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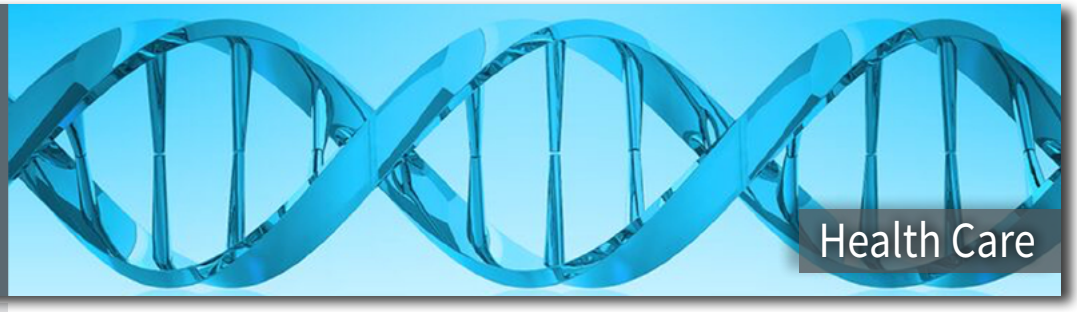

November 2017

Year 2 in the QPP: A Regulatory Update

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On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released the 2018 Quality Payment Program (QPP) Final Rule. **The Final Rule contains notable changes that may affect smaller practices participating in the Merit-based Incentive Payment System (MIPS) and clinicians' strategic participation in Alternative Payment Models (APMs).**

QPP Background

Authorized by the bi-partisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation, the QPP consists of two pathways – MIPS and APMs:

- MIPS requires certain clinicians to report specific quality and cost metrics and, as a result of such reporting and performance thereunder, clinicians may receive a positive or negative adjustment in their Medicare Part B reimbursement in future years.
- Under the QPP, clinicians may also participate in certain APMs that will exempt them from MIPS if, among other things, the APM involves financial risk and satisfies thresholds for Medicare patients and claims volume processed through the APM. For further background on MACRA and the QPP please reference our three-part overview, which can be found here.

Highlights of the Final Rule

2017 was a transition year under the QPP. The Final Rule continues this transition during the QPP's second performance year by addressing three major topics: changes to MIPS policies, changes to APM policies, and application of such policies in extreme and uncontrollable circumstances.

MIPS

The Final Rule largely codifies the 2018 QPP Proposed Rule, finalizing regulations regarding the following:

- **Cost considerations.** Clinicians are judged under MIPS based on four categories: Quality, Cost, Advancing Care Information (ACI), and Improvement Activities (AI). CMS previously weighted the cost category as 0%, but the Final Rule reweights the Cost category as 10% of the MIPS total score, which will be calculated based on clinicians' Medicare Part B claims. Thus, 2018 MIPS scores will be weighted as follows: 50% Quality; 10% Cost; 25% ACI; and 15% IA. Consideration of the Cost category means that resource use, in addition to quality, will become a factor in a clinician's success under MIPS for the 2018 performance year.

- **Small practice and exemption issues.** The Final Rule increases the low-volume threshold ($90,000 or less in Medicare Part B approved charges or 200 patients annually) to exempt additional clinicians from MIPS. CMS also finalized a policy to adjust benchmarks for Quality measures based on practice size, so small practices can be analyzed differently from other practices. CMS also will identify special status clinicians (i.e. "non-patient facing" clinicians, clinicians in practices with 15 or fewer clinicians, and practices in rural areas or Health Professional Shortage Areas) based on claims data, rather than requiring clinicians to attest to their status. These changes may reduce reporting MIPS burdens for small practices.

- **Multiple data submission methods.** CMS delayed until 2019 its proposal to allow data submission for a single MIPS reporting category (e.g., ACI) from multiple submission methods (e.g., CEHRT, qualified data registry, etc.). The Final Rule also clarified that in 2018 and 2019 clinicians will not be required to use multiple data submissions to meet minimum reporting requirements, which will allow clinicians to select one method for all their MIPS performance category data submissions.

