ENDOCRINE SOCIETY
Hormone Science to Health

# Proposed Updates to Year 3 of the Quality Payment Program

On July 11, 2018, the Center for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) for 2019, which for the first time included proposals for year 3 of the Quality Payment Program (QPP).

The rule in its entirety and the addenda can be found here. Comments on the QPP-related proposals, as well as the rule's payment provisions, must be submitted by September 10, 2018. The final MPFS is typically published in early November with most of the provisions being effective January 1, 2019 unless stated otherwise.

CMS proposes changes to the QPP that reflect feedback received from stakeholders on the first two years of the program. The proposed changes focus on reducing clinician burden, promoting interoperability, implementing the Meaningful Measures Initiative, supporting small and rural practices, empowering patients through the Patients Over Paperwork Initiative, and promoting price transparency. The agency is continuing its incremental approach to the implementation of MIPS by proposing to modestly increase the number of clinicians included in the program and increase both the weight of the cost component and the threshold score to avoid a penalty.

## MERIT-BASED INCENTIVE PAYMENT SYSTEM

Some of the key proposed changes to MIPS include the following:

- The agency proposes to reweight the performance categories that determine a clinician's threshold score.

| Category | 2018 Performance Year | Proposed 2019 Performance Year |
|---|---|---|
| Quality | 50% | 45% |
| Cost | 10% | 15% |
| Promoting Interoperability (formerly Advancing Care Information) | 25% | 25% |
| Improvement Activities | 15% | 15% |

- Inclusion of physical therapists, occupational therapists, clinical social workers, and clinical psychologists as MIPS eligible clinicians.
- Addition of covered professional services as a new low-volume threshold determination criteria.
- Clinicians or groups will be able to opt-in to MIPS if they meet or exceed one or two, but not all of the low-volume threshold criteria;
- Addition of new episode-based measures to the Cost Performance category;

2055 L Street NW
Suite 600
Washington, DC
20036

T. 202.971.3636
F. 202.736.9705

endocrine.org

- Creation of an option for facility-based scoring for the Quality and Cost Performance measures for certain facility-based clinicians

*MIPS Determination Period*

Beginning with the 2021 MIPS payment year/2019 performance year, CMS proposes to consolidate the determination periods to identify whether a clinician or practice qualifies for the following special statuses: low-volume threshold, non-patient facing physician, small practice, and hospital-based physician. The new consolidated determination periods will be October 1, 2017 to September 30, 2018 and October 1, 2018 to September 30, 2019.

CMS is proposing to retain the complex patient bonus, but is proposing changes to its eligibility determination period. The agency proposes that the determination period run from October 1 of the calendar preceding the applicable performance period and ending on September 30 of the calendar year in which the performance period occurs.

*Part B Services Subject to MIPS Payment Adjustments*

As outlined in the BBA, CMS is proposing that beginning with the 2019 MIPS payment year the payment adjustments will apply only to Part B payments for covered professional services furnished during the performance periods, not to Part B drugs.

*Low-Volume Threshold Changes*

Starting in the 2021 payment year, CMS proposes adding a third category to the low-volume threshold that assesses the minimum number of covered professional services furnished to Part B-enrolled individuals by the clinician. ***CMS requests comments on all three components of the low-volume threshold criteria.***

| **Low-Volume Threshold Qualifications for Exemption** | |
|---|---|
| **CY 2018 Final Policy** | **CY 2019 Proposed Policy** |
| ≤ $90,000 in Part B allowed charges, OR<br>≤ 200 Part B beneficiaries | ≤ $90,000 in Part B allowed charges, OR<br>≤ 200 Part B beneficiaries, OR<br>≤ 200 professional services covered |

Beginning with the 2021 payment year, if an eligible clinician, group or APM Entity group in a MIPS APM meets or exceeds at least one, but not all three, of the low-volume threshold determinations, then the eligible clinician or group may choose to opt-in to MIPS. Those choosing to opt-in must make an affirmative election to participate. Additionally, beginning with the 2021 payment year, CMS proposes that a virtual group election would constitute a low-volume threshold opt-in for any prospective member of the virtual group that exceeds at least one, but not all, of the low-volume threshold criteria.

*Virtual Group Eligibility Determinations*

The virtual group election will remain the same as the previous year with the following proposed change: physicians can inquire about their group's taxpayer identification numbers (TINs) size prior to making an election.

*Performance Threshold*

CMS proposes to increase the performance threshold from 15/100 points to 30/100 points. ***CMS seeks comments on the change to the threshold, and whether the threshold should be at a higher or lower number.*** There is also a proposed increase to the exceptional performance threshold from 70/100 points to 80/100 points. A performance threshold of 80 requires a clinician to perform well on at least two performance categories. In addition, 80 points is at a high enough level that clinicians must submit data for the Quality Performance category to achieve this category.

