MEMORANDUM

Date: November 10, 2017

Re: CMS Releases 2018 MACRA Final Rule

The Centers for Medicare & Medicaid Services (CMS) on Nov. 2, 2017, posted the CY 2018 Quality Payment Program (QPP) Final Rule. CMS finalized modifications to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) participation options and requirements for 2018.

The Final Rule adopts key policies for the QPP’s 2018 performance period, which will affect clinician payment in 2020. CMS estimates the vast majority of eligible clinicians and groups will participate in MIPS, making it the default track again in 2018.

Under the policies in this Final Rule, CMS estimates approximately 621,700 clinicians will be required to participate in MIPS in 2018 with a redistribution of approximately $118 million in payment adjustments on a budget-neutral basis. The exceptional performance bonus pool of $500 million also will be distributed to the highest performers. The chart on page 1274 of the Final Rule reflects the numbers noted above. Only 40 percent of Medicare physicians will be subject to participation.

Public comments are due to CMS by 5 p.m. ET on Jan. 1, 2018. For further details, see the CY 2018 QPP Final Rule and the CMS Fact Sheet.

Highlights of the Final Rule

- Quadruples the reporting period for the quality component of MIPS from 90 days to one calendar year
- Delays the mandate to move to 2015 Edition Certified Electronic Health Record (EHR) Technology
- Increases the low-volume threshold exclusion to $90,000 in Medicare Part B allowed charges or 200 Medicare Part B patients
- The threshold for avoiding the negative payment adjustment was increased from three Composite Performance Score points in 2017 to 15 points in 2018. This means that in 2018, submitting data for one measure will no longer enable you to avoid the penalty
- Counts the cost component as 10 percent of the MIPS final score
- Offers a virtual group option for solo practitioner and small practices to aggregate their data for shared MIPS evaluation

Key Provisions of the Final Rule

Merit-Based Incentive Program (MIPS)

The Final Rule focuses on reducing administrative burden for clinicians, especially those in small practices or rural settings. Under the MIPS, CMS finalized the following:

Low-Volume Threshold: In 2017, CMS exempted providers that had less than $30,000 in Medicare Part B revenue or saw fewer than 100 Medicare Part B patients per year. For 2018, CMS finalized its increases to the low-volume threshold to exclude clinicians with less than or equal to $90,000 in Part B allowed charges or who see less than 200 Part B beneficiaries – only 40 percent of all clinicians who bill Medicare will be subject to MIPS participation. This will mean that some clinicians and groups reporting in 2017 will not need to report in 2018.

However, the Final Rule also noted that even those clinicians who are interested in participating cannot opt in. CMS is seeking comment on how to allow clinicians to opt in if they choose to participate.
Virtual Group Participation: CMS also finalized its proposal to include virtual group participation. If solo practitioners or clinicians in groups of 10 or fewer meet the low-volume criteria and would still like to be eligible for bonuses, CMS is allowing them to "virtually" come together to meet the reporting requirements (regardless of specialty or location).

Those interested in forming virtual groups will need to participate in an election process. An eligible clinician or group may elect to be in no more than one virtual group for a performance period. The election period began Oct. 11, 2017, and will continue until Dec. 31, 2017.

Virtual group election consists of two stages:

• Stage 1 (optional): Solo practitioners and groups with 10 or fewer eligible clinicians may contact their designated Technical Assistance representative or the Quality Payment Program Service Center to determine if they are eligible to join or form a virtual group.

• Stage 2: For groups that choose not to participate in Stage 1 of the election process, CMS will determine if they are eligible in Stage 2. During Stage 2, the virtual group must name an official representative who will submit their election to CMS via email to MIPS_VirtualGroups@cms.hhs.gov by Dec. 31, 2017.

The initial election deadline was scheduled for Dec. 1; however, after receiving stakeholder comments concerning the timeline, CMS extended the deadline to Dec. 31. As a result, CMS noted that it is not operationally feasible for them to notify virtual groups of their official virtual group status prior to the start of the performance period. CMS intends to notify virtual groups of their official status as close to the start of the performance period as technically feasible.

