CLIENT ALERT

CMS Releases Updates to the Quality Payment Program

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On June 20, the Centers for Medicare and Medicaid Services (CMS) released for public comment a proposed rule, titled "Medicare Program; CY 2018 Updates to the Quality Payment Program," (2018 Proposed Rule). This rule would revise the Quality Payment Program (QPP) for the 2018 calendar year (for payment adjustments in 2020) and beyond.

CMS's stated goal is to simplify the QPP, especially for small, independent, and rural practices, while ensuring fiscal sustainability and high-quality care within Medicare. The 2018 Proposed Rule aims to ensure there are meaningful measurements and improved patient outcomes, but to also allow participating providers to more effectively "pick your pace" with greater flexibility and minimized burdens. A press release from CMS accompanying the 2018 Proposed Rule emphasizes the proposal's efforts to simplify the QPP and to reduce burdens on physicians, and notes that this proposal takes into account feedback the agency has received from physicians on the QPP. The rule also proposes implementation of new elements of MACRA.

Comments on the 2018 Proposed Rule are due to CMS by August 21, 2017. If finalized, this rule would impact fee-for-service payments under the physician fee schedule (PFS) for the Medicare program. Because of the volume of care covered under Medicare, these rules may dictate how quality improvement, capital investment, and other efforts may be best directed for medical practices and other entities. We recommend that health care organizations consider how this 2018 Proposed Rule will impact their business and provide timely input to CMS.

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114 10, enacted April 16, 2015) was a sweeping piece of legislation, repealing the maligned Medicare Sustainable Growth Rate (SGR) formula that CMS previously used to set reimbursement rates for Medicare and instead establishing the QPP for eligible clinicians.

CMS began implementing the QPP through a final rule published in 2016 for calendar year 2017 (2017 Final Rule). Under the QPP, eligible clinicians can participate via one of two tracks: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). CMS has stated that this program is expected to evolve over multiple years with the goal of "promoting innovative, outcome-focused, patient-centered, resource-effective health system that leverages health information technology."

1. MIPS: Combined three previously-existing Medicare programs (Physician Quality Reporting System, the Value-Based Payment Modifier, and the Medicare Electronic Health Record (EHR) Incentive Program) into a single, consolidated merit-based system, granting eligible providers adjusted Medicare payments based on their weighted performance in four categories.

2. APMs: Established bonuses and increased payments to incentivize providers to participate in innovative payment models that meet certain criteria, called Advanced APMs, to furnish coordinated, outcome-driven care to patients.

For additional background information on MACRA and MIPS, please refer to our discussions of the MACRA statute (MIPS and APMs) and the 2017 Final Rule.

MIPS PROGRAM: KEY PROPOSALS

Under MACRA, MIPS focuses on four categories: (1) improved quality through use of evidence-based, specialty-specific standards; (2) costs; (3) practice-based improvement activities; and (4) use of certified electronic health record technology (CEHRT) to support interoperability and improve quality. The 2018 Proposed Rule builds on existing MIPS QPP policies, addresses new elements of MACRA that did not take effect in the first year, including virtual groups, facility-based measurement, and improvement scoring, and implements flexibility through hardship exceptions enacted in the 21st Century Cures Act.

In terms of overall changes from the 2017 Final Rule, the 2018 Proposed Rule provides more flexibility to the MIPS program and seeks to ease the burden of participation. CMS states that these additional flexibilities and reduction in barriers will enhance the ability of all clinicians, and particularly the smaller practices, to participate successfully in the QPP.

Programmatic Changes

In the 2017 Final Rule, CMS implemented a "pick your pace" policy under which MIPS eligible clinicians could begin collecting data to report on January 1, 2017 or on any later date before October 2, 2017 without incurring a negative payment adjustment. The 2018 Proposed Rule would extend this ramp-up period for physicians by reducing burdens and limiting the number of physicians required to participate.

The 2018 Proposed Rule would raise the exemption threshold for providers to participate in the QPP. Under the 2017 Final Rule, physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists (collectively, "MIPS eligible clinicians") were part of the QPP if they billed Medicare more than $30,000 a year or provide care for more than 100 Medicare patients a year. The 2018 Proposed Rule raises this threshold to only cover providers who bill Medicare more than $90,000 a year or provide care for more than 200 Medicare patients, exempting significantly more providers and particularly more small practices and eligible clinicians in rural and Health Professional Shortage Areas. CMS projects 585,560 clinicians will fall under this exclusion. In addition, clinicians now have the option to choose how they will participate in MIPS, ranging from a full year performance period for the quality and cost performance categories to a 90-day minimum for the advancing care information and improvement activities.

The 2018 Proposed Rule also introduces the concept of a "virtual group." This concept allows solo practitioners and practices with ten or fewer MIPS eligible providers to form larger groups for MIPS participation. Once providers elect to be treated as a virtual group, those providers submit their MIPS reporting based on that group rather than as individuals. This may ease the MIPS burden for smaller providers through greater distribution of administrative costs.

