

Quality Payment Program Proposed Rule Highlights

Since the Centers for Medicare and Medicaid Services (CMS) issued the final Quality Payment Program (QPP) rule last fall, the AMA continued to actively engage various parts of the Administration to improve the program. These efforts paid off. Many of the policies in the proposed rule are based on AMA recommendations. In essence, the agency is providing another transition year. CMS is also proposing a number of policies to help small practices. In sum, CMS estimates that under this proposed rule more than 94 percent of eligible clinicians would earn either a positive or neutral payment adjustment.

Please remember this is a proposed rule and AMA staff will work to preserve favorable provisions in the proposed rule while continuing to press for additional changes in the final rule. The proposed rule is over one thousand pages long and AMA staff will be immersing themselves in the details in the coming weeks.

Here are some of the highlights from our initial read of the proposed rule: (The thumbs up signs reflect policies that address concerns raised by the AMA).

Additional accommodations for small practices

- Significantly expands the low-volume threshold to \$90,000 or less in Medicare Part B allowed charges OR 200 or fewer Medicare Part B patients (previously the threshold was \$30,000 in allowed charges or 100 patients) – CMS estimates that only 37% of clinicians who bill Medicare will be subject to MIPS;
- Creates virtual groups to assist small practices;
- Adds 5 bonus points to the final MIPS scores for practices of 15 or fewer clinicians; and

- Adds a hardship exception from the advancing care information (previously Meaningful Use) category for practices of 15 or fewer clinicians.

Advancing care information

- Allows the use of 2014 edition certified electronic health records technology (CEHRT) past 2017 – CMS will not mandate that physicians update their EHRs in 2018;
- Increases opportunities for bonus percentage points; and
- Permits physicians to continue to report on Modified Stage 2 measures in 2018 instead of new Stage 3 measures.

The AMA will continue to seek more flexible ACI measures.

Quality

- Increases the quality performance category weight to 60% in 2018 (due to the Cost category weight remaining at zero in 2018);
- No additional cross-cutting measure requirements added in 2018;
- Maintains data completeness threshold at 50% in 2018. (Measures that do not meet data completeness will receive 1 point, except small practices which will receive 3 points per measure);
- Maintains 3 point floor for measures scored against a benchmark, measures that do not have a benchmark, and measures that do not meet the case minimum;

- New and modified specialty measure sets for the 2018 performance period, including the removal of cross-cutting measures from most of the specialty sets (only retained in Family Practice, Internal Medicine and Pediatrics specialty sets);
- Maintains the number of quality measures a physician must report for full participation in the Quality performance category. (AMA asked that physicians be required to report even fewer quality measures in 2018);
- Proposes a phased-in approach to identify and remove topped out measures.

The AMA will continue to urge CMS to retain topped out measures, but if the agency insists on periodically removing them it should implement a more systematic and transparent process.

Cost category

- CMS proposes a zero weight for costs again in the 2018 performance/2020 payment year, which would rise to 30% the following year. The agency also is seeking comments on whether to stick with its prior plan to weight the category at 10% next year;
- 10 previously-finalized episode-based cost measures will be replaced in the future with measures developed with more input from clinical experts and stakeholders; and
- Physicians will receive information on how they would have scored under the two current value-based modifier measures (total costs per beneficiary and spending from 3 days before to 30 days after hospital admission) which the AMA has opposed but if the zero weight is finalized, the scores will not count.

The AMA had urged CMS to keep the score at zero for several more years and will continue to urge CMS and Congress to limit the weight of this category.

Improvement activities

- Continues to allow physicians to report on IAs through simple attestation;
- Creates stability in program requirements by not changing the number of IAs physicians must report; and
- Develops additional IAs, including adding two activities related to diabetes prevention programs, and clarifies existing IAs to be inclusive of additional activities.

The AMA will continue to work with CMS to increase the number of IAs available to physicians and strive to align the IA and ACI categories.

Alternative payment models

- The revenue standard for more than nominal financial risk remains at 8% of revenues;
- Other Payer APMs also have access to the 8% of revenues standard for more than nominal risk;
- Participants in the one medical home model currently recognized as an Advanced APM, CPC+ will not be excluded from the medical home risk standard if they have more than 50 clinicians; and
- The Physician-focused Payment Model committee may consider APMs for which Medicaid is a payer even if Medicare is not.

In addition, CMS has requested comments on methods for allowing physicians' participation in Medicare Advantage APMs to count toward the required thresholds for Advanced APM participation, as the AMA has recommended.