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CMS Proposes QPP Revisions: The Paths for QPP Participation Continue to Evolve

August 04, 2017

CMS recently proposed modified policies for continued implementation of the Quality Payment Program (QPP) in the 2017 Proposed Rule. Among other things, the Proposed Rule provides flexibility for clinicians in the second QPP performance year in 2018. CMS initially proposed complete provider participation in the first performance year in the Proposed Rule published on May 9, 2016. CMS introduced less stringent participation requirements in the Final Rule, published on November 4, 2016, for the first QPP performance period in 2017, by allowing clinicians options to test their participation, which CMS nicknamed "Pick Your Pace." As previously reported by Baker Donelson's Government Relations and Public Policy Group in their update, the 2017 Proposed Rule includes new paths, and modifications of existing ones, from which clinicians may choose when participating in the QPP. ***Comments on the 2017 Proposed Rule are due by August 21, 2017.***

Established under the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), the QPP developed a complex system of measures to adjust or supplement health care professionals' Medicare Part B reimbursements and combine previously distinct reporting programs under one program. The QPP accomplishes this through its two tracks: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). For additional context on the QPP, the Baker Ober Health Law Group has made available a white paper that discusses the inner workings of the program and its two tracks, which is available here.

The 2017 Proposed Rule includes broad changes to many elements of the QPP, such as eligibility thresholds for clinicians; additional options for participation in the second QPP performance year in 2018; and discussion of elements that were not applicable to the first QPP performance period, such as virtual groups, facility-based measurement, and improvement scoring.

The most substantial changes to the MIPS track in the 2017 Proposed Rule include:

- Raising the low-volume threshold, which would exempt a much larger percentage of clinicians from participation in MIPS. CMS would increase the low-volume threshold from $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients to $90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients. Additionally, beginning in the 2019 Performance Year, CMS proposes to allow providers to opt-in to MIPS participation if they fall under the higher low-volume threshold;
- Establishing the requirements for providers to form virtual groups to help disparate providers come together as a group for purposes of aggregating their data and streamlining reporting requirements under MIPS;
- Allowing the continued use of 2014 Certified Electronic Health Record Technology (CEHRT) during the 2018 QPP performance year instead of requiring the 2015 edition of CEHRT. However, a bonus may be offered to those clinicians who are able to implement a certified 2015 edition product;
- Setting the cost performance category of the MIPS score to zero percent for the 2018 QPP performance year to allow CMS additional time to develop episode-based measures and to

communicate individualized feedback to providers on how the cost performance category will impact their MIPS score in subsequent performance periods; and
- Establishing a method to assess the quality and cost performance of clinicians whose primary responsibilities are in a health care facility based on the performance of that health care facility.

For Advanced APMs, the 2017 Proposed Rule:

- Permits CMS to make determinations of a Qualifying APM Participant (QP) – an eligible provider who participates in an Advanced APM to a sufficient degree – for Advanced APMs that start or end during the QPP performance year and that operate continuously for at least 60 days. In those circumstances, CMS will use only data from Advanced APMs where they operated within the QPP performance year to make QP determinations;
- Seeks comments on allowing QPs to receive participation credit for Medicare Advantage as part of the Medicare Option rather than the All-Payer Combination Option. In general, providers have two scoring options to become QPs depending on their participation in Advanced APMs: the Medicare Option (only Medicare as the payer) or All-Payer Combination Option (payers other than Medicare) or both; and
- Establishes a Payer Initiated Other Payer Advanced APM Determination Process, which would allow payers to request CMS to make a determination on whether a payer's program meets Advanced APM status starting prior to the 2019 QPP performance year. The payers eligible for such determinations include Medicaid, Medicare Advantage, Programs of All Inclusive Care for the Elderly plans and Medicare-Medicaid plans, among others.

Baker Donelson's Comments:

- CMS proposes a higher low-volume threshold for providers effective for the 2018 Performance Year but only proposes to permit those exempted providers to opt-in to MIPS beginning in the 2019 Performance Year. Interestingly, CMS leaves providers with no option to "opt-in" for 2018, even though CMS proposes the new low-volume threshold to take effect in 2018. Providers who were preparing to participate in MIPS may, thankfully or disappointingly, find themselves excluded without an option to participate in 2018. This would eliminate the potential for those clinicians to earn a positive payment adjustment in the 2020 MIPS Payment Year.
- Health care providers wishing to form virtual groups might find themselves scrambling to meet the regulatory requirements, which have not yet been established. Assuming CMS finalizes the virtual group provisions later this year, health care professionals will only have a few months to meet the regulatory requirements for forming a virtual group prior to the 2018 QPP performance year. Such requirements will have to be in place by December 1, 2018, when a written agreement among the virtual group participants must be submitted to CMS. It is questionable at this time how many virtual groups will be able to satisfy the requirements in time for the 2018 Performance Year.
- As CMS continues to review and revise the QPP, it is important for health care professionals to remember that MACRA implementation will continue independent of any discussions about the future of the Affordable Care Act. We encourage health care professionals to evaluate the cost of participation in conjunction with the potential rewards of early implementation. Taking advantage of CMS's Pick Your Pace options provides clinicians with the opportunity to implement strategies related to the QPP measures while the financial impact is relatively low. As CMS increases the amount of Medicare reimbursement at risk, clinicians will benefit if they are in a position to fully participate with several years of experience and learning behind them.
- Given the option of investing in infrastructure to comply with MIPS or participating as part of an Alternate APM, clinicians should be in a position to determine the most effective option for their practices. For those clinicians unable to participate in Advanced APMs at this time, one goal of MIPS

appears to be establishing systems and practices that could translate to successful participation in an Advanced APM in the future.

- Reimbursement is shifting to payment based on performance measures that include cost and quality, among other factors. Waiting too long to understand what this means for a practice could place health care providers at a financial disadvantage.