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2020 Quality Payment Program Proposed Rule

Summary

On Monday, July 29, 2019, CMS issued the 2020 Quality Payment Program (QPP) proposed rule that includes updates to the current program and a new Merit-Based Incentive Payment System (MIPS) Value Pathways framework. Comments on the proposed rule are due September 27, 2019.

The QPP encompasses the MIPS and the Alternative Payment Model (APM) program, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. It's important that radiation oncology practices understand key aspects of the QPP, which includes a complex system of increasing payment bonuses and penalties under Medicare. For general information on the QPP, go to www.astro.org/qpp.

MIPS

MIPS Scoring Methodology

For 2020, CMS is proposing the following weights for the four MIPS performance categories:

- Quality – 40 percent (down from 45 percent in 2019)
- Improvement Activities – 15 percent
- Promoting Interoperability – 25 percent
- Cost – 20 percent (up from 15 percent in 2019)

CMS proposes an increase in the performance threshold from 30 to 45 points for the 2020 performance year, and 60 points for the 2021 performance year. The exceptional performance threshold is proposed to increase from 75 to 80 for 2020, and 85 for 2021.

The payment adjustment for 2022 (based on 2020 performance) is set to range from -9 percent to +9 percent, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated based on professional services paid under the Medicare physician fee schedule (PFS), removing Part B drugs.

Performance Category Reweighting

CMS continues to provide Promoting Interoperability hardship applications for the 2020 performance period. The Agency believes this is particularly important for small practices. The exemption re-weights the Promoting Interoperability category to zero, shifting an additional 25 percent to the Quality category.

CMS is proposing to reweight performance categories in rare events due to compromised data outside the control of the MIPS eligible clinician. MIPS eligible clinicians or third-party intermediaries can inform CMS that they believe they are impacted by a relevant event by providing information on the event. If CMS determines that reweighting for compromised data is appropriate, the Agency will redistribute points to the Promoting Interoperability and Quality performance categories, and in rare instances, to the Cost performance category.

CMS continues to assign a zero percent weight for the Promoting Interoperability performance category for groups defined as hospital-based and non-patient facing, and redistribute the points associated with the Promoting Interoperability performance category to another performance category or categories. However, the Agency is proposing new definitions for hospital-based and non-patient facing groups. According to the proposed modification, a group is identified as hospital-based and eligible for the reweighting if more than 75 percent of the NPIs in the group meet the definition of a hospital-based individual MIPS-eligible clinician. For non-patient facing groups (more than 75 percent of the MIPS-eligible clinicians in the group are classified as non-patient facing), CMS proposes to automatically reweight the Promoting Interoperability performance category.

Targeted Review

CMS is proposing that beginning with the 2019 performance period, all requests for targeted review would be required to be submitted within 60-days of the release of the MIPS payment adjustment factor(s) with performance feedback.

Clinician Eligibility

The 2020 QPP proposed rule continues current MIPS eligibility requirements by assessing thresholds only against covered professional services paid under or based on the PFS. The eligibility thresholds continue to be set at greater than $90,000 in covered professional services and 200 Medicare Part B beneficiaries, who are furnished covered professional services. The Agency continues to allow clinicians or groups to opt-in to MIPS, if they meet or exceed one or more criteria, but not all of the low-volume threshold criterion. Exceeding all criteria in the low volume threshold means that a physician or group will be included in the MIPS program for the 2020 performance year.

Clinicians choosing to opt-in are required to make an election via the Quality Payment Program portal by logging into their account and simply selecting either to opt-in or to remain excluded and voluntarily report. Those that remain excluded or voluntarily report will not receive a MIPS payment adjustment.

For the 2020 performance year, the Agency is proposing to revise the definition of hospital-based MIPS eligible clinician to include groups and virtual groups. CMS also proposes that a hospital-based MIPS eligible clinician means an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service

identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off-campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable. CMS also proposes revisions to account for a group or virtual group that meets the definition of a non-patient facing MIPS eligible clinician, such that the group or virtual group only has to meet a threshold of more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs.

CMS is maintaining the option for solo practitioners and groups with ten or fewer MIPS eligible clinicians to establish Virtual Groups. For all performance categories, the performance of individual members of the Virtual Group will be combined to determine the entire groups' performance. For the 2020 performance year, Virtual Groups must complete required contracting and notify CMS of their intention to become a Virtual Group by December 31, 2019.