- **Performance Data.** The Final Rule requires that all QPP-related data submissions include a certification regarding the truthfulness, accuracy, and completeness of the data, and maintain all data for 6 years. CMS also may reopen and revise payment adjustments under MIPS. The attestation, coupled with the fact that MIPS performance data results will be publicly available through the Physician Compare or a similar website no later than July 2018, may increase fraud and abuse risk associated with MIPS data submissions, particularly given that such data attestations previously have served as the basis for False Claims Act suits in other government health care programs.

- **Quality Reporting and Scoring.** The Final Rule institutes a number of policy changes for quality reporting and scoring under MIPS:

  - *Reducing Topped Out Quality Measures* – CMS finalized a methodology to slowly fade out Topped Out measures and specified that, in 2018, these measures will receive a maximum score of 7 points. Topped Out measures require performance at the measure's highest level to achieve points because most clinicians perform highly under the measures.
  - *Improvement Points* – Participants can now earn bonus points in the Quality (10 points) and Cost (1 point) categories for demonstrating improvement in the category. Participants also may earn 5 additional points under the ACI category by reporting to certain public health registries.
  - *Minimum Case Requirements* – CMS finalized that only 3 points will be available for measure submissions that do not reach the case minimum (20 cases) or that cannot be assigned a benchmark based on actual 2018 performance data. Measures that do not meet data completeness standards will be assigned only 1 point.

- **MIPS APMs Scoring Standard.** The Final Rule establishes an additional date (December 31) upon which CMS will identify participants (and their associated data) for consideration in calculating performance under the MIPS APM scoring standard; however, this additional date only applies to MIPS APMs that require all clinicians under a single tax identification number (TIN) to participate in the APM (e.g., Track 1+ of the Medicare Shared Savings Program, CPC+). Notably, this additional review date does not serve as an additional date for determining whether clinicians are exempt from MIPS based on APM participation.

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- **Virtual Groups.** The Final Rule finalizes a number of policies on virtual groups, offering another pathway for certain clinicians to participate in MIPS. Virtual groups allow solo practitioners and groups with 10 or fewer MIPS clinicians to be treated under MIPS as groups, meaning that each individual clinician is eligible for a payment adjustment based on the virtual group's performance in MIPS. However, each participant (e.g., solo practitioner or small group) in a virtual group must exceed the low-volume threshold and virtual groups must elect to participate in MIPS prior to the performance year. The Final Rule clarifies that a group may not split its TIN to form a virtual group, but that multiple TINs within a health care delivery system may form a virtual group as long as each TIN has 10 or fewer MIPS eligible clinicians.

APMs

The Final Rule largely builds on regulations established in year 1 of the QPP for APMs, but contains the following significant changes and clarifications:

- **Testing APM Models.** Clinicians who participate in an APM that starts or ends during the performance year may be exempt from MIPS if, among other things, the APM was tested for at least 60 or more consecutive days from January 1 through August 30 of the performance year. This flexibility may encourage participation in newly-approved (and untested) APMs, while reducing clinician concern that participation in such new APMs may affect their ability to be exempt from MIPS as a result of that participation.

- **All-Payer Combination Option.** Commencing in 2019, CMS will consider a clinician's participation in other-payer APMs in determining whether the clinician is exempt from MIPS, but clinicians must still participate in at least one APM in which Medicare is the payer. Consideration of other-payer APMs in MIPS exemption determinations may encourage participation in value-based payment arrangements with other payers (e.g., Medicaid, and multi-payer models including commercial payers). However, operational issues may arise given that clinicians must submit other-payer APM data to CMS in order for such data to be considered in MIPS exemption determinations.

- **Incentive Payment Implications.** CMS estimates that APM incentive payments – the 5% bonus (based on the clinician's Medicare Part B claims) awarded to qualifying eligible clinicians participating in advanced APMs – will increase in 2018 to between $675 and $900 million. This increase (to be paid out in 2020) is expected due to the reopening of the CPC+ and Next Generation Accountable Care Organization Program and the creation of Track 1+ of the Medicare Shared Savings Program.

- **Other Payer APMs.** The Final Rule notes CMS' interest in testing alternative payment arrangements with Medicare Advantage, especially for clinicians who would not receive credit for APM participation under current QPP rules. CMS stated it is considering potential demonstration project designs to test APMs that would include Medicare Advantage plans.

