American Hospital Association

Special Bulletin

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CMS FINALIZES KEY PHYSICIAN QUALITY PAYMENT PROGRAM POLICIES FOR 2020

The Centers for Medicare & Medicaid Services (CMS) Nov. 2 issued a final rule with comment period updating the requirements of the quality payment program (QPP) for physicians and other eligible clinicians mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The QPP includes two tracks – the default Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). Data reporting for the QPP began on Jan. 1, 2017. Most of the final rule's policies specify what eligible clinicians must report for the QPP's 2018 performance period, which will affect eligible clinicians' payment under the Medicare physician fee schedule (PFS) in calendar year (CY) 2020. In addition, CMS issues an interim final rule to provide MIPS relief to clinicians impacted by the recent hurricane season.

Select highlights follow.

AHA View. This final rule continues a flexible approach to the MACRA's physician quality payment program. While we believe it could be adopted in 2018, we understand CMS's decision to eventually adopt a facility-based clinician measurement option that will allow many hospitals and clinicians to spend less time collecting data, and more time collaborating to improve care. In addition, we applaud CMS for providing much-needed relief from unrealistic and unfunded mandates for EHR capabilities for clinicians. But we are disappointed the agency has yet to provide similar relief for hospitals. Finally, we urge CMS to provide additional avenues for clinicians to earn incentives for partnering with hospitals to provide better quality, more efficient care through advanced alternative payment models.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The MIPS is the default payment system for eligible clinicians. The MIPS must assess eligible clinicians on four performance categories – quality measures, cost measures, improvement activities and advancing care information (ACI), which is a re-worked version of the Medicare Electronic Health Record (EHR) Incentive Program for eligible clinicians. Based on their MIPS performance, eligible clinicians will receive positive or negative payment adjustments of 5 percent in CY 2020, rising to a maximum of 9 percent in CY 2022 and beyond.

Eligible Clinicians and Group Reporting. As required by MACRA, the CY 2020 MIPS will continue to apply to physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists that are billing under the Medicare PFS. Eligible clinicians may continue to 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).

Several categories of clinicians are exempt from the MIPS, including qualifying APM participants, partially qualifying APM participants, clinicians in their first year of accepting Medicare patients, and clinicians who fall below a low-volume threshold during the performance period (described below).

Low-volume Threshold. In response to stakeholder concerns about the readiness of small and rural practices to meet MIPS requirements, CMS finalized its proposal to substantially increase the low-volume threshold for CY 2018 reporting. Specifically, the new threshold would exclude from MIPS participation clinicians billing $90,000 or less of Medicare charges, or that see 200 or fewer Medicare patients. CMS estimates this proposal would result in the exclusion of more than 540,000 clinicians from the MIPS in 2018.

Facility-based Measurement. MACRA gives CMS the option to allow facility-based clinicians to be scored on the MIPS quality and cost categories using measures and results from CMS's quality reporting and pay-for-performance programs for hospitals and other facilities. The agency had proposed to make a facility-based measurement option available for the CY 2018 performance period. **However, due to concerns about operational readiness and a desire to further educate the field about the option, CMS will instead make the option available for the CY 2019 performance period**. **While we do not believe the delay is necessary, the AHA applauds CMS for responding to our longstanding request to develop a facility-based measurement option for the MIPS.**

In addition, CMS finalizes a number of policies related to facility-based measurement. The option will be available only to facility-based clinicians that have at least 75 percent of their covered professional services provided in the inpatient hospital or emergency department settings, as identified by place of service (POS) codes 21 (for inpatient hospitals) and 23 (for emergency departments). Group practices using the option must have at least 75 percent of their clinicians meet the *individual* definition of facility-based. CMS states it intends to provide reports that inform clinicians and groups whether they qualify as facility-based.

Those clinicians using facility-based measurement will have their MIPS quality and cost scores tied to their hospital's CMS value-based purchasing (VBP) program

performance. That is, CMS will convert a hospital's total performance score in the hospital VBP program into scores for the MIPS quality and cost categories. Clinicians and groups will be attributed to the hospital where they provide services to the most Medicare beneficiaries.