*Small Practice Bonus*

CMS will continue to provide a small practice bonus to adjust for the unique challenges small practices experience related to financial and other resources. The agency is proposing to add the small practice bonus to the Quality Performance category, rather than in the MIPS final score calculation. The bonus will add 3 points in the numerator of the Quality Performance category for clinicians in small practices who submit data on at least one quality measure.

*Facility-Based Measures Scoring Option for the 2021 MIPS Payment Year for the Quality and Cost Performance Categories*

In 2019, CMS will implement its facility-based scoring, where facility-based clinicians can use their facility's Hospital Value-Based Purchasing (VBP) program score in lieu of their Quality and Cost Performance Category scores. These clinicians must still report data for the Improvement Activities and Promoting Interoperability categories.

CMS will automatically apply the facility-based measurement standard to MIPS eligible clinicians and groups who are eligible for facility-based measurements and who would benefit from having a higher combined quality and cost performance score. There are no submission requirements for individual clinicians in facility-based measurements.

MIPS Scores would be established by determining the percentile performance of the facility in the VBP purchasing program for the specified year and awarding Quality and Cost Performance Category scores associated with that same percentile performance in those two MIPS performance categories.

- *Facility-Based Measurement by Individual Clinicians*

For individuals to be eligible for facility-based measurements, 75 percent or more of their covered professional services in inpatient hospital, on-campus outpatient hospital, as identified by POS code 22, or an emergency room, must be established based on claims for a period prior to the performance period. The clinician must have at least a single service billed with the POS code used for the inpatient hospital or emergency room.

- *Facility-Based Measurement by Group*

A facility-based group is one in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurements as individuals.

- *Facility Attribution for Facility-Based Measurement*

A facility-based clinician is attributed to the hospital at which they provide the most Medicare beneficiaries during the year claims are drawn. If an equal number of Medicare beneficiaries are treated at more than one facility, CMS will use the VBP score for the highest-scoring facility. A facility-based group is attributed to the hospital at which the plurality of its facility-based clinicians are attributed.

- *Expansion of Facility-Based Measurements to Use in Other Settings*

CMS is considering ways to expand facility-based measurements into post-acute care (PAC) and the end-stage renal disease (ESRD) setting. ***For PAC, CMS seeks comment on how to attribute the quality and cost of care for patients in PAC settings to clinicians, and how a hospital's VBP score could work for PAC given the number and variation of PAC settings and clinicians. For ESRD, CMS seeks comment on how to integrate the ESRD Quality Incentive Program (QIP) into CMS' current approach but recognizes that the structure of ESRD QIP is different than the Hospital VBP Program.*** CMS also recognizes that MIPS eligible clinicians' roles in dialysis centers differ from their roles in hospitals. ***CMS seeks comment on the extent to which the quality measures of dialysis centers reflect clinician performance, and whether CMS might be able to attribute the performance of a specific facility to an individual clinician.***

**Quality Performance Category: 45 percent**

*Meaningful Measures Initiative*

CMS is proposing the following updates: 1) adding 10 new MIPS quality measures that include 4 patient reported outcome measures, 7 high priority measures; and 2) removing 36 measures immediately; and 3) removing 52 measures using the more gradual process finalized in the 2018 rulemaking cycle. The agency is proposing that a high-priority measure include outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related quality measure.

Due to the immense impact of the opioid epidemic across the U.S., CMS believes it is imperative to promote the measurement of opioid use and overuse, risks, monitoring, and education through quality reporting. Therefore, CMS proposes to amend the high priority measure definition to include quality measures that related to opioids. Beginning with the 2021 MIPS payment year, CMS proposes to define a high priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related quality measure. Outcome measures would include intermediate-outcome and patient-reported outcome measures. ***CMS is specifically asking for feedback on whether they should solely focus on opioid overuse, and for suggestions on what other aspects of opioids should be measured.***

The following changes to the measures set are of interest:

**Measures proposed for inclusion:**

- Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

**Measures proposed for removal in Payment Year 2021:**

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Comprehensive Diabetes Care: Foot Exam

*Quality Data Submission Criteria*

Individual eligible clinicians would be able to submit a single measure via multiple collection types and be scored on the data submission with the greatest number of measure achievement points. Groups and virtual groups will be able to submit data multiple ways; however, the CMS Web Interface cannot be scored with other collection types other than the CMS approved survey vendor measure and/or administrative claims measures.