Bonus Points

Complex Patients

CMS proposes to continue the additional five bonus points to the overall Composite Performance Score (CPS) for complex patients based on the combination of the dual eligibility[1] ratio and the average Hierarchical Conditions Category (HCC)[2] risk score.

Small Practice Bonus

CMS proposes to keep the small practice bonus of six points for the 2020 performance year to be applied to the 2022 payment year. The bonus will continue to be added to the Quality performance category, as it was in 2019, rather than in the MIPS final score calculation, as it was in 2018. To receive the bonus, a small practice must submit Quality data. This applies to individual clinicians, group practices, virtual groups, or MIPS APM entities that consist of 15 or fewer clinicians.

Quality Performance Category

The Agency is proposing to change the weighting of the Quality category from 50 percent to 45 percent for the 2020 performance year. The reporting period for the Quality category will continue to be a full calendar year.

[1] "Dual eligible beneficiaries" is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through a "Medicare Savings Program" (MSP) category.

[2] Hierarchical Conditions Category (HCC) is a risk adjustment model using patient diagnoses and demographic information to predict medical spending.

CMS is proposing to increase the data completeness threshold from 60 to 70 percent of Medicare Part B patients for the 2020 performance year, with a minimum of 20 cases per measure. CMS is also maintaining the 1-point floor for measures that do not meet data completeness requirements. This policy does not apply to small practices, who will continue to earn three points for submitting measures that do not meet data completeness.

CMS proposes to remove MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance periods. The Agency believes that removing measures using this methodology ensures that the MIPS quality measures available in the program are truly meaningful.

Cost Performance Category

The Balanced Budget Act (BBA) of 2018 provided flexibility in the weighting of the Cost category, and CMS is proposing a 20 percent weight for the Cost category for 2020, with a 5 percent increase each year until the 2022 performance year when the category will be weighted at 30 percent. The reporting period for the Cost category continues at a full calendar year.

The BBA of 2018 also retroactively delayed implementation of improvement scoring in the Cost category until the 2022 performance year. As a result, improvement scoring is removed from the 2020 performance year.

CMS is proposing the addition of 10 newly developed episode-cost measures to the list of cost measures, although none of these measures apply to radiation oncology. Cost measures will continue to include Medicare Spending Per Beneficiary (MSPB) and total per capita cost (TPCC) for all attributed beneficiaries.

Total Per Capita Cost Measure (TPCC)
CMS proposes changing the attribution methodology for TPCC to more accurately identify clinicians who provide primary care services, by the addition of service category exclusions and specialty exclusions. Specifically, as proposed, candidate events are excluded if they are performed by clinicians who (i) frequently perform non-primary care services (for example, global surgery, chemotherapy, anesthesia, radiation therapy) or (ii) are in specialties unlikely to be responsible for providing primary care to a beneficiary (for example, podiatry, dermatology, optometry, ophthalmology). While radiation therapy would be excluded from this measure, physician assistants and nurse practitioners are not included in the proposed exclusions.

Medicare Spending Per Beneficiary (MSPB) Clinician
CMS is proposing to rename the MSPB measure to "MSPB clinician" measure to distinguish it from measures with similar names in use in other CMS programs and to improve clarity. The Agency also proposes to change the attribution methodology to distinguish between medical episodes and surgical episodes. A medical episode is first attributed to the TIN billing at least 30 percent of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay. The episode is then attributed to any clinician in the TIN who billed at least one inpatient E/M service that was used to determine the episode's attribution to the TIN. Medical episodes

are attributed first at the clinician group (TIN) level, and then at the clinician (TIN-NPI) level. For example, a surgical episode is attributed to the surgeon(s) who performed any related surgical procedure during the inpatient stay, as determined by clinical input, as well as to the TIN under which the surgeon(s) billed for the procedure. Unrelated services specific to groups of Diagnosis Related Groups (DRGs) aggregated by Major Diagnostic Category (MDC) level are excluded.

Improvement Activities Performance Category

CMS proposes to keep the weight for Improvement Activities performance at 15 percent, based on a selection of medium and high weighted activities, and retains the 90-day minimum performance period. CMS is proposing to increase the group, and virtual group reporting threshold from at least one clinician to at least 50 percent of the group beginning with the 2020 performance year. The Agency also proposes that at least 50 percent of a group's NPIs must perform the same activity for the same continuous 90 days in the performance year, beginning with the 2020 performance year.

CMS proposes adding two new Improvement Activities, modifying seven existing activities and removing 15 activities.

