“Push-Pull” for Providers in Medicare’s Proposed 2021 Rule for Physician Fees and Quality Reporting

written by Dave Halpert | August 6, 2020



The newly published 2021 CMS Physician Fee Schedule and Quality Payment Program (QPP) Proposed Rule reflects our harsh reality: Operate under the constraints of the COVID-19 pandemic, while moving toward uniformity and Risk. That tension is palpable in the Proposed Rule's "push-pull" of CMS trying to continue to advance a Value agenda while stuck in the mud of the pandemic.

Rather than launching the next step of integrating CMS quality improvement activities, the Proposed Rule stays the current course for MIPS Quality Reporting to avoid additional stress on providers during the COVID-19 pandemic. But the Proposed Rule also continues to clear the path toward a common system of quality measurement for all providers, and toward financial Risk.

CMS explicitly declares that a public health emergency is not the time to make big program changes, delaying the MIPS Value Pathways (MVPs) model until 2022. However, the Proposed Rule—

which also covers Physician Fee Schedule (PFS) modifications for 2021—includes provisions for new, permanent telehealth codes.

COVID-19 has led to a massive upswing in telehealth; in turn, the Proposed Rule provisions for new telehealth codes include adjustments for complexity and prolonged services, along with other changes. They also allow flexibility to use these codes in new settings, including home visits. In the Merit-Based Incentive Payment System (MIPS), many quality and cost measures will be adjusted to reflect the increased use of telehealth codes.

While there has been an attempt to maintain QPP consistency for the sake of the COVID-19 pandemic, the 1,353-page Proposed Rule covers a lot of ground. Reading between the lines, it's clear that CMS remains committed to moving providers from a fee-for-service system into Value-Based reimbursement models. Specifically, they want providers out of MIPS and into Alternate Payment Models (APMs), which are the most significant ways that CMS is advancing this agenda.

Forfeited to the Pandemic in 2021: MIPS Value Pathways (MVPs)

The clearest example of "give" to providers in the Proposed Rule is the delayed release of the MIPS Value Pathways (MVPs) model. MVPs were previously scheduled for implementation in 2021, as finalized in the 2020 Final Rule. However, as we are in the midst of a pandemic, organizations have had neither the time nor the resources to prepare for these changes, so CMS proposes limiting disruptions to MIPS. Nevertheless, CMS has updated the MVP Guiding Principle and the Proposal provides

insight on how MVPs will be used to move providers into APMs.

In particular, organizations will have greater control over their scoring than previously understood. First and foremost, CMS "envisions" (this is a Proposed Rule) that MVPs will be optional for providers when a set of measures and activities align with their practice. Organizations will need to formally submit their MVP as a candidate to CMS, using a to-be-defined template. The submitter will propose the measures, Improvement Activities, and cost measures to be included in the MVP. This may help alleviate concerns among practices that CMS would arbitrarily hand down pre-defined MVPs, without regard to the specific types of care they provide.

To earn MVP approval, organizations should tie the 21st Century Cures Act and Patient Protection and Affordable Care Act into their MVP framework. This will obviously include a link to the Promoting Interoperability category of MIPS, but should go much further.

On the Quality side, CMS has proposed an additional guiding principle of MVPs, which is the use of "Digital Quality Measures" (dQMs). These are rooted in digital data sources, ranging from the mainstays like EHRs, HIEs and Registries, down to newer sources, including assessment data and even wearable devices. This signals CMS's desire to amplify the patient voice in the measurement process. In fact, CMS advocates through this Proposed Rule the belief that patients should be involved in the MVP development process itself, in order to ensure that the measurement is meaningful to them.

CMS has made no secrets about its desire to move providers out

of MIPS and into the APM world, and this MVP process will give organizations the chance to develop their own “APM-Lite” structure, enabling them to succeed in MIPS in 2022, while spring-boarding them into APM readiness.

Simplified QPP Scoring for APM Participants: Introducing an APM Performance Pathway (APP)

This Proposal introduces an APM Performance Pathway, intended to standardize participation options among MIPS and APM tracks, while simultaneously facilitating APM participation. As proposed, the APP is only available for MIPS APM participants, but it does allow reporting at the individual, group (by TIN), or the APM entity level.

The APP is structured in a similar manner to a Medicare Shared Savings Program (MSSP) ACO. Those who volunteer for the APP would be able to report a single set of measures and receive an Improvement Activities credit. The cost performance category would be re-weighted, as providers are already scored on cost within the context of their APMs.

The integration of the APP marks the end of the “APM Scoring Standard,” which will substantially simplify QPP scoring for APM participants. The proposed measure set is primary-care centric, with one measure each for patients with hypertension and diabetes, a depression screening measure, performance on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and two administrative claims-based measures.

