radiation oncologists	~97 percent
>2,500 medical oncologists	~98 percent
~6,500 hematologist/oncologists	~97 percent
800 gynecologic oncologists	~98 percent
~11,600 neurologists	~95 percent
>20,000 cardiologists	~97 percent
~10,600 psychiatrists	~94 percent
9,500 dermatologists	~92 percent

[25] Proposed Rule at 30,238.