The proposed new Improvement Activities include:

- Drug Cost Transparency
- Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes

The proposed modified activities include:

- Completion of an Accredited Safety or Quality Improvement Program
- Anticoagulant Management Improvements
- Additional improvements in access as a result of Quality Innovation Network/Quality Improvement Organization Technical Assistance
- Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
- Participation in a Qualified Clinical Data Registry (QCDR), that promotes use of patient engagement tools
- Use of QCDR data for ongoing practice assessment and improvements
- Completion of Collaborative Care Management Training Program

The activities proposed for removal include:

- Participation in Systematic Anticoagulation Program
- Implementation of additional activity as a result of technical assistance TA for improving care coordination

- Participation in Quality Improvement Initiatives
- Annual Registration in the Prescription Drug Monitoring Program
- Initiate CDC Training on Antibiotic Stewardship
- Unhealthy alcohol use
- Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan
- Use of QCDR to support clinical decision making
- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement
- Participation in a QCDR, that promotes implementation of patient self-action plans
- Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination
- Leveraging a QCDR for use of standard questionnaires
- Leveraging a QCDR to standardize processes for screening
- Use of QCDR data for quality improvement such as comparative analysis reports across patient populations
- TCPI Participation

CMS proposes the following criteria for removal of improvement activities:

- It is duplicative of another activity
- An alternative activity exists with stronger relationship to quality care or improvements in clinical practice
- The activity does not align with current clinical guidelines or practice
- The activity does not align with at least one meaningful measures area
- The activity does not align with Quality, Cost, or Promoting Interoperability performance categories
- There have been no attestations of the activity for threeconsecutive years
- The activity is obsolete

Improvement Activity scores continue to be based on simple attestation in 2020.

<u>Promoting Interoperability (PI) Performance Category</u>

The Agency proposes retaining both the 25 percent weight for the PI category and the 90-day minimum performance period for 2020. Additionally, CMS proposes to continue the requirement that eligible clinicians use 2015 Edition CEHRT for 2020.

For the 2021 performance year, CMS is proposing to continue the PI performance period of a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year. The Agency believes this would be an appropriate performance period because of the maturation needed within the

performance category. In addition, it would offer stability and continuity for the PI performance category after the performance category overhaul that was finalized in the 2019 final rule.

The Agency is proposing that the Query of Prescription Drug Monitoring Program measure require a yes/no response for the current (2019) performance year, instead of a numerator and denominator. For the 2020 performance year, the Agency proposes to keep this measure as optional. CMS proposes to remove the Verify Opioid Treatment Agreement measure beginning in the 2020 performance period.

For the 2019 performance year, CMS proposes to redistribute the Support Electronic Referral Loops by Sending Health Information to the Provide Patients Access to Their Health Information measure if an exclusion is claimed.

Facility-Based Quality and Cost Performance Categories

CMS is proposing to clarify the definition of facility-based clinician to state that a MIPS eligible clinician is facility-based if the clinician can be assigned to a facility with a value-based purchasing score for the applicable period.

Qualified Clinical Data Registry (QCDR)

CMS is proposing that beginning in the 2021 performance period, QCDRs be required to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories. The Agency also proposes that beginning in the 2021 performance period, feedback reports include information on how participants compare to other clinicians within the QCDR cohort who have submitted data on a given measure. QCDRs would be required to attest during the self-nomination process that they can provide performance feedback at least four times a year. In instances where the QCDR does not receive data from their clinician until the end of the performance period, the QCDR could be exempted from this requirement.

CMS proposes that beginning in the 2020 performance period, in instances in which multiple, similar QCDR measures exist that warrant approval, the Agency may provisionally approve the individual QCDR measures for one-year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years. Duplicative QCDR measures would not be approved if QCDRs do not elect to harmonize identified measures as requested by CMS within the allotted timeframe.

CMS proposes that beginning in the 2021 performance period, at the time of self-nomination, QCDRs must identify a linkage between their QCDR measures to the following: cost measure, Improvement Activity, or CMS developed MIPS Value Pathways (MVPs) (see section on MVP below). QCDR measures will be required to be fully developed with completed testing results at the clinician level and must be ready for implementation at the time of self-nomination. QCDRs will also be required to collect data on a QCDR measure, appropriate to the measure type, prior

to submitting the measure for CMS consideration during the next nomination period. CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure. CMS further proposes that a QCDR measure that does not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance years, may not continue to be approved in the future.