Extreme and Uncontrollable Circumstances

CMS proposed a number of policies in the 2018 QPP proposed rule that discussed adjustments under MIPS for clinicians impacted by extreme and uncontrollable circumstances, such as natural disasters. **These proposals recognize that certain catastrophic events may affect a clinician's ability to submit quality measures or collect necessary data for MIPS reporting.**

The Final Rule adopts CMS' proposal to reweight the MIPS quality performance categories for clinicians impacted by extreme and uncontrollable circumstances beginning in the 2018 performance period. **For 2018, physicians seeking a hardship exemption from MIPS due to extreme and uncontrollable circumstances must submit an application by December 31, 2018.** However, for the 2017 performance period, hardship applications are not required. Rather, CMS will determine whether an extreme and uncontrollable circumstance has occurred and, if the clinician is in the affected area, automatically weight the MIPS quality performance categories in a manner that credits the clinician. Areas of focus for the 2017 determinations include: all 67 counties in Florida; all 159 counties in Georgia; 20 parishes in Louisiana; 16 counties in South Carolina; 53 counties in Texas; all of Puerto Rico; and all of the U.S. Virgin Islands.

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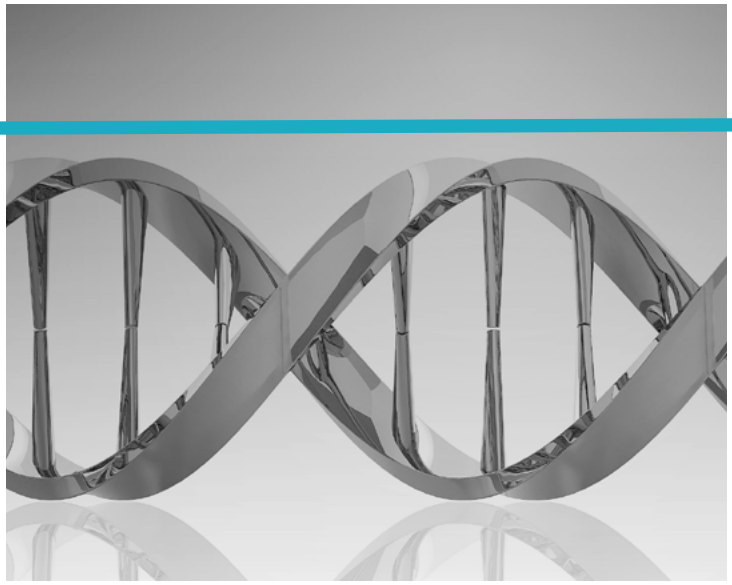

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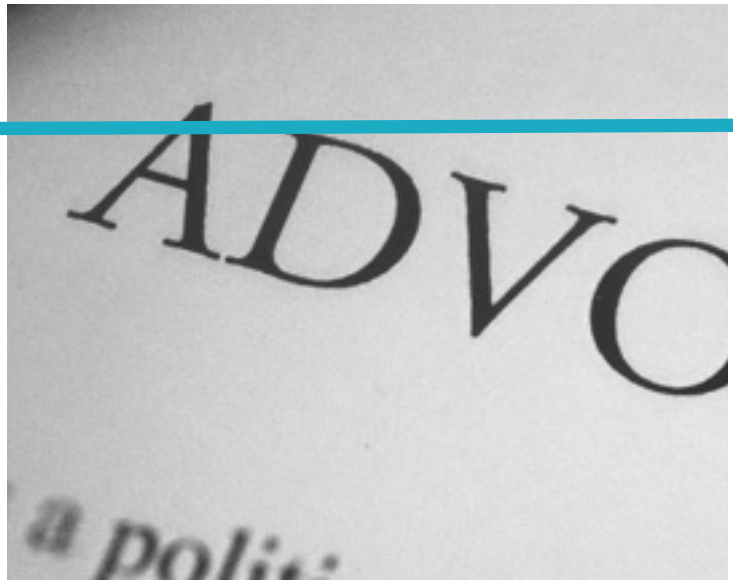

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