Scoring Updates

Following the 2018 Proposed Rule's general approach of greater flexibility and improved access for smaller groups, CMS proposed many updates and changes to the scoring section. How CMS will score a MIPS eligible clinician is significant, as the final score dictates the performance-based payment adjustment they will receive for their Medicare payments.

To provide greater flexibility, various amendments were made to each performance category's scoring methodology. For instance, beginning in 2020, the 2018 Proposed Rule would add an improvement score for both the quality and cost performance categories. The effect of these additional points should be to incentivize providers, not only to improve from year to year, but to have the flexibility of continued participation should they score below a desired level. For the advancing care information performance category, the 2018 Proposed Rule will continue to allow the use of 2014 Edition CEHRT, while encouraging the use of 2015 Edition CEHRT through a bonus payment.

Additionally, the 2018 Proposed Rule adds scoring methodology specific to facility-based measurements, meant to add more flexibility for clinicians to be assessed in the context of the facilities at which they work.

To improve the participation for smaller practice groups, the 2018 Proposed Rule seeks to ease the scoring burden for such groups. The 2018 Proposed Rule offers five additional bonus points to the final score of small practices (defined as those with 15 or fewer clinicians) that submit data on at least one performance category. Similarly, practices that treat complex patients would be measured by Hierarchical Conditions Category (HCC) risk score and could earn from one to three bonus points. CMS also introduced a MIPS hardship exception for small practices, allowing for the advancing care information performance category to be reweighted from 25 percent to 0 percent and reallocated to the quality performance category.

Public Reporting

Under the 2017 Final Rule, much clinician performance information was meant to be made public on Physician Compare. While the 2018 Proposed Rule maintains many of these public reporting standards, it also provides CMS with the flexibility to seemingly cut those standards way back.

For instance, the 2018 Proposed Rule adds that any measure in its first year of use in the quality and cost performance categories will not be reported by CMS and, after the first year, CMS will reevaluate the measures to determine when and if they are suitable for public reporting. Additionally, the 2018 Proposed Rule specifies a new 30-day preview period, requiring CMS to provide a 30-day preview period for providers with QPP data before the data is made public on Physician Compare.

Data Validation and Auditing

In the 2017 Final Rule, CMS stated that it would selectively audit MIPS eligible clinicians and groups on a yearly basis. This 2018 Proposed Rule would codify many of the provisions related to this requirement that were discussed but were left out of that 2017 Final Rule.

Specifically, the 2018 Proposed Rule would add that all MIPS eligible clinicians and groups that submit electronic data must certify to its accuracy and completeness as part of the submission process and if the data submitted is inaccurate, CMS may reopen and revise a MIPS payment determination. Additionally, all MIPS eligible clinicians or groups that submit data and information to CMS for purposes of MIPS must retain such data and information for a period of 10 years from the end the MIPS Performance Period.

APM PROGRAM: KEY PROPOSALS

On the APM track, eligible clinicians whose payment would otherwise have been determined based on MIPS instead receive some incentive bonuses and higher reimbursement for covered professional Medicare Part B services. As discussed below, key changes under the 2018 Proposed Rule would ease requirements for clinicians to participate in Advanced APMs and further prepare for implementation of an expanded APM track.

Criteria for Qualified Practitioners

Qualifying APM Participants or "QPs" are eligible clinicians who are on the APM track—that is, they receive the financial rewards associated with participation in Advanced APMs. In general, a participant in an Advanced APM is a QP if she is in an APM Entity group that meets either the payment amount threshold or the patient count threshold. The payment amount threshold percentage is calculated by dividing the numerator of the Medicare Part B covered professional services furnished by the APM Entity to attributed beneficiaries under the APM by the denominator of aggregate Medicare Part B covered professional services furnished by the APM Entity to all attribution-eligible beneficiaries. Similarly, the patient count threshold is generally the numerator of the number of attributed beneficiaries to whom the APM Entity provides Medicare Part B covered professional services divided by the denominator of the number of attribution-eligible beneficiaries.

CMS recognized in the preamble to the 2018 Proposed Rule that the timing of participation in some of its Advanced APM models did not match the timing of reporting under the QPP, which could arbitrarily disadvantage participants in those APMs. For example, if an Advanced APM model begins on May 1, its participants would be considered to have participated in the APM for the entire performance year for purposes of calculating the payment amount or patient count threshold. The numerator, by no fault of the APM Entity or its members, would include only claims from May through the end of the year, but the denominator would include four additional months beginning in January of the performance year. In this example, the late start of the APM would effectively raise the applicable threshold requirement in the first partial year of the APM by one third, making it exceptionally difficult for APM participants in such a year from meeting the definition of QP. Thus, the 2018 Proposed Rule would modify its methodology by limiting the denominator in certain situations to reflect the time period for which the clinician participated in the Advanced APM.

