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MEMORANDUM

To: Mike Zarski
Executive Director, AAHKS

From: Epstein Becker & Green, P.C.

Date: November 15, 2017

Re: Summary of the Final Rule: Quality Payment Program

On November 4, 2017, the Centers for Medicare & Medicaid Services (CMS) published a final rule, "CY 2018 Updates to the Quality Payment Program" (Quality Payment Program Final Rule). CMS proposed these changes June 20, 2017 and AAHKS offered comments on August 21, 2017.

The following is a summary of CMS actions in the final rule related to the comments submitted by AAHKS.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

I. Low-Volume Threshold – Sec. II.C.2

CMS proposed exempting clinicians from the Merit-Based Incentive Payment System (MIPS) in 2018 if they have less than $90,000 in Medicare Part B revenue or care for fewer than 200 Medicare patients in the year. This would be a change from the 2017 policy exempting physicians with less than $30,000 in Medicare Part B revenue or fewer than 100 Medicare patients in 2017.

AAHKS Comments:

AAHKS endorsed the proposal to lower the threshold for a physician to quality for a MIPS exemption based on low-volume. AAHKS supports CMS acknowledgement that physician practices and those practices in rural regions and Health Professional Shortage Areas lack the capacity or patient volume to have an opportunity to succeed under MIPS.

Outcome in the Final Rule:

CMS finalized the proposal to lower the threshold by exempting clinicians that have less than $90,000 in Medicare Part B revenue OR care for fewer than 200 Medicare Part B beneficiaries' in a year.

II. Virtual Groups - Sec. II.C.4.

CMS proposed allowing solo practitioners and groups of 10 or fewer eligible clinicians, eligible to participate in MIPS, to come together "virtually" with at least 1 other such solo practitioner or group to participate in MIPS for a performance period of a year. Virtual Groups would report as a Virtual Group across all 4 MIPS performance categories and will need to meet the same measure and performance category requirements as non-virtual MIPS groups. Virtual Groups would need to exceed the low-volume threshold at the group level, regardless of location or specialties.

AAHKS Comments:

AAHKS acknowledged that the option of forming Virtual Groups will help small and rural practices, but noted the burdens of establishing a Virtual Group would be substantial for many of the smaller practices in greatest need. AAHKS expressed insufficient time remaining in 2017 for perspective Virtual Group participants to prepare for 2018. AAHKS suggested the following:

- Viewing 2018 as a demonstration test for Virtual Groups in order to inform a process for 2019 that can more realistically serve physicians
- CMS should reduce the financial burden closer to its estimate by providing frequent webinars and other technical assistance to walk physicians through the necessary steps towards becoming a Virtual Group
- CMS should weight the cost performance and clinical practice improvement categories to zero for the first two years of operation to allow a Virtual Group time to develop systems to coordinate and improve performance in these categories
- CMS should work with the HHS Office of the Inspector General and the Department of Justice to develop and disseminate guidance regarding safe harbors for Virtual Groups from anti-kickback, physician self-referral, civil monetary penalties, and other fraud and abuse laws.

Outcome in the Final Rule:

CMS finalized the proposed rule as written, without incorporating AAHKS suggestions. Virtual Groups can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually", regardless of specialty or location, to participate in MIPS for a performance period of a year. Additionally, solo practitioners and small groups may only participate in a Virtual Group if they exceed the low-volume threshold. CMS did acknowledge the need for technical assistance and will make it available for participants in Virtual Groups. CMS created a toolkit with technical assistance for Virtual Groups. Lastly, CMS notes that if certain members of a Virtual Group are in a MIPS APM, they would apply the APM Special Scoring Standard instead of the Virtual Group score.

III. Data Completeness Criteria - Sec. II.C.6.b.(3)(b)

CMS proposed awarding *small* practices 3 points for quality measures data that are submitted, but that do not meet the data completeness criteria. Whereas larger practices that do

not meet the data completeness criteria will only receive 1 point.

AAHKS Comments:

AAHKS endorsed the continuation of a 3-point quality measure award for small practices that submit quality measures but do not meet data completeness standards. AAHKS supports CMS efforts to reduce clinician burden and to promote widespread clinician participation under MIPS, particularly with respect to small physician practices and those practices in rural regions and Health Professional Shortage Areas.