Bonus Points in the Scoring Methodology: CMS finalized its policy allowing clinicians to receive extra credit if they 1) see complex patients as measured by Hierarchical Conditions Category (HCC) risk scores and submit data for at least one performance category, 2) participate in a practice with 15 or fewer clinicians, or 3) are using a 2015 Certified EHR Technology.

Part B Drugs: CMS provided additional clarity to the MIPS payment adjustment, which applies to Medicare Part B items and services, and may also include Part B drugs. CMS noted that this payment adjustment would apply to Part B drugs in the following scenario: A clinician keeps medication in the office and then bills Medicare for the drug as well as the office visit to administer the drug; in this case, the cost of the drug itself and the administration of the drug are directly attributed to the clinician by Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) and would be included in the clinician's MIPS payment adjustment.

MIPS Performance Categories: The MACRA statute requires CMS to measure physician performance in four categories – quality, cost, practice improvement and advancing care information (i.e., use of a Certified EHR) – that each contribute to an overall performance score. However, in 2017 CMS did not measure cost performance, but will beginning in 2018. Notably, CMS has retained a full-year reporting period for cost and quality.

CMS also is allocating bonus points that will increase physicians' performance scores for things such as demonstrating year-to-year improvement in quality or cost performance, treating complex patients and reporting data as a solo practitioner or part of a small practice. Physicians will need to earn 15 points in 2018 to avoid a 2020 payment cut (up from three points in 2017). The significant increase means that in 2018 it will no longer be possible to avoid a negative payment adjustment by reporting just one measure. The "exceptional performance" bonus threshold remains a score of 70 points for 2018. This is the threshold above which you are eligible to earn incentive payments from the $500 million bonus pool.

Potential 2020 payment adjustments under MIPS will be on a sliding scale from +/- 5 percent (up from +/- 4 percent in 2017), based on 2018 performance. This increase is required by law.
Quality (50 percent): For 2018 performance (2020 payment), quality will be weighted at 50 percent. This is a decrease from 60 percent in 2017. Next year, CMS will quadruple the reporting period for the Quality performance category to a full calendar year. The new 12-month reporting period mirrors Physician Quality Reporting System (PQRS) requirements.

CMS delayed its proposal to allow clinicians who see 75 percent or more of their patients in the hospital to report under the Hospital Value-Based Purchasing program, given the operational constraints of this policy. The option will allow hospital-based clinicians to use their hospital's value-based purchasing results for the MIPS cost and quality categories. This proposal will become effective in Year 3 (CY 2019).

The data completeness requirement for quality measures will also increase to 60 percent from 50 percent in 2018. This is an increase in the percentage of eligible patients required to be reported for each quality measure.

Advancing Care Information (ACI) (25 percent): Weighting will remain at 25 percent for the second year of the QPP. CMS will also continue using a 90-day reporting period for the advancing care information category in 2018. Most notably, clinicians are allowed to continue using 2014 Edition Certified Electronic Health Record Technology (CEHRT), rather than upgrading to 2015 Edition technology, to report the Advancing Care Information (ACI) transition measures (i.e., Modified-Stage 2 equivalent measure set). Clinicians that exclusively use 2015 CEHRT to report the ACI objectives and measures (i.e., Stage 3 equivalent measure set) could be eligible for 10 percent bonus score.

CMS also finalized a significant hardship exception from the ACI performance category for MIPS-eligible clinicians in small practices.

Improvement Activities (15 percent): Weighting will remain at 15 percent for the second year of the QPP.

Cost (10 percent): CMS will begin to assess providers on Cost measures in 2018 – a significant change from the proposed rule, which initially delayed the cost measures entirely until 2019. The Cost category will be weighted at 10 percent of the MIPS final score in 2018 and will increase to 30 percent in 2019. CMS will use the Medicare Spending Per Beneficiary (MSPB) and total per-capita cost measures to calculate the Cost performance category. Performance will be calculated by CMS based on administrative claims.