Performance Period and Data Reporting Mechanisms. CMS will use CY 2018 as the performance period for CY 2020 payment adjustments under the MIPS. CMS will require a full-year of data for the quality and cost categories, but only a 90-day reporting period for both the improvement activity and ACI categories. CY 2018 performance data must be submitted to the agency by March 31, 2019.

CMS will continue to provide multiple options for submitting data, including registries, EHR reporting, Medicare claims-based reporting and attestation. CMS will continue to require the selection of one submission mechanism for each MIPS performance category for CY 2018 reporting. However, starting in CY 2019, clinicians and groups may use more than one submission mechanism for each MIPS performance category

Performance Categories and Requirements. CMS adopts the measures, activities and data submission standards for each of the MIPS categories. In addition, CMS finalizes the weights it will assign to each category in determining a MIPS Final Score, which will be used in determining payment adjustments in 2020. **Against the AHA's recommendation, CMS will assign a weight of 10 percent to the cost category for CY 2020, rather than the zero percent weight it had proposed.** The agency believes this approach will smooth the transition to the higher cost category weight of 30 percent that the MACRA statute requires starting in CY 2021.

CMS's final policies and weights for each category for CY 2020 are briefly summarized below.

- Quality (50 percent of MIPS Final Score). CMS will retain its requirement that clinicians and groups report at least six measures. Among the six measures, at least one must be an outcome measure. Alternatively, clinicians can choose to report all of the measures from a particular specialty measure set, even if that set includes fewer than six measures.

- Improvement Activities (15 percent of MIPS Final Score). MACRA requires that CMS establish a MIPS performance category that rewards participation in activities that improve clinical practice, such as care coordination, beneficiary engagement and patient safety. CMS finalizes updates to the list of activities from which clinicians can select to fulfill this category, and each activity is assigned a weight towards the overall score. There are no significant changes to how improvement activities are scored.

- Cost (10 percent of MIPS Final Score). CMS will score clinicians and groups on two measures reflecting overall cost – Medicare spending per beneficiary, and total cost per capita – as well as "episode-based" measures reflecting costs for specific treatments and conditions. The episode-based measures will be proposed in future rulemaking.

- Advancing Care Information (25 Percent of MIPS Final Score). CMS finalizes that eligible clinicians may use EHRs certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two for the CY 2018 performance period. Eligible clinicians will have the option to report the ACI "Transition Category" objectives and measures, derived from meaningful use modified stage 2 objectives and measures, for the CY 2018 performance period. CMS finalizes a Dec. 31, 2017 deadline for significant hardship exception requested for the CY 2017 performance period. CMS also finalizes a 90-day reporting period for the ACI category in CY 2019. The AHA appreciates the much-needed relief provided by extending the use of modified stage 2 meaningful use requirements through 2018 and expanding opportunities to receive hardship exceptions and exemptions.

Virtual Groups. MACRA permits individual clinicians and group practices of 10 or fewer clinicians to form "virtual groups" to participate jointly in the MIPS. CMS will implement a virtual group participation option beginning with the 2018 reporting period. To participate in a virtual group, CMS will require a formal written agreement among all members of the virtual group. Virtual groups who wish to use the option for the CY 2018 reporting period have until Dec. 31, 2017 to elect it. CMS has made technical assistance available to clinicians considering this option, including a Virtual Group Toolkit outlining the election process in more detail.

Interim Final Rule for Extreme and Uncontrollable Circumstances. To provide relief to clinicians in areas affected by Hurricanes Harvey, Irma and Maria, CMS issues an interim final rule that will not require clinicians to apply for an exemption from the MIPS for the CY 2017 reporting period. Specifically, for clinicians in the areas affected by the hurricanes, CMS will automatically assign a weight of zero percent to the quality, improvement activities, and advancing care information performance categories of the MIPS. This would result in a MIPS final score equal to the performance threshold, thereby holding clinicians harmless from MIPS payment adjustments in CY 2019. Clinicians in the counties defined as major disaster areas by the Federal Emergency Management Agency would be eligible for this policy, including all counties in Florida and Georgia, all municipios in Puerto Rico, selected counties in Texas and South Carolina, selected parishes in Louisiana, and all of the U.S. Virgin Islands. The most current list of impacted areas is available on CMS's website.

