The Proposed 2019 Quality Payment Program (QPP) Rule: What You May Have Missed

written by Dave Halpert | July 26, 2018

Whoever said bureaucracy doesn't foster change did not anticipate CMS's Proposed Rule for the Quality Payment Program (QPP), 2019 performance year version, released on July 12. While the familiar overarching structure of MIPS remains, there are a number of revisions that activate newly developed policies. These include "Patients Over Paperwork" and "Meaningful Measures" efforts that CMS initiated in 2018 to streamline the requirements-heavy MIPS program.

To be honest, there are some rough patches within the wrangling of old and new MIPS provisions in the 1,473 page 2019 Medicare Physician Schedule Proposed Rule, set to be published in the Federal Register on July 27, 2018. The new policies also represent a very small part of MIPS and essentially overlay the MIPS structure that remains in place. In Year 3 of the QPP, the program becomes more challenging, but some requirements come with caveats or are less intense than originally proposed.

No doubt you've already seen the first round of "five things to know" posts, so let's examine the implications and impacts of the Proposed Rule, as well as some of its less publicized provisions.

CMS Efforts to Reduce "Check-the-Box" Reporting Will Raise Bar for Performance

CMS has proposed adding 10 new measures that they feel reflect the Meaningful Measures goals, four of which are patient-reported outcome measures. These include:

> Continuity of Pharmacotherapy for Opioid Use Disorder
> Functional Status Following Lumbar Spine Fusion Surgery (Patient-Reported)
> Functional Status Following Total Knee Replacement Surgery (Patient-Reported)
> Functional Status Following Lumbar Discectomy Laminotomy Surgery (Patient-Reported)
> Appropriate Use of DXA Scans in Women Under 65 Years Without Risk for Osteoporotic Fracture
> Leg Pain Following Lumbar Spine Fusion Surgery (Patient-Reported)
> Ischemic Vascular Disease, Use of Aspirin or Anti-platelet Medication
> Shingles Vaccination

The inclusion of patient-reported outcomes is a positive step for a meaningful quality program, but it may not please providers who feel patient input is subjective. Nevertheless, inclusion of a fledgling set of patient-report of outcomes introduces the idea that patients' own results can and should be considered in quality scoring,

CMS has also proposed substantial changes for 23 measures and recommends completely dropping 34 measures they determine are duplicative or do little to improve outcomes. These proposed deletions primarily include specialty care measures. As a result of the deletions, some specialists may have a more difficult time finding relevant measures to meet reporting requirements. A few of the deleted measures will be replaced by new proposed versions, but these will not have established benchmarks and will not be scored as favorably as in the past.

Some specialty providers will be challenged to meet the proposed minimum performance threshold of 30 points, double the minimum for 2018. This substantial change will outweigh the total possible points in either the Improvement Activities or Promoting Interoperability categories. In other words, it will take more than one of those two categories for providers to avoid penalties. The Exceptional Performance Bonus threshold has been raised to 80 points. Not only is it harder to avoid a penalty, but it will take a higher leap to qualify for bonus.

However, those who do qualify can expect the monetary value of that incentive payment to increase, as there will almost certainly be more penalties for failing to meet minimum standards. Since only 9 percent of MIPS-eligible clinicians failed to meet the minimum in 2017, the 2019 positive payment adjustments are comparatively small, maxing out at just over 2 percent. Under this Proposed Rule, it's fair to anticipate that more providers will fail to meet the minimum in 2019, while those who succeed will see higher incentives in 2021. Those who fail will also stand to lose up to 7 percent of allowed charges for Part B professional charges in 2021, up from 5 percent. CMS estimates that approximately $372 million will be shuffled between those penalized and those rewarded.

MIPS Cost Component Has Higher Weight but Also Reflects Policy Gap

Cost will be scored more in 2019, at 15 percent of the total MIPS score. That is a 50 percent increase, but half the previously planned level of 30 percent. Along with the continued easing of MIPS requirements for quality reporting, the low weight on Cost may indicate that CMS—unlike the previous administration—does not necessarily see MIPS as a regulatory "stick" to push providers toward Alternative Payment Models.