Criteria for Advanced APMs

The 2017 Final Rule provided that a physician's participation in an APM, in order to qualify that physician for the bonuses and other payment perks under the APM framework, had to be in an *Advanced* APM. In general, Advanced APMs are APMs that require the use of CEHRT, incorporate quality measures similar to those under MIPS, and subject participants to sufficient downside risk. One way downside risk can be calculated to determine whether an APM is an Advanced APM is using the generally applicable revenue-based nominal amount standard. The 2017 Final Rule set forth a generally applicable revenue-based nominal amount standard of 8 percent for 2017 and 2018. That 8 percent figure is calculated from "the estimated average total Medicare Parts A and B revenues of participating APM Entities." The 2018 Proposed Rule would extend to performance years 2019 and 2020 the generally applicable revenue-based standard of 8 percent—effectively holding steady the degree of financial risk that APMs must apply to be "Advanced" and to thereby confer on their participants the financial rewards of payment under the APM framework.

As an alternative to the generally applicable nominal amount standard, the 2017 Final Rule provided that an APM could qualify to be an Advanced APM by meeting the definition of a Medical Home Model and meeting a lower nominal amount standard. For performance year 2017, that standard was 2.5 percent, and the 2017 Final Rule provided for the percentage to increase to 3 percent in 2018, 4 percent for 2019, and 5 percent for 2020 and subsequent years. The 2018 Proposed Rule would relax this threshold to 2 percent for 2018, 3 percent for 2019, 4 percent for 2020, and 5 percent for 2021 and subsequent years.

Other-Payer Advanced APMs

The 2017 Final Rule focused initially on Medicare-only APMs, but, as required by MACRA, provided that Other-Payer Advanced APMs would be introduced and would be implemented for performance years beginning in 2019. The 2018 Proposed Rule would expand and clarify the role of Other-Payer Advanced APMs in the QPP.

CMS's recognition of Other-Payer Advanced APMs would permit physicians who would not meet the applicable thresholds for Medicare-only APMs to nevertheless be considered QPs for Medicare payment purposes based on participation in Medicaid or private-payer APMs. Physicians would still need to participate in Medicare APMs, but with a lesser proportion of the physician's billings or patients. Under the "All-Payer Combination Option," the method of determining QP status for practitioners who do not meet the Medicare-only thresholds, a physician could be considered a QP if she met a lower Medicare threshold in addition to an overall-APM participation threshold. For example, in performance year 2019 (for payment year 2021), a practitioner under the Medicare-only option will need to meet a payment amount threshold of 50 percent, whereas a practitioner under the All-Payer option would need to meet an overall payment amount threshold of 50 percent in addition to a Medicare payment amount threshold of only 20 percent. In general, this option will allow QP status to be applied to APM-participating practitioners whose Medicare business comprises a smaller portion of overall business.

The criteria and characteristics of Other-Payer Advanced APMs largely track those of Medicare-Only Advanced APMs. These APMs generally must require the use of CEHRT, measure quality, and place downside risk on participants. The 2018 Proposed Rule sets forth the same risk percentage thresholds as set forth for Medicare-Only Advanced APMs: 8 percent for the generally applicable nominal amount standard for performance years 2019 and 2020 and escalating percentages, beginning with 3 percent in 2019, for the Medical Home Model standard.

But unlike Medicare-Only Advanced APMs, CMS will require submissions of information to make determinations on many Other-Payer Advanced APMs. The 2018 Proposed Rule would allow payers, including Medicaid Managed Care Organizations, or eligible clinicians to submit to CMS information that would allow CMS to recognize their arrangements as Advanced APMs under the "Payer Initiated Other Payer Advanced APM Determination Process" and the "Eligible Clinician Initiated Other Payer Advanced APM Determination Process," respectively. In addition, CMS would consider Medicaid and Medical Home models as Other-Payer Advanced APMs.

The proposal notes that substantial further guidance will be forthcoming regarding Other-Payer Advanced APMs.

CONCLUSION

Physicians' and physician group practices' Medicare payment for the foreseeable future will depend on how effectively they fit within the new MIPS and APM payment regimes. But a survey by KPMG and the American Medical Association conducted in

April and May 2017 found that only about 70 percent of physicians have begun preparing to meet QPP requirements, and, of those, a scant 23 percent felt well prepared to meet the new requirements.

The effects of the QPP will extend well beyond the physicians directly receiving reimbursement under Medicare. For example, vendors that provide EHR services to physician groups can tailor offerings to maximize physician participation to improve MIPS scores for practices. Hospitals operating APMs may be able to design gainsharing or other arrangements with physicians and physician groups that, while complying with regulatory and fraud and abuse restrictions, will maximize reimbursement opportunities for MIPS and APM physicians to attract the participation of the most qualified and highest achieving practices. Private payers and state Medicaid agencies may want to design APMs to promote participating physicians' and physician groups' abilities to reach QP status.

The QPP represents a sea change in Medicare payment. Crowell & Moring attorneys are here to help you determine how the QPP may affect you and what you can do about it.

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