

Slow but Steady: CMS Proposes to Simplify and Slow Down the Quality Payment Program Rollout

June 23, 2017

On Tuesday, June 20, the Centers for Medicare & Medicaid Services (CMS) released a Proposed Rule¹ to continue the rollout of the Quality Payment Program (QPP), an initiative to adjust Medicare payments to eligible clinicians based on the quality and cost of the care they deliver. The Proposed Rule sets the ground rules for the second year of the QPP, which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to extend and replace Medicare's earlier value-based physician payment programs. CMS proposes to keep the basic structure of the QPP – requiring clinicians to choose between payment adjustments based on quality and cost of care or participation in an alternative payment model – while making adjustments intended to simplify the program, especially for small, independent, and rural practices.

The due date for comments on the Proposed Rule is **August 21, 2017**. If you have questions about the Proposed Rule or would like assistance drafting comments, please do not hesitate to contact any of the Hogan Lovells lawyers listed on this alert.

Background

The QPP is part of an industry-wide movement to shift from paying providers based on the volume of services to paying based on quality and cost-efficiency of care. Despite the considerable uncertainty in Congress regarding the future of health reform, quality-based payment initiatives such as the QPP have received broad bipartisan support, and we expect such initiatives to continue to expand and deepen their impact on provider payment.

Fundamentally, the QPP aims to incentivize eligible clinicians to deliver higher-quality care at a lower cost. In 2015, MACRA repealed the Medicare sustainable growth rate and set in motion a transition of physician payment to reward value and outcomes in one of two ways: (1) mandatory participation (with certain exceptions) in the Merit-Based Incentive Payment System (MIPS), under which eligible clinicians receive a percentage adjustment to Medicare payments based on a four-part score designed to measure quality, cost, and improvement of care, as well as effective use of health care information; or (2) optional participation in an Advanced Alternative Payment Model (APM), under which eligible clinicians who successfully participate in an APM are exempt from MIPS and receive a payment bonus. These two systems together make up the QPP. The Proposed Rule includes modifications to the QPP that simplify the program for small, independent, and rural practices; change the way clinician

¹ CMS, CY 2018 Updates to the Quality Payment Program, (June 20, 2017), <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-13010.pdf>.

performance is measured in the four MIPS performance categories; and open APM participation to other payer arrangements.

Proposed Changes to MIPS

Increasing MIPS Threshold

- Under the Proposed Rule, clinicians would not be subject to MIPS adjustments if they have \$90,000 or less in Medicare Part B allowed charges or see 200 or fewer Medicare Part B beneficiaries each year.² These thresholds were originally set at \$30,000 and 100 beneficiaries.³
- CMS estimates that these increased thresholds will exclude approximately 134,000 additional clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible under the old threshold.⁴
- CMS is also soliciting comments on whether to add a third low-volume threshold for “items and services.”⁵ CMS suggests it could define an items and services threshold to impose a minimum number of patient encounters or procedures furnished to Part B beneficiaries.⁶ CMS also solicits comments on other alternative methods to define an items and services threshold.⁷
- Starting with 2019 MIPS performance period, CMS proposes to allow clinicians the ability to voluntarily opt in to MIPS if the clinician would otherwise be exempted from the MIPS adjustments.⁸

Virtual Groups

- Beginning in the 2018 plan year, CMS proposes to add virtual groups as a participation option for MIPS.
- CMS proposes to define a virtual group as a combination of two or more taxpayer identification numbers (TINs), made up of either solo practitioners or groups with 10 or fewer clinicians.⁹ CMS proposes that a virtual group may include clinicians excluded from MIPS,¹⁰ but the group as whole must meet the MIPS low-volume thresholds.¹¹ For purposes of the MIPS payment adjustment, the adjustment would apply only to clinicians in the virtual group who meet the definition of a MIPS eligible clinician.¹²
- CMS proposes to require clinicians who elect to formulate a virtual group to do so by December 1 of the calendar year preceding the applicable performance period.¹³

² *Id.* at 54-55.

³ *Id.*

⁴ *Id.* at 55.

⁵ *Id.* at 59.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.* at 60.

⁹ *Id.* at 67.

¹⁰ *Id.* at 66

¹¹ *Id.* at 76.

¹² *Id.* at 67.

¹³ *Id.* at 74.

Calculation of MIPS Payment Adjustment

Payment Adjustment

- CMS proposes to continue to base payment adjustments in a given year on performance two years earlier, so a clinician's performance in 2018 would result in adjustments to Medicare payment in 2020.¹⁴ (As in 2017, payment adjustments in 2018 will continue to be based on performance under the legacy systems like the Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier (VBPM).)
- For payment year 2020, CMS proposes to use a performance threshold set at 15 points, compared to three points for payment year 2019, meaning that any clinician or group must earn a MIPS score of at least 15 points to avoid an automatic payment cut of up to 5%.¹⁵ Eligible clinicians with a composite score above the 15 point threshold would receive a positive adjustment (payment bonus) on a linear sliding scale. CMS solicits comments about whether the payment threshold should be higher or lower.¹⁶

New Facility-Based Category

- CMS proposes to implement a new voluntary facility-based category modeled on the hospital value-based purchasing program.¹⁷
- CMS proposes the facility-based category will only be available to clinicians who furnish at least 75% of their covered professional services in inpatient hospital settings or emergency rooms.¹⁸
- For clinicians who choose to be scored using the facility-based option, the facility's total performance score (based on a methodology spelled out in the Proposed Rule) would be converted into a MIPS quality performance score and cost performance score for each clinician associated with the facility.¹⁹

Changed Weight to Quality Performance Category

- CMS previously finalized that the quality performance category would comprise 60% of the final score for payment year 2019, 50% in payment year 2020, and 30% in future years. In the Proposed Rule, CMS proposes to increase the weight to the quality performance category in the final score for payment year 2020 to 60% and keep it at 30% in future years.²⁰

Changed Weight to Cost Category

- CMS previously finalized that the cost performance category would comprise 0% of the final score for payment year 2019, 10% in payment year 2020, and, as required by statute), 30% in future years. In the Proposed Rule, CMS proposes to reduce the cost performance category to 0% of the final score for payment year 2020, but solicits comments on keeping the weight at 10% for that year.²¹ The Proposed Rule would still increase the weight of the cost score to 30% in payment years after 2020.