The lower Cost weight takes some pressure off health care organizations for cost increases. That weight will be negotiated in each of the next three years (2019-2021), with the stipulation that Cost may be valued as no less than 10 per cent and no greater than 30 per cent of the total MIPS points.

We hope that CMS will develop strategies within the reimbursement system to promote reduction of health care costs, both within MIPS, Medicare's largest Value-Based Health Care program, and independent of it. But the retrenchment on Cost weight, along with delayed or non-distribution of cost detail to providers, sends a different message. Providers need comparative cost data, cost measures, and a fee model to influence them to control expenses under a Fee-for-Service reimbursement that rewards the opposite. The alternative, a dramatic cut in Medicare and Medicaid budgets, doesn't solve either consumer or provider issues.

New Episodes of Care Will Apply to Some Specialists

For most physicians, the MIPS Cost component will be scored on the basis of two measures: Total Per Capita Cost (TPCC), and Medicare Spending Per Beneficiary (MSPB). TPCC measures all Medicare Part A and Part B costs during the MIPS performance period and attributes them to providers based on who provided primary care or equivalent services to a patient. MSPB, alternatively, calculates episodic costs related to generic inpatient admissions and related

services, and assigns these to providers.

But some specialists will have one or more of eight proposed episode-based cost measures based on specific conditions. The episode measures are geared toward patients who have received care for specific conditions or who have undergone certain procedures. These additions are particularly noteworthy, as they may be attributable and scored for individual clinicians, depending on whether they have reported on their own or as part of a Group.

Five episodes are procedural; they will be attributed to each clinician who performs a trigger service, as identified by procedure code. A provider would need at least 10 cases for one of these measures to be counted in his/her Cost score:

Elective Outpatient Percutaneous Coronary Intervention (PCI)
Knee Arthroplasty
Revascularization for Lower Extremity Chronic Critical Limb Ischemia
Routine Cataract Removal with Intraocular Lens (IOL) Implantation
Screening/Surveillance Colonoscopy

The remaining three episodes are acute inpatient medical conditions. These are attributed to each MIPS eligible clinician who bills the inpatient E/M claim lines during the trigger inpatient hospitalization, provided that it's billed under a TIN that renders at least 30 percent of the inpatient E/M claim lines for that hospitalization. A provider would need at least 20 cases for one of these measures to be figured into his/her Cost score:

Intracranial Hemorrhage or Cerebral Infarction
Simple Pneumonia with Hospitalization
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

More Physicians Get a Break from MIPS Reporting, but Other Professions Now Included

Physical Therapists, Occupational Therapists, Clinical Social Workers and Clinical Psychologists are now MIPS-Eligible Clinicians, assuming that they exceed the low-volume threshold. However, the low-volume threshold will require that, besides a minimum of $90,000 in allowed Part B charges and at least 200 Medicare beneficiaries, a provider must also provide at least 200 covered professional services under the Physician Fee Schedule. Note that a provider meeting at least one of the criteria can opt in to MIPS.

MIPS applicability to hospital-based providers was a gray area in terms of MIPS eligibility

previously, and that will change under the Proposed Rule. Instead of having Quality and Cost scores calculated like other MIPS eligible clinicians, hospital/facility-based providers will be scored in MIPS in conjunction with the Hospital Value-Based Purchasing Program (HVBP).

A provider performing at least 75 percent of services in a hospital or emergency room may be attributed to a facility with a HVBP score and be eligible for facility-based measurement. Scoring will come from the methodology used in the HVBP. To be considered a facility-based group, at least 75 percent of the providers meet the definition of facility-based clinician. No additional data submission is required for Quality and Cost, but those providers will need to submit data for the Improvement Activities and Promoting Interoperability components.

A Soft Sell for Alternative Payment Models (APMs)

CMS anticipates that between 160,000 and 215,000 eligible clinicians will be Qualified Participants (QPs) in an APM, and would be excluded from MIPS. CMS does expect the number of MIPS-eligible clinicians to rise and to continue (for now) to outweigh the number who participate in the Quality Payment Program via an APM.