Outcome in Final Rule:

CMS finalized the policy as proposed.

IV. Substantive Changes to Measures - Background and Policies for the Call for Measures and Measure Selection Process – Sec. II.C.6.c.(1)

In Table A of the QPP Proposed Rule Appendix, CMS listed the quality measures proposed for inclusion in MIPS for the 2018 performance period and future years. The proposal included changes, requested by AAHKS, to Quality Measures #375 and #376. These CMS steward measures assess the percentage of adult patients who complete baseline and follow-up functional status assessments following TKA and THA procedures.

AAHKS Comments:

AAHKS thanked CMS for making the substantive changes to these measures as requested by AAHKS.

Outcome in Final Rule:

CMS finalized the Orthopedic Surgery Specialty Measure Set as proposed for the 2018 Performance Period and future years.

V. Significant Hardship Exception for MIPS Eligible Clinicians in Small Practices – Sec. II.C.6.f.(7)(a)(ii)

In the proposed rule, CMS created a new hardship exception for clinicians in small practices under the Advancing Care Information performance category. For clinicians that qualify for the exception, CMS would reweight the Advancing Care Information performance category to 0 and the Quality performance category to 85%.

AAHKS Comments:

AAHKS endorsed the reweighting of the Advancing Care Information performance category to zero for small practices.

Outcome in Final Rule:

CMS supported AAHKS endorsement of reweighting the Advancing Care Information performance category. For clinicians that qualify for the exception, CMS would reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25%. The new significant hardship exception will be available to MIPS eligible clinicians in small practices (15 or fewer clinicians), eligible MIPS hospital based clinicians, Ambulatory Surgical Center (ASC)-based MIPS eligible clinicians, and for MIPS eligible clinicians whose EHR was decertified.

VI. Small Practice Bonus – Sec. II.C.6.g.(4)(c)

CMS proposed adding a 5 point bonus for clinicians, group practices, virtual groups, or APM entities that consist of 15 or fewer clinicians that participate in MIPS by submitting data on at least one performance category in the 2018 performance period.

AAHKS Comments:

AAHKS endorsed the small practice bonus, particularly because small practices have the likelihood of serving a disproportionately high number of complex patients.

Outcome in Final Rule:

CMS finalized the proposal and will add 5 points to any MIPS eligible clinician or small group in a small practice. The small practice must submit data on at least 1 performance category in an applicable performance period.

VII. Quality Performance Improvement Score – Sec. II.C.7.a.(1)(i)

CMS proposed measuring improvement at the performance category level for the quality performance category score. The improvement score will be awarded based on the rate of increase in the quality performance percent score of individual clinicians or groups from the current performance period compared to the score in the year immediately prior to the current performance period. Additionally, CMS would add an explicit regulatory provision that an improvement percent score cannot be negative. To calculate the quality performance category percent score, the total measures achievement points would be summed with the total measure bonus points and then divided by the total available measure achievement points. The improvement percent score would be added to that calculation. The resulting quality performance category percent score cannot exceed 100 percentage points.

AAHKS Comments:

AAHKS strongly endorsed the creation of a quality improvement score. AAHKS emphasized that the proposal may (1) recognize and encourage achieving higher standards of quality among all providers, (2) increase opportunities for providers to succeed under MIPS considering challenges with cost performance measures, and (3) increase opportunities for

providers to succeed under MIPS considering the challenges associated with serving patients with high social risk factors. AAHKS emphasized the significance of the use of quality improvement measures in MIPS scoring.

Outcome in Final Rule:

CMS finalized the improvement score policy as proposed.

VIII. Cost Performance Category Weights – Sec. II.C.7.b.(3)(d)

CMS proposed assigning the cost performance improvement category to zero which would not impact a clinician's ultimate score. CMS would calculate a cost improvement score only when data sufficient to measure improvement is available, that is when a clinician participates in MIPS using the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods.

AAHKS Comments:

AAHKS strongly endorsed CMS action to assign the cost measures at zero for the 2020 payment year because existing total cost and spending per beneficiary measures are poor tools to capture the complexity of the spending and its assignation. Additionally, AAHKS stated that while MACRA requires the weighting of 30% starting with the 2021 payment year, CMS should examine its authority to adjust weighting beyond that time frame for the purposes of transitioning certain small and rural providers with fewer means available to perform under MIPS.