¹⁴ *Id.* at 90.

¹⁵ *Id.* at 448.

¹⁶ *Id.*

¹⁷ *Id.* at 375-76.

¹⁸ *Id.* at 377-78.

¹⁹ *Id.* at 389.

²⁰ *Id.* at 100.

²¹ *Id.* at 136-37.

Changes to Improvement Activities Scoring

- The Proposed Rule would not make significant changes to the scoring of improvement activities, which would continue to be weighted at 15% of the final score, though CMS does propose additional activities to report and changes to certain existing activities.

Changes to Advancing Care Information Scoring

- MIPS eligible clinicians would be allowed to use either 2014 or 2015 edition certified electronic health record (EHR) technology (CEHRT) for payment year 2020, although they would receive a bonus for using the 2015 edition.
- The Proposed Rule also would add more improvement activities related to the use of CEHRT to the list of activities eligible for an advancing care information bonus.
- The Proposed Rule would reweight the advancing care information score to 0% of the final score for (1) eligible clinicians who practice primarily in an Ambulatory Surgical Center (ASC) (retroactive to the initial 2019 payment year) and (2) eligible clinicians whose EHR systems are decertified (only for the 2020 payment year and beyond).²²

New Complex Patient Bonus

- For payment year 2020, CMS proposes to add a complex patient bonus of up to three points to an eligible clinician's final score.²³
- CMS proposes the payment bonus would be calculated using the hierarchical conditions category risk score, which uses demographic information (age, sex, Medicaid dual eligibility, disability status) and beneficiaries' diagnoses to predict Medicare expenditures.²⁴
- CMS also seeks comment on an alternative complex patient bonus methodology based on the ratio of Medicare patients who have Medicaid dual eligibility.²⁵

New Small Practice Bonus

- For MIPS payment year 2020, CMS proposes to add a small practice bonus of five points to the MIPS final score for practices that consist of 15 or fewer clinicians.²⁶
- The bonus payment is meant to acknowledge the challenges small practices face in participating in MIPS and to help small practices meet the performance thresholds.²⁷
- Although CMS does not propose to do so for payment year 2020, the agency also seeks comments for whether it should include a bonus in future years for clinicians that practice in a rural area.²⁸

Proposed Changes to Advanced APMs

Adjustments to Criteria for Qualification as an Advanced APM

- As noted above, clinicians otherwise subject to MIPS may avoid any MIPS adjustment and instead earn a 5% payment bonus by successfully participating in a qualifying Advanced APM.
- CMS proposes certain changes to the criteria for an APM to qualify as an Advanced APM. To qualify, the APM must (1) require its participants to use CEHRT, (2) pay its participants based in

²² *Id.* at 189.

²³ *Id.* at 416-17.

²⁴ *Id.* at 409.

²⁵ *Id.* at 418.

²⁶ *Id.* at 422-23.

²⁷ *Id.* at 423.

²⁸ *Id.* at 424.

- part on quality measures similar to the MIPS quality measures, and (3) either be a CMS-approved medical home or require participants to bear more than a nominal risk of losses.
- CMS proposes to retain for an additional two years the basic standard for whether an APM requires participants to bear more than a nominal risk (the 8% revenue-based standard).²⁹ CMS also proposes adjustments to the criteria necessary to be a CMS-approved medical home, including making it easier for participants in the Comprehensive Primary Care Plus Model (CPC+) to qualify as a medical home.³⁰

All-Payer Combination Option

- MACRA requires that, beginning in payment year 2021, eligible clinicians may become qualifying Advanced APM participants through an All-Payer Combination Option. This would allow eligible clinicians to become qualifying participants through successful participation in both a Medicare Advanced APM and an Advanced APM sponsored by a non-CMS payer, such as a state or a Medicare Advantage organization.³¹ (For the time being, an eligible clinician cannot qualify as an Advanced APM participant by participating only in an APM sponsored by an entity other than CMS.)
- The Proposed Rule takes the first steps toward implementing this alternative path to qualifying as a successful participant in an Advanced APM and avoiding any MIPS payment adjustment. Among other proposals, CMS proposes:
 - o To establish a different performance period for eligible clinicians seeking to qualify for Advanced APM participation through the All-Payer Combination Option.³²
 - o To determine whether a clinician is a qualifying participant under the All-Payer Combination Option at the clinician level, rather than the APM level.³³
 - o To establish processes by which payers, APM entities, or eligible clinicians would be able to submit payment arrangements for approval as Advanced APMs, beginning in performance year 2019 for payment arrangements authorized under Medicaid, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models, followed by other payer types in future years.³⁴

Special thanks to Laura McDonald for her contribution to this alert.

²⁹ *Id.* at 533.

³⁰ *Id.* at 536.

³¹ *Id.* at 546.

³² *Id.* at 613.

³³ *Id.* at 617.

³⁴ *Id.* at 561; 570.

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