PUBLICATION

QPP Year 3 – CMS Continues Implementation with Proposed Changes

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On July 12, 2018, CMS issued proposed revisions to Year 3 of the Quality Payment Program (QPP) in the rule entitled Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program. This proposed rule is meant to incorporate stakeholder feedback received to clarify the options for participation as well as to reduce clinician burden for participating in the QPP via the Merit-based Incentive Payment System (MIPS) or through Advanced Alternative Payment Models (APMs).

The first two performance years of the QPP were considered transition years and CMS continues its efforts to assist clinicians navigate the QPP world as we prepare for clinicians to realize the impact of their efforts, or lack thereof, when the first payment adjustments are implemented in CY 2019 based on participation in the first year of the QPP. (For discussions of the previous two years of the QPP, please refer here: Year 1 and Year 2.)

With the enactment of the Bipartisan Budget Act of 2018, CMS was afforded some additional flexibility in implementing the QPP. The changes resulting from this legislative change include: repeal of the application of the MIPS payment adjustment to Part B drugs – MIPS payment adjustments will now apply only to covered professional services; MIPS eligibility with respect to the low-volume threshold will be based on allowed charges for covered professional services and the number of covered professional services provided; the implementation of the cost performance category of MIPS was slowed down so that the category "shall be not less than 10 percent and not more than 30 percent of the MIPS score" through 2023 as CMS works to develop applicable cost measures for the program; and the transition of full implementation of the MIPS program as the performance threshold will increase during the third through fifth years of the program. CMS has incorporated these changes into the proposed rule and reported that it has tried to focus on simplification and burden reduction where possible while still implementing the program as Congress established it.

MIPS Proposals for Year 3

The proposed rule includes extensive discussion of the proposals put forth in this Proposed Rule. Some of the most substantial proposals include:

- Continuing to identify low-value or low-priority measures to be recommended for removal. CMS has committed to implementing the Meaningful Measures Initiative to allow the program to focus on meaningful quality outcomes for patients as well as working towards streamlining reporting requirements for clinicians.
- Expanding the definition of MIPS eligible clinicians to include additional clinician types, such as physical therapists, occupational therapists, clinical social workers, and clinical psychologists.
- Keeping the parameters of the low-volume threshold consistent with the values established for Performance Year 2 ($90,000 or less in Part B services or 200 or fewer Part B beneficiaries with the eligibility determined covered professional services, rather than all Part B allowed charges and services furnished to patients) and adding an additional element to the determination. CMS has proposed to also consider the number of covered professional services provided by the clinician, setting the low-volume threshold at 200 or fewer covered professional services to Part B enrolled individuals.

- Creating an opt-in policy beginning in the 2021 MIPS payment year that permits individuals or groups who would otherwise be excluded from MIPS to opt-in if they meet or exceed one or two, but not all of the low-volume threshold criteria. The opt-in policy is not available to those individuals or groups who do not exceed any of the low-volume threshold criteria.
- Restructuring the Promoting Interoperability (formerly Advancing Care Information) performance category to include a smaller set of objectives and measures for clinicians and scoring based on performance within these objectives.
- Supporting small practices with continued flexibilities including: the small practice bonus which will be included in the quality performance category score rather than as a standalone bonus; awarding a three point bonus to small practices for quality measures that do not meet data completeness requirements; and consolidating the low-volume threshold determination periods with the determination period identifying small practices.
- Retaining performance periods for the cost and quality performance categories that consist of the full calendar year – for purposes of the 2022 MIPS payment year and future years, the performance period for the quality and cost performance categories would be the full calendar year (January 1 – December 31) that occurs two years prior to the applicable MIPS payment year. For the 2022 MIPS payment year, the performance period would be January 1, 2020 – December 31, 2020. For the improvement activities and promoting interoperability performance categories the performance period would be a minimum of a continuous 90-day period within the calendar year that occurs two years prior to the applicable MIPS payment year, up to and including the full calendar year.
- Updating terminology used within MIPS to identify the ways clinicians and vendors participate in the program. The newly proposed terms include collection type, submitter type, and submission type, and CMS has requested feedback on these new terms.

Advanced APM Proposals for Year 3

In an effort to increase participation in Advanced APMs, these proposals include:

- Focusing again on the use of CEHRT and updating the criteria for Advanced APMs to include a requirement that at least 75 percent of the eligible clinicians in an APM Entity use CEHRT.
- Continuing the financial risk bearing of monetary losses required and maintaining the generally applicable revenue-based nominal amount standard at eight percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for QP Performance Periods 2021 – 2024.
- Increasing flexibility for non-Medicare payers to participate in the QPP via the All-Payer Combination Option and Other Payer Advanced APMs. This includes proposals to streamline the process for payers and eligible clinicians providing information regarding the duration of agreements related to initial Other Payer Advanced APM submissions; and allowing QP determinations at the TIN level as well as at the APM entity level and the individual level, when all clinicians who bill under the TIN participate as a single APM Entity.

Notes to Stakeholders

With proposals to expand the scope of the program to additional categories of clinicians and the financial impact increasing each year it is important to take note of the additional clarification from CMS and ensure clinicians are implementing the necessary components of the QPP via MIPS or an Advanced APM to avoid negative payment impacts. For those encountering challenges as they work toward implementing a successful MIPS participation plan or becoming part of an Advanced APM, taking the opportunity to comment to CMS regarding those challenges might provide the guidance or clarification needed. The comment period for the Proposed Rule closes on September 10, 2018 and the final determination for Year 3 will be published with the Physician Fee Schedule Final Rule.