Outcome in Final Rule:

CMS finalized a weight of 10 percent for cost performance improvement for the 2020 MIPS payment year. This way the Quality Performance Category weight will be 50 percent. However, CMS will continue to assign the cost performance category weight for the transition year to zero through the 2019 payment year.

IX. Incentives to Use CEHRT To Support Quality Performance Category Submissions – Sec. II.C.7.a.(2)(g)

CMS sought comments in general on the use of health IT in quality measurement and how HHS can further encourage the use of certified EHR technology in quality measurement.

AAHKS Comments:

AAHKS expressed its support for incentives for CEHRT compliance and stated that CEHRT compliance remains prohibitively costly for many small groups and individual providers. We emphasized that incentives and inducements from CMS for CEHRT use will be necessary, especially if there is an interest to preserve small practices as a resource to serve Medicare beneficiaries. AAHKS proposed providing MIPS credit for partial years of compliance while practices transition into use through a given year.

Outcome in Final Rule:

CMS has accepted the feedback and will consider AAHKS comment for possible inclusion in future rulemaking. A 10% scoring bonus will be given only if participants use the 2015 Edition CEHRT.

X. Accounting for Risk Factors – Considerations of Social Risk – Sec. II.C.7.b.(1)(a)

CMS sought comments on whether MIPS should account for social risks factors, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Example methods include:

- adjustment of MIPS eligible clinician scores (for example, stratifying the scores of MIPS eligible clinicians based on the proportion of their patients who are dual eligible);
- confidential reporting of stratified measure rates to MIPS eligible clinicians;
- public reporting of stratified measure results;
- risk adjustment of a particular measure as appropriate based on data and evidence; and
- redesigning payment incentives (for instance, rewarding improvement for clinicians caring for patients with social risk factors or incentivizing clinicians to achieve health equity).

CMS also solicited comments on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to the following: dual eligibility/low-income subsidy; race and ethnicity; and geographic area of residence.

AAHKS Comments:

AAHKS proposed using zip codes *in addition to* Medicare/Medicaid dual eligibility status as a better surrogate for socioeconomic risk factors than dual status alone.

Outcome in Final Rule:

CMS has accepted the feedback and will consider it for possible inclusion in future rulemaking.

XI. Complex Patient Bonus – Sec. II.C.7.b.(1)(b)

CMS proposed an interim adjustment for patients with numerous, complex factors that impact health outcomes. CMS would calculate the average Hierarchical Conditions Category (HCC) risk score for a clinician or group by averaging the HCC risk scores for beneficiaries cared for by the clinician or group. Clinicians would then be awarded 1 to 3 bonus points if their patient population is deemed particularly complex. CMS solicited comments on any alternative complex patient methodologies, under which a bonus would be applied based on the ratio of dual eligible patients.

AAHKS Comments:

AAHKS strongly endorsed the complex patient bonus. AAHKS has consistently raised the need for adequate risk adjustment in all value based care models and programs.

Outcome in Final Rule:

In alignment with AAHKS views, CMS finalized the complex patient bonus. Clinicians can earn up to 5 points for the treatment of complex patients. The measure bonus will be based on a combination of HCC risk scores and the number of dually eligible patients treated.

ALTERNATIVE PAYMENT MODELS

I. Advanced APM Policies

a. Advanced APM Nominal Risk Standard

To be considered an Advanced APM, an APM must either require that participating providers bear risk for monetary losses of a more than nominal amount under the APM, or be a Medical Home Model. Currently, the total potential risk that an APM must bear must be equal to at least: either 8% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in the participating APM for the performance period (the revenue standard), **OR** 3% of the expected expenditures that an APM entity is responsible for under the APM for all performance years (the benchmark-based standard).

CMS proposed to extend the 8% revenue-based financial risk standard established for 2017 and 2018 to the Performance Periods in 2019 and 2020. CMS asked if it should consider a lower or higher revenue-based standard for the 2019 and 2020 Medicare qualified practitioner (QP) Performance Periods.