*Removal of Process Measures*

CMS proposes a process to remove non-high priority process measures. This would be done incrementally, since nearly 94 percent of specialty sets would be impacted. Beginning with the 2019 performance period, the agency proposes to incrementally remove process measures where prior to removal, considerations will be given to: whether the removal of the process measure impacts the number of measures available for a specific specialty, whether the measure addresses a priority area highlighted in the Measure Development Plan, whether the measure promotes positive outcomes in patients, considerations and evaluations of the measure's performance data, whether the measure is designated as high priority or not, and whether the measure has reached a topped out status within the 98th to 100th percentile range.

*Measures Impacted by Clinical Guideline Changes*

In the instance where clinical guideline changes impact measures, the measure will be given a score of 0 and the Quality Performance denominator score would be reduced by 10.

*Bonus Points*

CMS is proposing to stop awarding bonus points to CMS Web Interface reporters for reporting high-priority measures, but would continue the high priority bonus for all other reporting types. Also, the agency proposes to continue to assign bonus points for end-to-end reporting for the 2021 payment year to incentive reporting through electronic means.

**Cost Performance Category: 15 percent**

CMS is proposing to change the weight of the cost performance category to 15 percent for the 2021 payment year. They are only proposing this modest increase in category weight because the agency recognizes that it is still early in the development process of these measures and that clinicians do not have the level of familiarity or understanding of cost measures that they do of comparable quality measures. CMS expects to increase the weight by 5 percentage points each year.

CMS is proposing to add 8 episode-based measures in addition to two existing cost measures: total per capita cost and Medicare spending per beneficiary. The new episode-based cost measures include:

- Elective Outpatient Percutaneous Coronary Intervention
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens Implantation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction with Percutaneous Coronary Intervention.

All of the measures include both Part A and Part B costs and are calculated from administrative claims. The agency is also considering increasing the length of the cost category measurement period to two years in the future so more physicians would meet minimum case thresholds to be counted in at least one cost measure.

**Improvement Activities Performance Category: 15 percent**

CMS does not proposes no changes to the 15% weight for this category.

*Proposed New Criteria*

CMS is seeking comment on proposed new criteria for improvement activities, specifically a criterion around the opioid epidemic and other public health emergencies. The agency proposes to adopt a criterion entitled "Include a public health emergency as determined by the Secretary" to the criteria for nominating new improvement activities beginning with the CY 2019 performance period and future years. New activities will not be required to meet this criterion, but it will be an additional option for stakeholders submitting nominations for new activities.

*Weighting of Improvement Activities*

CMS intends to address improvement activity weighting in next year's rulemaking but ***is seeking comments on the need for additional transparency and guidance on weighting.***

*Timeframe for the Annual Call for Activities*

For the timeframe for the annual call for activities, improvement activity nominations received in Year 3 will be reviewed and considered for possible implementation in Year 5 of the program. The submission timeframe/due dates for nominations would be from February 1st through June 30th, providing approximately 4 additional months to submit nominations.

**Promoting Interoperability Performance Category: 25 percent**

CMS has changed the name of the Advancing Care Information Performance Category to Promoting Interoperability. The weight to the final score will remain the same as in year 2 of MIPS: 25 percent.

*Certification Requirements*

Beginning with the 2019 performance period, CMS proposes that all clinicians must use 2015 Certified Electronic Health Record Technology (CEHRT). The agency hopes moving to the 2015 Edition will reduce burden by better streamlining workflows and utilizing more comprehensive functions to meet patient safety goals and improve care coordination.

*Proposed Scoring Methodology*

Based on feedback received from stakeholders, CMS is proposing a new methodology for the 2019 performance period that moves away from the base, performance and bonus score methodology that is currently used. CMS believes this will provide a simpler, more flexible, less burdensome structure.

Under the proposed scoring methodology, MIPS eligible clinicians would be required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual-measure level. The smaller set of objectives includes: 1) e-Prescribing; 2) Health Information Exchange; 3) Provider to Patient Exchange; and 4) Public Health and Clinical Data Exchange. The scores for each of the individual measures would be added together to calculate the score of up to 100 possible points. If exclusions are claimed, the points for measured will be reallocated to other measures. If a clinician fails to report or claim an exclusion for a required measure, they would receive a total score of zero for the Promoting Interoperability category.

