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2018 Quality Payment Program (MACRA) Proposed Rule: A Focus on Flexibility and Gradual Transition in Year 2

+Insights

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CMS also sets sights on operational streamlining and reducing clinician reporting burdens.

On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) posted the 2018 Quality Payment Program (QPP) Proposed Rule (CMS-5522-P). Established through the Medicare Access and CHIP Reauthorization Act (MACRA), the QPP includes two tracks for Medicare physician payment under Part B: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

The physician community and other stakeholders have eagerly awaited this year's QPP Proposed Rule because of the expectation that the new Administration would put its mark on implementation with significant changes. While the new Administration's fingerprints are obvious and plentiful, most notably through new relief targeting solo practitioners and rural and small practice groups, the proposed updates continue the current implementation path of transition to value-based care, and do not significantly alter the trajectory that was set in 2017.

For 2017, the first year of the program, CMS implemented the "Pick Your Pace" approach that allowed clinicians to select their level of participation and gradually ease into the program requirements. Under this transition, clinicians are able to avoid a negative payment adjustment by submitting even a minimal amount of data.

QPP Strategic Objectives
1. Improve beneficiary outcomes and engage patients through patient-centered Advanced APMs and MIPS policies
2. Enhance the clinician experience through flexible and transparent program design and interactions with easy-to-use program tools
3. Increase the availability and adoption of Advanced APMs
4. Promote program understanding and maximize participation through customized communication, education, outreach and support that meets the needs of the diversity of physician practices and patients, especially the unique needs of small practices
5. Improve data and information sharing to provide accurate, timely and actionable feedback to clinicians and other stakeholders
6. Improve IT systems capabilities that meet the needs of users, and that are seamless, efficient and valuable on the front- and back-end
7. Ensure operational excellence in program implementation and ongoing development

The Proposed Rule for QPP Year 2 (2018) reflects not only a continued gradual ramp-up to the full implementation of the QPP, but also a deliberate tilt towards improving the efficiency of the operation of the program itself through proposals related to streamlining requirements and reducing clinician burden. This approach is perhaps most clearly reflected in the addition of a seventh objective to the agency's QPP strategic objectives (see table) that is focused on maintaining operational excellence as the QPP develops and matures.

CMS states in the Proposed Rule that the Year 2 proposals have been designed to ease the burden on small and solo practices. The regulatory impact analysis included in the Proposed Rule estimates that at least 80 percent of clinicians in small practices (defined as 1–15 clinicians) will receive a positive or neutral payment adjustment as a result of the numerous proposed modifications.

Key Takeaways from CY 2018 QPP Proposed Rule

Merit-Based Incentive Payment System

Under MIPS, by statute clinicians will be measured in four performance categories: Quality, Cost, Improvement Activities and Advancing Care Information (ACI). A composite score will be calculated based on a weighted score in the four performance areas. For QPP Year 2, eligible clinicians can earn a positive, negative or neutral payment adjustment of up to 5 percent based on their performance in MIPS.

MIPS Timeline 2017–2020

<table>
<tr><th>CY 2017</th><th>CY 2018</th><th>CY 2019</th><th>CY 2020</th></tr>
<tr><td rowspan="2">Year 1
Performance Period</td><td rowspan="2">Year 2
Performance Period</td><td>Year 3
Performance Period</td><td>Year 4
Performance Period</td></tr>
<tr><td>Year 1
Payment Year</td><td>Year 2
Payment Year</td></tr>
</table>

Key proposed changes for CY 2018 include the following:

1. A new, more relaxed low-volume threshold policy
2. Increased expectations to avoid a payment penalty in 2020
3. Continued postponement of the Cost Performance Category
4. New proposals to implement virtual groups and facility-based measures
5. Opportunities for bonus points

Proposed Changes in Low-Volume Threshold

The original MACRA statute allows for a low-volume threshold exception for the MIPS program. Subsequent implementing regulations excluded from the program's requirements any clinician who billed less than or equal to $30,000 to Medicare under Part B of the program, or who saw less than or equal to 100 beneficiaries. In response to stakeholder feedback on the challenges faced by solo practitioners, rural providers and small practice groups, CMS proposes to raise the low-volume threshold bar to $90,000 or 200 beneficiaries.

Low-Volume Threshold Qualifications for Exemption	
CY 2017 Final Policy	**CY 2018 Proposed Policy**
• ≤ $30,000 in Part B allowed charges, OR • ≤ 100 Part B beneficiaries	• ≤ $90,000 in Part B allowed charges, OR • ≤ 200 Part B beneficiaries

CMS estimates that in 2018, 647,219 clinicians will be excluded from MIPS based on the low-volume threshold exception. In contrast, in the 2017 MACRA Final Rule, CMS estimated that only 383,514 clinicians would be excluded by the low-volume threshold finalized at that time.