But the relationship between MIPS and APMs under the Proposed Rule remains connected—and voluntary. There are still APMs in which providers are required to report MIPS due to lack of downside risk, and the 5 percent bonus remains the only financial incentive for APM participation. Note, however, that in addition to this Proposed Rule covering the Physician Fee Schedule and general aspects of the QPP, there is an additional Rule likely to be released later that will focus on ACOs and other APMs.

However, the Proposed Rule does move forward in enfolding providers in the “APM world” by annexation of providers participating in other types of risk-based reimbursement programs. The key details about this are not mentioned in the high-level CMS Fact Sheet.

Some of the biggest news is related to Medicare Advantage. The separation of MA from the QPP (and PQRS before) has long been a source of confusion; this proposal indicates that CMS hears the call to tie the programs together. There will be a test run, called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration. Its goal will be to determine whether clinicians who are participating in Medicare Advantage Organizations (MAOs) can be excluded from MIPS and scored similarly to those participating in APMs. The provider would need to have a sufficient amount of Medicare FFS payments coming through a combination of MAO and APM services to qualify, but it may make a difference for those who aren’t considered Qualified Participants in one APM.

The Proposed Rule also includes more specifics on the All-Payer Combination Option APM. Currently, all APMs apply only to Medicare patients, and providers get no credit for participating in health plan-negotiated ACOs. The Rule proposes that to achieve Qualified Participant Status, a provider would need to have 25 percent of Medicare payments and 50 percent of total payments coming through the APM, or 20 percent of Medicare patients and 40 percent of total patients coming through the APM, whichever is more advantageous for the provider. These minimum thresholds are set to increase each year.

Buried within the proposal, capitation is specifically called out as meeting the APM criteria for the All-Payer option, provided that it is a full capitation arrangement. To meet this definition, a fixed payment must be allocated for care spanning a specific time period, and there can be no reconciliation between the health plan and provider organization if the cost of treatment exceeds the cost allotted under the capitation arrangement.

CMS has distributed guidelines to payers interested in being a part of the All-Payer Combination Option.

New challenges will also be applied to Alternate Payment Models (APMs). The Proposal states an APM will need to have at least 75 percent of its clinicians using Certified EHR Technology (CEHRT), rather than the simple majority required now. Additionally, the MIPS-comparable measures required for reporting must now include at least one outcome measure. Financial risk, the remaining criteria of an APM, is largely unchanged, including the 8 percent nominal amount standard.

Qualified Clinical Data Registries (QCDRs): A Higher Standard and Additional Benefits

CMS has proposed that, beginning with the 2020 measurement year, a QCDR must have clinical expertise in medicine and quality measure development. According to CMS, the need has arisen due to their belief that certain QCDRs are too technically focused, without the clinical knowledge to facilitate quality improvement. Measuring and improving performance has always been the focus of the Roji Health Intelligence QCDR, and we welcome this additional requirement.

Additionally, due to the duplication and scoring concerns with QCDR measures, CMS has also proposed that QCDRs that design their own measures must enter into a licensing agreement with CMS that allows other QCDRs to report the same measure (with the same designation and without modification) for MIPS. This is very good news for those who are interested in QCDR measures, but who had concerns related to a lack of benchmark or who had a greater risk of

appearing to have poor performance based on a small number of entities reporting that measure. In some situations, the smallest difference can separate the winners and losers.

Progress for Price Transparency, but Nothing Is Decided

In an interesting inclusion to the Proposed Rule, CMS is specifically requesting input on how to create price transparency for consumers. Bravo!

CMS also states its long term interest in addressing health inequities by addressing risk stratification methodologies, which is positive.

As we've seen in previous years, there can be substantial changes between what's proposed and what's finalized in CMS Rules. However, nothing has surprised us in this Proposed Rule, apart from what it is missing: the CMS plan for cost control.

Your comments may be positive or negative; CMS considers both types of feedback when finalizing a Rule, but will not accept comments after September 10, 2018. Make your voice heard at regulations.gov.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Erwan Hesry