Clinicians in the affected areas still have the option of submitting MIPS data by the deadline, in which case all established scoring policies for the MIPS would apply. In other words, clinicians have the option of overriding the zero percent payment adjustment and participating in the MIPS if they chose to do so.

INCENTIVES FOR PARTICIPANTS IN ALTERNATIVE PAYMENT MODELS (APMS)

MACRA provides incentives for clinicians who participate in advanced APMs. These include a bonus payment of 5 percent of payments for professional services in 2019 through 2024; exemption from MIPS reporting requirements and potential payment cuts; and higher base payment updates beginning in 2026. In 2016, CMS finalized the initial criteria by which physicians and other professionals will qualify for these incentives. In this rule, CMS adopts modifications to certain existing policies and establishes new policies related to advanced APMs.

Comprehensive Primary Care Plus (CPC+). In 2016, CMS finalized a policy that limited advanced APM "credit" for participation in the CPC+ program to medical homes owned and operated by organizations with fewer than 50 clinicians, beginning in 2018. As urged by the AHA, CMS will exempt from this policy organizations that enrolled in the first round of CPC+, which began Jan. 1, 2017. **The AHA believes this proposal will allow more clinicians in hospital-affiliated CPC+ practices to receive credit for participation in advanced APMs.**

Nominal Financial Risk. In 2016, CMS established two standards for calculating the amount of financial risk an entity must accept for a model to qualify as an advanced APM. Specifically, an APM entity that demonstrates annual losses must potentially owe a total amount equal to either:

- 8 percent of the average estimated total Medicare Parts A and B revenues of the APM entity (the "revenue standard"), or
- 3 percent of the expected expenditures (i.e., the benchmark or target price set under the model) for which the APM entity is responsible (the "benchmark-based standard").

CMS had previously made the revenue standard option only available for performance years 2017 and 2018, while the benchmark-based standard is applicable for all performance years. However, the agency finalized its proposal to extend the revenue standard to performance years 2019 and 2020.

Additionally, CMS will limit planned increases in the amount of risk required for medical homes. To qualify as an advanced APM under a medical home model, CMS will require that the amount the APM entity potentially forgoes or owes CMS must be at least the following percent of the entity's total Medicare Parts A and B revenue:

- 2018 – 2.5 percent (reduced from 3 percent)
- 2019 – 3 percent (reduced from 4 percent)
- 2020 – 4 percent (reduced from 5 percent)
- 2021 and beyond – 5 percent

Other Payer Advanced APMs. MACRA allows clinicians to earn advanced APM incentives only for participation in Medicare advanced APMs in 2017 and 2018. Beginning in 2019, clinicians will be able to earn incentives for combined participation in Medicare advanced APMs and "other payer advanced APMs" with non-Medicare payers (e.g., Medicare Advantage, Medicaid and private payers). In 2016, CMS finalized the criteria for determining whether a payment arrangement is an advanced APM. The agency now adopts a process for payers, entities participating in APMs or clinicians to request such a determination. CMS also adopts requirements for the information that must be submitted by payers and clinicians to make other payer advanced APM determinations and evaluate clinician participation in these arrangements.

NEXT STEPS

While the rule is final, CMS requests comment on the policies it has adopted, along with several specific areas of future policy development. For example, the agency is interested in additional feedback on how to inform clinicians of their eligibility for the facility-based measurement option, and the process for opting in or out of the option. The agency also is accepting comments on the interim final rule providing relief to clinicians in Hurricane-affected areas. The agency will accept comments through Jan. 1.

Watch for more detailed AHA analysis of the final rule in the coming weeks. Additional resources on the MACRA QPP can be found at www.aha.org/MACRA.

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