

## **2019 Quality Payment Program Final Rule**

### **Summary**

On Thursday, November 1, 2018, CMS issued the 2019 Quality Payment Program (QPP) final rule that includes new eligibility requirements, category weights, and reporting options. Comments on the final rule are due December 31, 2018.

The QPP encompasses the Merit-based Incentive Payment System (MIPS) and the APM program, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and CHIP Reauthorization Act 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](http://www.astro.org/qpp).

### **Merit-based Incentive Payment System (MIPS)**

#### **Eligible Clinicians**

The Final Rule expands the definition of MIPS eligible clinicians to include physical therapists, occupational therapists, speech-language pathologists, audiologists, clinical psychologists, and registered dietitians or nutritional professionals. This may result in changes to how small practices are determined.

#### **MIPS Scoring Methodology**

For 2019, CMS finalized the following weights for the four MIPS performance categories:

- Quality – 45% (down from 50% in 2018)
- Improvement Activities – 15%
- Promoting Interoperability (previously Advancing Care Information) – 25%
- Cost – 15% (up from 10% in 2018)

For 2019, CMS finalized an increase in the performance threshold from 15 to 30 points. The exceptional performance threshold will increase from 70 to 75, for 2019.

The payment adjustment for 2021 (based on 2019 performance) is set to range from -7 percent to +7 percent, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated on professional services paid under the Medicare physician fee schedule (PFS), removing Part B drugs.

### Clinician Eligibility

The 2019 QPP final rule changes the MIPS eligibility requirements by assessing thresholds only against covered professional services paid under or based on the PFS, instead of all Part B expenses as it has been in previous performance years. 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. In addition, the final rule adds a new eligibility criterion: more than 200 covered professional services under PFS. The Agency finalized its proposal 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 2019 performance year.

The Agency finalized its proposal that clinicians choosing to opt-in would be 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.

Under the final rule, CMS maintained 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 2019 performance year, Virtual Groups must complete required contracting and notify CMS of their intention to become a Virtual Group by December 31, 2018.

### Determination Period

CMS finalized a single MIPS determination period that would be used for purposes of the low-volume threshold and to identify MIPS eligible clinicians and non-patient facing, small practice, hospital-based, and Ambulatory Surgical Center (ASC)-based, as applicable. Beginning in 2019, the virtual group eligibility determination period aligns with the first segment of data analysis under the MIPS eligibility determination period. The Agency is not including the facility-based eligibility determination periods or the rural and Health Professional Shortage Areas (HPSA) determinations in the MIPS determination period, as they each require a different process or timeline that does not align with the other determination periods, or do not utilize determination periods.

## Bonus Points

### *Complex Patients*

CMS is keeping the additional five bonus points to the overall Composite Performance Score (CPS) for complex patients based on the combination of the dual eligibility<sup>1</sup> ratio and the average Hierarchical Conditions Category (HCC)<sup>2</sup> risk score.

### *Small Practice Bonus*

CMS increased the small practice bonus from five to six points for the 2019 performance year to be applied to the 2021 payment year. However, the small practice bonus will be added to the Quality performance category, rather than in the MIPS final score calculation. 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

In the 2019 QPP final rule, the Agency changed the weighting of the Quality category from 50 percent to 45 percent for the 2019 performance year. The reporting period for the Quality category will continue to be a full calendar year.

CMS is maintaining the data completeness threshold of 60 percent for the 2019 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 finalized a proposal for measures impacted by clinical guideline changes, or other changes that CMS believes may pose patient safety concerns. Such measures will be given a score of 0 and the Quality performance category denominator would be reduced by 10. If this situation occurs, the clinician would be required to submit data for one less measure.

The Agency is retaining the policy of scoring achievement as well as performance improvement, if sufficient data is available. The Agency is also continuing the policy of measuring improvement in the Quality performance category based on percentage changes in achievement from one performance year to the next. Percentage changes in achievement are calculated for the

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<sup>1</sup> “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.

<sup>2</sup> Hierarchical Conditions Category (HCC) is a risk adjustment model using patient diagnoses and demographic information to predict medical spending.

entire Quality category, rather than on a measure-specific basis, in each performance period. CMS is continuing to allow physicians to retain the ability to report on different quality measures from year to year. Performance periods are compared to one another to determine if the eligible clinician qualifies for an improvement award that is added into the Quality score. CMS is maintaining the rule to use an assumed Quality performance category score of 30 percent for clinicians who score lower than 30 points in 2018. CMS will cap the size of the improvement award at 10 percentage points.