CMS is also considering establishing an additional criterion for the low-volume threshold exception that would be based on the number of items and services a MIPS-eligible clinician provides to Part B beneficiaries. Specifically, CMS is considering defining items and services by using the number of patient encounters or procedures associated with a clinician. CMS is soliciting comments on methods to define items and services furnished by a clinician. CMS is also soliciting comments on a process for clinicians that meet the low-volume threshold criteria to voluntarily opt-in to MIPS.

Payment Penalty Bar
Under the MIPS scoring system, a participant's MIPS score ranges from 0 to 100 points, and the payment adjustment applied is based upon that score. The "performance threshold" represents the score that is needed to receive a neutral to positive payment adjustment for the year. A score below the performance threshold will result in a negative payment adjustment, while a score above the payment threshold will result in a positive payment adjustment (a score at the payment threshold will result in a neutral payment adjustment).

For 2017, the performance threshold is three points, which can be earned by submitting a single Quality measure or attesting to performing one Improvement Activity for 90 consecutive days. CMS proposes to raise the performance threshold to 15 points for the 2018 Performance Period. While this definitely raises expectations and increases exposure for participating physicians, CMS believes that 15 points is still low enough to provide flexibility with multiple pathways to achieve that score.

Continued Delay for the Cost Performance Category
CMS chose to not implement the Cost Performance Category in 2017, instead assigning the category a zero percent weight towards the MIPS score. While CMS views the Cost Performance Category as a vital part of assessing the value of care provided by clinicians, it declined to assign it weight in 2017 because of implementation challenges, and to help clinicians ease into the QPP in Year 1.

For 2018, CMS proposes to maintain a zero percent weight on the Cost Performance Category. The agency continues to believe that more time is necessary to allow clinicians to better understand the methodology and impact of the cost measure, and to allow CMS time to develop measures that will be used in this category in future years. CMS explains that the MACRA statute *requires* a 30 percent weight for the Cost Performance category by 2021 that cannot be waived by the agency. As such, maintaining the zero percent weight for Cost for the 2018 Performance Period is expected to result in a sharp increase in the Cost Performance Category to 30 percent in

Performance Period 2019. In order to avoid such a large change, CMS also seeks comments on an alternative approach of weighing the Cost category at 10 percent for 2018. If CMS maintains the proposed zero percent weight, the weights for the four MIPS performance categories would remain unchanged from 2017, as summarized below.

MIPS Performance Weights (CY 2017 Final and 2018 Proposed)			
Quality	**ACI***	**Improvement Activities**	**Cost**
60 percent	25 percent	15 percent	0 percent

*If a clinician is exempted from reporting ACI, Quality will be reweighted to 85 percent.

Proposal to Implement Virtual Groups

The MACRA statute allows CMS to establish "virtual groups" for purposes of reporting and measuring performance under MIPS. Virtual groups can be composed of solo practitioners and small group practices that join together to report on MIPS requirements as a collective entity, and the members of a virtual group share the same financial adjustments as the result of that reporting. The statute envisioned this as a way for smaller practices to pool resources and achieve efficiencies. CMS did not implement a virtual group option in 2017, but the agency proposes to do so for 2018.

CMS proposes to allow solo practitioners and groups of 10 or fewer eligible clinicians to come together "virtually" with at least one other solo practitioner or group to participate in MIPS. CMS notes that all National Provider Identifiers (NPIs) billing under the Tax Identification Number (TIN) joining the virtual group must participate. They are assessed collectively as a virtual group, but only the NPIs that meet the definition of a MIPS-eligible clinician would be subject to a MIPS payment adjustment. Virtual groups may submit data through any of the mechanisms available to groups under the broader program requirements, such as a registry. While CMS did consider limiting the size of virtual groups, it does not propose to put any limits on the number of TINs that may form a virtual group. Because of the lead time needed to form a virtual group, CMS estimates that the number of virtual groups will be very small in 2018 but will grow over time.

Facility-Based Measures

MACRA also authorized CMS to use measures from other payment systems (*e.g.,* inpatient hospitals) for the Quality and Cost performance categories for "hospital-based" MIPS-eligible clinicians, but the statute excluded measures from hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists and anesthesiologists. CMS declined to establish facility-based measures in last year's rule, but proposes to provide this option for 2018. The facility-based measures option is intended to reduce the reporting burden for facility-based MIPS clinicians.

