HealthCare
Kentucky Regional Extension Center

Quick Look: QPP Year 3 NPRM Summary

On July 12, 2018, CMS issued a Notice of Proposed Rulemaking (NPRM) related to the Quality Payment Program (QPP) in addition to the Medicaid Promoting Interoperability Program and payment polices under Physician Fee Schedule. The Medicare Access and CHIP Reauthorization Act (MACRA) allows Medicare to increase or decrease reimbursements to clinicians based on quality, cost and utilization of certified electronic health records. The amount at risk increases from +/- 5% in Performance Year 2018 to +/- 7% in 2019, and then 9% in subsequent years. CMS adjusts the QPP (created by MACRA) NPRM and subsequent Final Rules. Following the NPRM there is a 60-day comment period where the public can make recommendations for changes to the following year's requirements. This NPRM is set to impact Year 3 or the 2019 Performance Year.

The deadline for NPRM comments is September 10, 2018.

Proposed Changes to Year 3 of the Quality Payment Program

ELIGIBILITY

MIPS Eligible Clinicians: MIPS applies to Medicare Part B clinicians including: Physicians, PAs, NPs, CNS, & CRNAs

Proposed to Include:

- Physical therapist
- Occupational therapist
- Clinical social worker
- Clinical psychologist

EXCEPTIONAL PERFORMANCE BONUS

$500M is still available to split for those deemed exceptional performers (See Scoring Thresholds). That is exempt from budget neutrality over the first five years of the program.

LOW VOLUME THRESHOLD AND OPT-IN

To be excluded from MIPS, clinicians or groups would need to meet one of the following three criterion:

- Have ≤ $90K in Part B allowed charges for covered professional services
- Provide care to ≤ 200 beneficiaries
- OR provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)

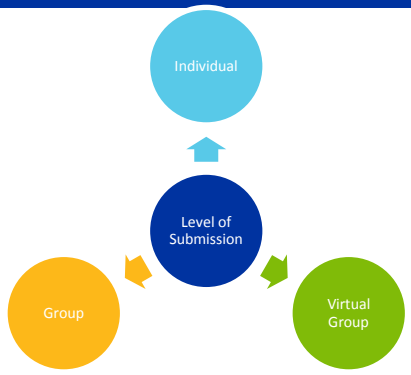
Clinicians or groups would be able to opt-in to MIPS if they meet or exceed 1-2, but not all, of the low-volume threshold criterion.

SUBMISSION METHODS

In an effort to simplify the terminology surrounding submission methods for QPP, CMS is proposing to allow for the following submission methods:

- Direct
- Log-in and Upload
- Log-in and Attest
- Medicare Part B Claims
- CMS Web Interface

LEVEL OF SUBMISSION



SCORING THRESHOLDS

- Scores < 30 points will receive penalties up to 7% penalty in Medicare payments
- EC's must submit for 2 or more performance categories to qualify for a positive adjustment
- Scores +80 are in the exceptional performance category

FACILITY-BASED SCORING

CMS is proposing to provide the option to use facility-based scoring for facility-based clinicians that does not require data submission, in order to reduce the burden

INDIVIDUAL:

- EC must furnish 75% or more of covered professional services in inpatient hospital, on-campus outpatient hospital or ED based on claims
- EC is attributed to the hospital at which they provide services to the most Medicare patients
- No submission requirements and is automatically applied

GROUP:

- Group must have 75% or more of EC NPIs billing under the group's TIN who are eligible for facility-based measurement as individual ECs
- Group is attributed to the hospital at which a plurality of its facility-based clinicians are attributed
- Groups must submit IA and PI in order to be measured as a group under facility-based measurement

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QUALITY

- Proposed weighting for Year 3: 45%
- Individual ECs would be allowed multiple submissions across different collection types for each measure – final score based on highest achieved points for measure across collection types
- Groups and Virtual Groups would be able to use multiple collection types
- Discontinue bonus points for High-Priority Measures (after first required measure) for CMS Web Interface reporting
- Small Practice Bonus is proposed to be moved to the Quality category and up to 3 points will be added to the numerator for qualifying practices

COST

- Proposed weighting for Year 3: 15%
- Score continues to be based on data submitted via claims
- Measures include Total Per Capita Cost and MSPB, as in Year 2; BUT, proposed to be extended to include an additional 8 episode-based measures
- Threshold for Cost: Must have a case minimum for 10 procedural episodes and 20 inpatient medical condition episodes during the performance year

PROMOTING INTEROPERABILITY

- No change to weighting for Year 3: Remains 25%
- Must use 2015 Edition CEHRT in Year 3
- Elimination of Transitional Measure Set
- Automatic re-weighting applies and would expand to include PT, OT, CSW, and Clinical Psychologists
- Significant scoring and objective changes proposed:
  - Eliminating Base, Performance, and Bonus methodology
  - Shift to only Performance-based scoring model across four main objectives
  - Scores added together for each measure to calculate for 100 possible points
  - Exclusions available for HIE and Public Health & Clinical Data Exchange
  - If exclusion claimed, points are reallocated to other measures
  - Bonuses available for e-Prescribing Objective: Query of Prescription Drug Monitoring Program & Verify Opioid Treatment Agreement

IMPROVEMENT ACTIVITIES

- No change to weighting for Year 3: Remains 15%
- Proposing the removal of the CEHRT Bonus

ALTERNATIVE PAYMENT MODELS

Increasing the CEHRT use criterion threshold for Advanced APMs so that an Advanced APM **must require at least 75%** of ECs in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals.

ALL PAYER COMBINATION OPTION FOR APMs

- All-Payer Combination Option is available in the 2019 QP performance period
- All-Payer Combination Option is one of two pathways through which ECs can become a QP or partial QP
- Option for ECs to achieve QP status based on a combination of participation in: Advanced APMs with Medicare, and Other Payer Advanced APMs offered by other payers

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