The APP will shake up MSSP ACO scoring, as ACOs will need to report via the APP process, rather than the CMS Web Interface. *In fact, the CMS Web Interface is being retired altogether, for*

both MIPS and ACO quality measure submission. The number of measures that the ACO (or APP participant) will "actively" submit (as opposed to being calculated by CMS or the survey vendor) will be reduced from 10 to 3. While this is a clear signal that CMS is focusing more on costs and patient feedback than scoring a multitude of quality measures, it is also *a warning to ACOs that they will need to find an alternate method of quality data submission.*

Uncertain MIPS Quality Scoring: Providers Who Don't Aggressively Push for Success, Beware

While the category itself may not undergo massive changes, that's not the case with the specifics. As we know, "the devil is in the details."

The majority of the Quality scoring system will remain intact. MIPS measures will still be graded on a 3 to 10 point scale, provided the measure has a historical benchmark, at least 20 eligible cases, and a response for at least 70 percent of the applicable denominator (although CMS anticipates using a 1 to 10 point system for MVPs). Measures with fewer than 20 denominator-eligible cases or without an assigned benchmark will continue to earn 3 points, provided that at least 70 percent are reported eligible cases. In a change of course that providers should appreciate, CMS has proposed that points will continue to be awarded for those reporting additional outcome and high-priority measures.

Things get complicated when looking further, though, starting with the measures themselves. Of the 206 proposed quality measures, 112 of the 2020 measures will undergo "substantive changes." While many of these changes relate to the inclusion

of telehealth services, providers would behoove themselves to review updated specifications before beginning in 2021—additional updates are scattered throughout. There may be more to these changes than meets the eye. *A measure with substantive changes may lose its historical benchmark. This means that the measure may only earn a maximum of 3 points, even though the prior-year iteration of that measure could earn up to 10 points.*

The benchmark issue is further compounded by the COVID-19 pandemic. CMS has raised concerns that the pandemic will compromise the integrity of benchmarks, as they are calculated based on the prior year. For 2021, that would mean measures reported in 2020—as we know, this is far from a normal year, and benchmarking based on 2020 data is suspect. Therefore, CMS will calculate 2021 benchmarks based on what is actually submitted in 2021. As a result, clinicians will not have the ability to track their performance against an established standard during the year, which has been a feature of MIPS in prior years (with the right partner).

While this may create a scenario where additional measures receive benchmarks (potentially earning more points), the overall impact will be challenging to providers. They will not be able to track comparative performance at a program-level and will not know how a measure will impact MIPS scoring—and future reimbursement. CMS has stated that they are seeking feedback on potentially using the 2019 performance period to calculate 2021 benchmarks, but the official proposal is to calculate performance after the fact (comments—through regulations.gov, code CMS-1734-P—are due by October 5, 2020!).

Complicating things further, two new administrative claims measures have been proposed. One is global (Hospital-Wide 20-Day All-Cause Unplanned Readmissions), requiring at least 200 cases in the denominator, and one is episode-specific (Risk-Standardized Complication Rate Following Elective Primary Total Hip and/or Knee Arthroplasty), requiring 25 cases. CMS Feedback on prior episode-based cost measures has been sparse, and the same type of information (i.e. the relationship between costs and re-admissions and surgical complications.) would have been useful for preparing providers for these two measures. Unfortunately, the details provided by legacy programs' (PQRS and the VBPM) feedback reports have historically not been included in MIPS feedback reports.

Both Give and Take for Providers: Maximizing MIPS Penalties (but Limiting MIPS Rewards)

MIPS is a budget-neutral program, meaning that (with the exception of Exceptional Performance bonuses), CMS cannot distribute incentive payments beyond what CMS has recouped through penalties. If most providers meet the minimum performance threshold, the penalty pool is relatively small, and so is the corresponding incentive.

In the 2018 performance year (the 2020 payment year), 98 percent of MIPS participants earned a positive incentive payment in 2020. Unfortunately, that means the incentive was funded by the mere two percent who did not meet the minimum requirement—a thin incentive spread for the 98 percent of successful participants. CMS is still calculating 2019 results, as the submission period was extended due to the pandemic. However, with the opt-out opportunity and extension, given the

trend (a similarly high success rate was achieved in 2017), it is likely that the 2021 incentive payment (based on 2019 performance) will be equally modest.

For 2021, CMS has proposed that the Performance Threshold will only be increased to 50 points, rather than the 60 points that were established in the Calendar Year (CY) 2020 policy. Nevertheless, CMS is standing by the increase to the Exceptional Performance Threshold; it remains at 85 points. The result will likely be a large percentage of providers who avoid penalties, with fewer earning the Exceptional Performance bonus.

Furthermore, in keeping with the proposed APP framework and end to the APM scoring standard, CMS has adjusted its scoring hierarchy, such that, should a provider have more than one type of data submission (i.e. Virtual Group, APM, Group Practice, Individual), as long as the provider is not in a Virtual Group, CMS will assign the provider the highest possible score—even if that provider is in an APM. That means more opportunity for providers to exceed the 50-point threshold and claim a sliver of the incentive pie.

Even though the penalty is staggering (9 percent in 2023, if failing to meet 2021 requirements), having a comparatively small group in this contingent will mean that incentive payments will be nominal, especially when compared to successful APM participants.

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