CMS proposes to implement a voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. This option would be available only for facility-based clinicians who have 75 percent of their covered professional services supplied in the inpatient hospital or emergency department setting.

Bonus Points
CMS also proposes to award bonus points for caring for complex patients or using the 2015 edition of CEHRT exclusively.

Advanced Alternative Payment Models
Similar to the approach for MIPS, CMS largely maintains the framework for qualifying for the Advanced APM track while making minor modifications and expanding upon future program options. The most impactful changes included in this portion of the rule relate to (1) a minor modification in the nominal risk threshold requirement for the Medicare Medical Home track and (2) additional details on the forthcoming All Payer APM Option available beginning in 2021, including the qualifications and process for determining models that will count towards the Advanced APM participation threshold.

Medicare Advanced APM
In the Proposed Rule, CMS reviews the requirements for qualifying for the Medicare APM Option, including the electronic health record utilization threshold, the quality measurement standard and the minimum threshold for meeting the nominal risk requirement. While the agency acknowledges that it intends to ramp up the performance requirements in each of these categories eventually, it also notes that it believes eligible clinicians are still trying to understand how QPP works and advance towards the initial requirements. As such, the Proposed Rule maintains the 2017 requirements for the Medicare option under the Advanced APM track in 2018, specifically discussing the 8 percent threshold for the revenue-based nominal risk standard. However, the agency does seek comments on whether it should increase or decrease the revenue-based threshold in future years, as well as whether it should consider implementing a lower threshold for revenue-based nominal risk for small or rural practices participating in APMs.

Medical Home Track
One area where CMS does provide some additional relief on the nominal risk standard is for eligible clinicians participating in the Medical Home Model track, because those participants tend to be smaller practices that may have less ability to manage financial risk. Under the revised approach, CMS proposes that to be an Advanced APM, a Medical Home Model must require that the total annual amount that an APM Entity potentially owes or loses meet the following minimums:

- For 2018, at least 2 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities
- For 2019, at least 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities
- For 2020, at least 4 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities
- For 2021 and later, at least 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities

All Payer Option

In the Proposed Rule, CMS also provides much greater detail on the process for qualifying an Advanced APM under the All Payer Option that will become available in payment year 2021. In last year's rule, CMS put forth the general parameters for this track, noting that in order to qualify under this option; the following process would be used:

- The eligible clinician submits to CMS sufficient information on all relevant payment arrangements with other payers
- Based upon that information, CMS determines that at least one of those payment arrangements is an Other Payer Advanced APM
- CMS determines whether the eligible clinician meets the relevant Qualified Participant (QP) thresholds by having sufficient payments or patients attributed to a combination of participation in Other Payer Advanced APMs and Advanced APMs

CMS discusses each step of this process in more detail for the All Payer Option performance period beginning in 2019. First, CMS notes that the minimal risk requirements under the All Payer Option will differ slightly from those used under the Medicare Option because CMS does not have access to as much information on payment arrangements operated by other payers. Table 48 from the Proposed Rule, copied below, summarizes the nominal risk requirements proposed for the Medicare Option and All Payer Option.

Generally Applicable Nominal Amount Standards for Advanced APMs and Other Payer Advanced APMs Finalized in the CY 2017 Quality Payment Program Final Rule		
	Advanced APMs	**Other Payer Advanced APMs**
Generally Applicable Nominal Amount Standard	For 2017 and 2018, nominal amount of risk must be at least equal to either: • 8 percent of average estimated total Medicare Part A and Part B revenues of all providers and suppliers in participating APM entities; or • 3 percent of expected expenditures for which the APM Entity is responsible	Nominal amount of risk must be: • Marginal Risk of at least 30 percent; • Minimum Loss Rate of no more than 4 percent; and • Total Risk of at least 3 percent of the expected expenditures for which the APM Entity is responsible

Source: Table 48, 2018 QPP Proposed Rule (CMS-5522-P), Display Copy, page 555.

Additionally, CMS outlines the process that will be used to determine whether an Advanced Model will qualify under the All Payer Option criteria by establishing specific programs and submission forms that can be used to request a CMS determination of whether a model qualifies. CMS includes submission program details for specific model types (*i.e.,* Medicare Advantage, Medicaid and other commercial payers) as well as offering separate process details depending on whether

the determination request is being made by a payer or by an eligible clinician. In limited cases, such as determining whether an all payer model subject to a CMS waiver would qualify, CMS also allows a state to submit a request for determination. The determination timeline for each process varies slightly depending on the program, and CMS offers a comprehensive summary of the various options in Table 54 of the Proposed Rule, which is provided as an attachment at the end of this document.