MIPS Value Pathways (MVP)

CMS proposes a new MIPS Value Pathways (MVP) framework to future proposals, beginning with the 2021 MIPS performance period, to simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. The new framework would remove barriers to APM participation and promote value by focusing on quality, interoperability, and cost. MVP allows for a more cohesive participation experience by connecting activities and measures from the four MIPS performance categories that are relevant to the population they are caring for, a specialty or medical condition. Additionally, MVP would create a cohesive and meaningful participation experience for clinicians by moving away from siloed activities and measures toward an aligned set of measures that are more relevant to a clinician's scope of practice, while further reducing reporting burden and easing the transition to APMs.

CMS outlined four guiding principles for MVP in the proposed rule:

1. MVP should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.
2. MVP should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care.
3. MVP should include measures that encourage performance improvements in high priority areas.
4. MVP should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.

The most significant change with MVP is that eventually all MIPS eligible clinicians would no longer be able to select quality measures or improvement activities from a single inventory. Instead, measures and activities in an MVP would be connected around a clinician specialty or condition. Cost measures would be specific to the MVP and applied only when a clinician or group meets the case minimum.

CMS is seeking feedback on all aspects of MVPs.

Alternative Payment Models (APMs)

<u>RO Model</u>

The 2019 QPP proposed rule did not contain any additional information regarding the proposed radiation oncology alternative payment model (RO Model) that was issued as a part of Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures proposed rule that was issued on July 10th. For information about the proposed RO Model please see ASTRO's summary on the proposed rule.

Advanced APMs

In the 2020 QPP, CMS is proposing modifications that are designed to address fluctuations in risk associated with risk-based APMs. According to the proposal, when a payment arrangement's marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the Agency will use the average marginal risk rate across all possible levels of actual expenditures. This average marginal risk rate will be compared to the marginal risk rate to determine whether the payment arrangement has a marginal risk rate of at least 30 percent, as required by MACRA. The Agency proposes exceptions for large losses and small losses as provided in CMS regulations.

Additionally, CMS is proposing that beginning in the 2020 an eligible clinician will not be deemed a Qualified APM Participant (QP) Performance Period or Partial QP if the APM Entity voluntarily or involuntarily terminates their Advanced APM contract before the end of the performance period or if the APM Entity no longer bears financial risk. The proposed also clarifies that Partial QP status only applies to the TIN/NPI combination(s) through which an eligible clinician attains QP status.

MIPS APMs

In the 2019 QPP proposed rule, CMS clarifies the requirement for MIPS APMs to assess performance on quality measures and cost/utilization; modify the Promoting Interoperability (PI) reporting requirement related to the shared savings program; and updates the MIPS APM measure sets.

In the 2017 proposed rule, CMS proposed the following requirements for MIPS APMs: 1) APM entities participate in an APM under an agreement with CMS or by law or regulation; 2) the APM requires that the APM Entities include at least one MIPS eligible clinician on a Participation List; and 3) the APM bases payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures.

Stakeholder feedback on the established criteria indicated that there is some confusion regarding the intent of the third criterion. CMS proposes to modify the criterion to specify that a MIPS APM must be designed in such a way that participating APM Entities are incented to reduce costs of care or utilization of services, or both. According to the Agency, this makes it clear that a MIPS APM could take into account performance in terms of cost/utilization using model design features other than the direct use of cost/utilization measures.

Additionally, the Agency is proposing that for MIPS APMs where quality data is unavailable through the APM model, MIPS eligible clinicians will be scored under the APM scoring

standard and receive a score in the Quality performance category based on Quality data submitted by the APM Entity, individual, or TIN. CMS proposes a 50 percent credit be applied to the quality category for MIPS APMs that are unable to receive a quality score through the model.

Bundled Payment Comment Solicitation

CMS is soliciting comment on the extent to which principles of bundled payment, such as establishing per-beneficiary payments for multiple services or condition-specific episodes of care, can be applied within the statutory framework of the MPFS. The Agency is exploring opportunities to expand the concept of bundling payments to improve MPFS services and more broadly align MPFS services with the broader Agency goal of improving accountability and increasing efficiency in payment the healthcare of Medicare beneficiaries.

For a fact sheet on the 2020 Quality Payment Program proposed rule, please visit: https://qpp.cms.gov/about/resource-library

To view the 2020 Quality Payment Program proposed rule, please visit: https://www.federalregister.gov/documents/2019/08/14/2019-16041/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

For ASTRO resources, please visit: https://www.astro.org/qpp/