An alternative approach that is being considered would have the scoring occur at the objective level instead of the individual measure level, and MIPS eligible clinicians would be required to report on only one measure form each objective to earn and score for that objective. Instead of six required measures, the total Promoting Interoperability score would be based on only four measures, one from each objective. ***CMS is seeking comments on both the proposed scoring methodology and the alternative approach.***

Within the existing e-Prescribing objective, CMS proposes to add two new measures: Query of Prescription Drug Monitoring Program (PDMP); and Verify Opioid Treatment Agreement. Both of the measures would be optional for the MIPS performance period in 2019; however, clinicians may choose to report them and earn up to 5 additional bonus points for each measure. ***CMS is seeking comments on requiring these two measures starting in 2020.***

CMS is proposing to reweight the other measures accordingly in 2019:

| Objectives | Measures | Maximum Points |
|---|---|---|

| | | |
|---|---|---|
| e-Prescribing | e-Prescribing | 10 points |
| | Bonus in 2019: Query of PDMP | 5 point bonus |
| | Bonus in 2019: Verify Opioid Treatment Agreement | 5 point bonus |
| Health Information Exchange | Support Electronic Referral Loops by Sending Health Information | 20 points |
| | Support Electronic Referral Loops by Receiving and Incorporating Health Information | 20 points |
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information | 40 points |
| Public Health and Clinical Data Exchange | Choose two of the following:<br>Immunization Registry Reporting<br>Electronic Case Reporting<br>Public Health Registry Reporting<br>Clinical Data Registry Reporting<br>Syndromic Surveillance Reporting | 10 points |

In 2020, the Query of PDMP and Verify Opioid Treatment Agreement would be required. Additionally, e-Prescribing would be reduced from 10 to 5 points, making the total objective of e-Prescribing worth 15 points. The Provider to Patient Exchange objective would be reduced to 35 points in 2020.

***CMS seeks comment on whether these measures are weighted appropriately, or whether a different weight distribution such as equal distribution across all measures would be better suited for this proposed scoring methodology.***

**MIPS APMs**

In the 2019 performance period CMS anticipates that there will be up to six "Other MIPS APMs" in which they will use the APM scoring standard: the Oncology Care Model; Comprehensive ESRD Care Model; Comprehensive Primary Care Plus Model; the Bundled Payments for Care Improvement Advanced; Maryland Primary Care Program; and Independence at Home Demonstration.

**MEDICARE ADVANTAGE QUALIFYING PAYMENT ARRANGEMENT INCENTIVE (MAQI) DEMONSTRATION**

The MAQI Demonstration will allow participating clinicians to have the opportunity to be eligible for waivers that will exempt them from the MIPS reporting requirements and payment adjustments for a given year if they participate to a sufficient degree in qualifying payment arrangements with Medicare Advantage Organizations(MAOs) during the performance period of that year, without requiring them to be Qualifying APM Participants (QPs) or Partial QPs in Medicare fee-for-service, or to otherwise meet MIPS exclusion criteria.

The Demonstration will test whether:

- There is an increase in clinician participation in payment arrangements with MAOs that meet the criteria of Qualifying Payment Arrangements;
- Participating in Qualifying Payment Arrangements and Advanced APMs to the degree required to be eligible for the Demonstration Waiver incentivizes providers to transform their care delivery (assessed by interviews with participating clinicians);
- Whether there is a change in utilization patterns among participants in the Demonstration; and
- If there are changes in utilization, how those changes affect MA plan bids.

The first performance period will start in 2018 and will last for five years.

For detailed information including eligibility requirements, application process and other criteria, please see the resources from CMS:

- MAQI Demonstration Website
- Fact Sheet
- Frequently Asked Questions

**ADVANCED ALTERNATIVE PAYMENT MODELS**

In general, there are minor modification to the advanced Alternative Payment Models (APM) pathway in this year's proposed rule.

*CEHRT Use Threshold for Advanced APMs*
Of note, because CMS has prioritized interoperability, the agency is proposing to increase CEHRT use criterion threshold for Advanced APMs such that at least 75 percent of eligible clinicians in each APM Entity meet CEHRT requirements to document and communicate clinical care with patients and other health professionals. This is an increase from 50 percent in 2018 to the proposed 75 percent in 2019.

*MIPS Comparable Quality Measures*
CMS has previously established the Advanced APM criteria that the quality measures upon which an Advanced APM bases payment must be reliable, evidence-based and valid. CMS proposes to amend the Advanced APM quality criteria to state that at least one of the quality measures upon which an Advanced APM bases payment must be: 1) on the MIPS final list; 2) endorsed by a consensus-based entity; or 3) otherwise determined by CMS to be evidence-based, reliable and valid. CMS believes that this proposal will better align with their regulations and inform stakeholders of the applicable quality measure requirements, while also helping non-Medicare payers to continue developing payment arrangements that mean the quality measure criterion to be an "Other Payer Advanced APM".

*Generally Applicable Nominal Standard*

CMS proposes maintaining the revenue-based nominal amount standard at 8 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. CMS believes that this represents an appropriate standard for more than a nominal amount of financial risk, and that maintaining a consistent standard for several more years will help APM Entities plan for multi-year Advanced APM participation. ***CMS seeks comment on this proposal as well as comment on as if the agency should consider increasing the nominal amount standard for APM Entities and participating eligible clinicians as they grow more comfortable with assuming risk.***