Finally, CMS offers additional details for the QP determination under the All Payer Option, noting two significant differences from the Medicare Option. First, the Proposed Rule establishes a separate QP Performance Period for the All Payer Option that would begin on January 1 and end on June 30 of the calendar year that is two years prior to the payment year. This term is slightly shorter than the Medicare Option performance period because of differences in the availability of program data. Also, CMS proposes to make QP determinations under the All Payer Combination Option at the individual eligible clinician level only, rather than at the APM Entity level, because it believes that there will be significant challenges associated with making QP determinations at the APM Entity level. Specifically, CMS explains that when it makes QP determinations at the APM Entity level under the Medicare Option, it can do so more easily because it has Participation Lists and claims data necessary to identify the payment or patient data that belong in the numerator and denominator of the Threshold Score calculations for QP Determinations. Because it is more difficult to obtain this information in the All Payer model, CMS will not allow determinations at the group level for the 2021 payment year.

Physician-Focused Technical Advisory Committee (PTAC)
CMS Considers Expanding Focus to Medicaid

Established by MACRA, PTAC is tasked with providing comments and recommendations to CMS on physician-focused payment models (PFPMs). PTAC includes 11 members who are nationally recognized for their expertise in PFPMs and related delivery of care.

Currently, PTAC has been focused on models where Medicare is the payer. CMS is seeking comments on broadening the definition of PFPMs to include payment arrangements that involve Medicaid or the Children's Health Insurance Program as a payer even if Medicare is not included as a payer.

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The QPP Proposed Rule (CMS-5522-P) is available here. CMS's factsheet is available here. Comments are due on August 21, 2017.

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ATTACHMENT

Table 54: Timeline for Other Payer Advanced APM Determination Process for the 2019 QP Performance Period by Payer Type*

Year	Date	Payment Arrangements Authorized Under Title XIX	Payment Arrangements in CMS Multi-Payer Models	Medicare Health Plan Payment Arrangements	Remaining Other Payer Payment Arrangements
2018	January	Guidance sent to states – Submission Period Opens	Guidance made available to payers – Submission Period Opens		
	April	Submission Period Closes for states		Guidance sent to Medicare Health Plans – Submission Period Opens	
	June	Guidance made available to ECs – Submission Period Opens for ECs	Submission Period Closes for Payers	Submission Period Closes for Medicare Health Plans	
	July–August	CMS makes Other Payer Advanced APM Determinations for States	CMS makes Other Payer Advanced APM Determinations for payers	CMS makes Other Payer Advanced APM Determinations for Medicare Health Plans	
	September	CMS posts Other Payer Advanced APM List	CMS posts Other Payer Advanced APM List	CMS posts Other Payer Advanced APM List	
	November	Submission Period Closes for ECs			
	December	CMS posts Other Payer Advanced APM List			
2019	August	Submission Period Opens for ECs	Submission Period Opens for ECs	Submission Period Opens for ECs	Submission Period Opens for ECs
	September		Latest time where ECs can request Other Payer Advanced APM determinations to get notification prior to close of data submission period Submission Period	Latest time where ECs can request Other Payer Advanced APM determinations to get notification prior to close of data submission period Submission Period for	Latest time where ECs can request Other Payer Advanced APM determinations to get notification prior to close of data submission period Submission Period

Year	Date	Payment Arrangements Authorized Under Title XIX	Payment Arrangements in CMS Multi-Payer Models	Medicare Health Plan Payment Arrangements	Remaining Other Payer Payment Arrangements
			for QP determination data opens	QP determination data opens	for QP determination data opens
	December		Submission Period Closes for EC requests for Other Payer Advanced APM determinations and QP determination data CMS makes Other Payer Advanced APM Determinations for ECs CMS posts Other Payer Advanced APM List	Submission Period Closes for EC requests for Other Payer Advanced APM determinations and QP determination data CMS makes Other Payer Advanced APM Determinations for ECs CMS posts Other Payer Advanced APM List	Submission Period Closes for EC requests for Other Payer Advanced APM determinations and QP determination data CMS makes Other Payer Advanced APM Determinations for ECs CMS posts Other Payer Advanced APM List

*The process repeats beginning I 2019 for the 2020 QP Performance Period.
Source: Table 54, 2018 QPP Proposed Rule (CMS-5522-P), Display Copy, page 594.