AAHKS Comments:

AAHKS commented in favor of moving to a lower percentage revenue-based risk standard. The current required level of 8% risk for a provider is so high that it discourages provider participation in Advanced APMs. If CMS sets potential losses at a level above 5%, the incentive for physician participation is reduced. AAHKS emphasized that when the 8% risk standard is combined with only one currently available Advanced APM for TJA (under which physicians have no input or control over the episode), surgeons specializing in TJA procedures see little incentive for Advanced APM participation.

Outcome in Final Rule:

CMS finalized the proposal and will maintain the applicable revenue-based nominal amount standard at 8% for Performance Periods 2019 and 2020.

II. Other Payer Advanced APM Policies

a. Nominal Risk Standard

Previously, CMS had adopted a nominal risk standard for Other Payer Advanced APMs requiring: marginal risk of at least 30%; a minimum loss rate of no more than 4%; and total risk of at least 3% of the expected expenditures that the APM Entity is responsible for under the payment arrangement. CMS proposed to add a revenue-based standard of 8%, as an alternative to the benchmark-based standard.

AAHKS Comments:

AAHKS strongly supported the addition of a revenue-based standard for the purpose of measuring nominal risk for the designation of an Other Payer Advanced APM, but suggested that CMS should move to a lower percentage revenue-based risk standard. AAHKS noted that one of the most significant factors attracting physicians to Advanced APMs is the 5% bonus for participation. If CMS sets potential losses at a level above 5%, the incentive for physician participation is reduced. An 8% risk standard would lessen the incentive for providers to participate in Other Payer Advanced APMs.

Outcome in Final Rule:

CMS finalized the proposal and will add a revenue-based nominal amount standard of 8% that only applies to payer arrangements where the risk for APM Entities is expressly defined in terms of revenue.

b. Identification of Other Payer Advanced APMs

In the proposed rule, CMS allowed only certain payers to request that CMS identify a model as an Other Payer Advanced APM for the 2019 performance year. Those payers would be Medicare Advantage plans, Medicare-Medicaid plans, 1876 and 1833 cost plans, and Programs of All Inclusive Care for the Elderly ("PACE") plans, and payers with payment arrangements in CMS Multi-Payer Models (including the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model). CMS explained that other payer types, including commercial and other private payers, would be able to request that CMS identify a model as an Other Payer Advanced APM starting with the 2020 performance year.

AAHKS Comments:

AAHKS supports the availability of Advanced APMs and greater opportunity to achieve QP status and emphasized that CMS should allow all commercial payers to request that CMS identify their models as Other Payer Advanced APMs for the 2019 performance year. In light of the cancellation of the Medicare Episode Payment Models (EPMs), and the continued acceleration of private bundled payment models, this would be a realistic and appropriate path to QP status.

Outcome in Final Rule:

CMS finalized the policy as proposed without changes suggested by AAHKS.

c. ***QP Determinations and Threshold Scores***

CMS proposed the methodology through which it will determine if clinicians qualify as a QP through the All-Payer Combination Option. Beginning in performance year 2019, a clinician may qualify as a QP through the All-Payer Combination Option. To become a QP through the All-Payer Combination Option, a clinician must participate in an Advanced APM with CMS, as well as an Other Payer Advanced APM. For an eligible clinician, CMS would conduct QP determinations sequentially, so that CMS first looks at a clinician's participation in a Medicare Advanced APM (the Medicare Option), and then the clinician's participation in both a Medicare Advanced APM and an Other Payer Advanced APM (the All-Payer Combination Option).

AAHKS Comments:

AAHKS emphasized that the All-Payer Combination Option currently is a diminishing opportunity for providers. In light of the recent cancellation of the Medicare EPM models, the narrowing of the CJR, and the slow pace of CMS development of Advanced APMs, the All-Payer Combination Option will be relevant for very few providers. To mitigate this from happening, AAHKS recommended that CMS should accelerate the development of Advanced APM options in order for physicians to be able to benefit from the arrangements that they have in place with commercial payers. Additionally, CMS should decide whether virtual groups may contract for shared risk under and Advanced APM and how CMS will make QP determinations for physicians engaging in such APMs through such virtual groups

Outcome in Final Rule:

CMS finalized the proposal as drafted. Beginning in performance year 2019, a clinician may qualify as a QP through the All-Payer Combination Option. To become a QP through the All-Payer Combination Option, a clinician must participate in an Advanced APM with CMS, as well as an Other Payer Advanced APM.

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