Alternative Payment Models (APMs)

With the inclusion of the new Medicare Track 1+ program as a qualifying APM and the reopening of applications for the Next Generation ACO program and Comprehensive Primary Care Plus (CPC+) program, CMS estimates between 180,000 and 245,000 clinicians will participate in an Advanced Alternative Payment Model (AAPM) in the 2018 performance year and qualify for AAPM incentive payments (5 percent of their Part B payments) estimated to be between $675 and $900 million. The increase in APM-track participants, combined with an increase in clinicians exempt from QPP, would make MIPS far more competitive.

Medicare Advantage Demonstration: CMS intends to develop a demonstration program to test the impact of providing incentives to clinicians who participate in Advanced APMs under Medicare Advantage (MA) Plans. CMS plans to test whether this demonstration idea would encourage more clinicians to move into the Advanced APM track of the QPP. The rule is light on details: "We intend to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative alternative payment arrangements under Medicare Advantage that qualify as Advanced APMs, by allowing credit for participation in such Medicare Advantage arrangements prior to 2019 and incentivizing participation in such arrangements in 2018 through 2024, which we believe is especially important for eligible clinicians who do not participate in Advanced APMs with Medicare fee-for-service."

MA plans don't disclose pay arrangements with providers, so interested physicians may have to give CMS their Medicare Advantage contract terms for consideration as alternative pay models as well as a list of clinicians participating in MA-risk contracts.
Extending Nominal Amount Standard for Two Years: As part of the financial risk criteria to qualify as an AAPM, CMS will maintain the current revenue-based nominal amount standard at 8 percent of estimated APM Entity revenue for two years (through 2020).

Gradual Increase in Required Risk for Medical Homes: To accommodate medical home practices with little risk experience, CMS established a gradual increase in risk for medical home models. Specifically, for a medical home model to qualify as an AAPM, the APM Entity must owe or forgo 2.5 percent of the average estimated revenue in 2018, 3 percent in 2019, 4 percent in 2020 and 5 percent in 2021.

All-Payer Combination Option: CMS did not make any changes under this year’s rule that will significantly increase physician participation in advanced APMs. However, the agency has laid the groundwork for the all-payer option, which begins in performance year 2019 and will allow providers to receive credit for certain payment arrangements with non-Medicare payers (e.g., Medicaid and commercial payers) that are similar to Medicare Advanced APMs.

Payer-Initiated and Eligible Clinician-Initiated Process for Determination of Other Payer Advanced APMs: To determine if other payer arrangements qualify as Other Payer AAPMs, CMS finalized its proposal to allow specific payers (e.g., Medicaid, Medicare Health Plans and CMS Multi-Payer Models) to submit payment arrangements to CMS for performance year 2019. In future years, commercial payers and other private payers can submit this information. In addition, CMS will allow APM Entities or eligible clinicians to submit information on their payment arrangement if the payer did not already submit information.

Revenue-Based Nominal Amount Standard: CMS finalized its proposal to add a fourth option to the financial risk criteria for Other Payer AAPMs. Specifically, CMS added a revenue-based nominal amount standard that is the parallel to the revenue-based standard for Medicare AAPMs. However, the revenue-standard approach will only be applied to other payer arrangements in which risk is defined in terms of revenue.

Definition of Physician-Focused Payment Model (PFPM) is Unchanged: In the proposed QPP rule, CMS sought comments on broadening the definition of a PFPM to include payment arrangements that involve Medicaid and the Children’s Health Insurance Program (CHIP). In the Final Rule, CMS decided to maintain the current definition of a PFPM to include only payment arrangements that involve Medicare. CMS left open the option to change the PFPM definition in future rulemaking.

Providers in Areas Affected by Natural Disasters During 2017 will Receive a Neutral-Payment Adjustment in 2019: CMS adopted a policy to account for the recent hurricanes and other natural disasters during 2017. Providers in impacted regions are not required to submit 2017 MIPS data, and they can automatically avoid the 2019 penalty. Alternatively, they may choose to submit 2017 MIPS data to receive a MIPS score and a MIPS payment adjustment based on category-by-category performance similar to other eligible clinicians.