Additionally, CMS is retaining the four-year process for identifying and phasing out “topped out measures,” which are measures in which performance is so high and unvarying that meaningful measurement of change or improvement can no longer be achieved. CMS Special scoring, featuring a 7-point measure cap, will be applied to measure benchmarks that have been topped out for at least two consecutive years. If during one of the three performance periods, the measure benchmark is not topped out, then the cycle would start again at year one. However, CMS finalized its proposal for those measures that reach extreme topped out status (measures that are topped-out with an average performance rate between 98-100%), the Agency may propose removal during the next rulemaking instead of waiting through the four-year cycle. Based on this, the Agency finalized the removal of Radiation Dose Limits to Normal Tissues (NQF #0382) as an extreme topped out measure. This has reduced the Radiation Oncology Measure Set to only 3 measures. The Agency is clarifying that QCDR measures will not qualify for topped out measure cycle and special scoring.

Finally, because approximately 69 percent of the Medicare Part B claims measures are topped out, the Agency finalized its proposal to allow only small practices to submit quality data for covered professional services through the Medicare Part B claims submission type for the quality performance category, while removing that option for everyone else.

### Cost Performance Category

The BBA of 2018 provided flexibility in the weighting of the Cost category, and CMS finalized a 15 percent weight for the Cost category for 2019, 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.

CMS finalized the addition of 8 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 for all attributed beneficiaries.

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 2018 performance year.

### Improvement Activities Performance Category

The weighting for Improvement Activities performance category remains at 15%, based on a selection of medium and high weighted activities, and retains the 90-day minimum performance period. CMS added 6 new Improvement Activities, modified 5 existing activities and removed 1 activity. The new Improvement Activities include:

- Comprehensive Eye Exams
- Financial Navigation Program
- Completion of Collaborative Care Management Training Program
- Relationship-Centered Communication
- Patient Medication Risk Education
- Use of CDC Guidelines for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support

The modified activities include:

- Care Transition Documentation Practice Improvements
- Chronic Care and Preventative Care Management for Empaneled Patients
- Participation in MOC Part IV
- Use of Patient Safety Tools
- Implementation of Analytic Capabilities to Manage Total Cost of Care for Practice Population

CMS removed Participation in Population Health Research as they believe it is a duplicative measure.

CMS removed the availability of a bonus score within the Promoting Interoperability performance category for attesting to completing one or more specified improvement activities using CEHRT for the 2019 performance year.

The Agency retained the policy wherein a complete group may receive credit for an improvement activity that was completed by one eligible clinician.

Improvement Activity scores continue to be based on simple attestation in 2019.

### Promoting Interoperability (PI) Performance Category

The Agency is retaining both the 25 percent weight for the PI category and the 90-day minimum performance period for 2019. Additionally, CMS is requiring eligible clinicians use 2015 Edition CEHRT for 2019. The Agency finalized a completely new methodology for the category, removing the previous base, performance and bonus scoring. The new methodology is based on performance on individual measures, with the goal of increasing focus on patient care and health data exchange through interoperability.

Under the updated PI category requirements, clinicians must report measures from each of the newly reduced objectives (e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange). If a clinician fails to report on a required measure, or claims an exclusion for a required measure, the clinician would receive a total score of zero for the PI performance category. Each measure would be scored based on the performance for that measure, which is based on the submission of a numerator and denominator, except for the measures associated with the Public Health and Clinical Data Exchange objective, which requires “yes or no” submissions. The Agency added two new bonus measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement. These measures will be mandatory beginning in the 2020 performance year. Additionally, MIPS eligible clinicians must attest to having completed the actions included in the Security Risk Analysis measure, even though this measure is not scored and does not contribute any points to the clinician’s total score.

CMS continues to provide PI hardship applications for the 2019 performance period. The Agency believes this is particularly important for small practices. The exemption re-weights the PI category to zero, shifting an additional 25 percent to the Quality category.

The following chart shows the final 2019 scoring methodology:

<b>Objectives</b>	<b>Measures</b>	<b>Maximum Points</b>
e-Prescribing	e-Prescribing	10 points
	<i>Bonus:</i> Query of Prescription Drug Monitoring Program	5 bonus points
	<i>Bonus:</i> Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Choose two of the following: <ul style="list-style-type: none"> <li>• Immunization Registry Reporting</li> <li>• Electronic Case Reporting</li> <li>• Public Health Registry Reporting</li> <li>• Clinical Data Registry Reporting</li> <li>• Syndromic Surveillance Reporting</li> </ul>	10 points

Facility-Based Quality and Cost Performance Categories

CMS finalized its proposal to expand facility-based scoring for the 2019 performance year to physicians in on-campus outpatient hospitals, where facility-based clinicians can use their facility’s Hospital Value-based Purchasing (VBP) score as a proxy for their Quality and Cost performance categories. This applies to a MIPS eligible clinician who furnishes 75 percent or

more of their covered professional services in inpatient hospital (POS code 21) or on-campus outpatient hospital (POS code 22) or an emergency room (POS code 23), based on claims for a period prior to the performance period. However, the clinician must have at least a single service billed with the POS code used for the inpatient hospital or emergency room.

Facility-based measurement will automatically be applied to MIPS eligible clinicians and groups who are eligible and who would benefit by having a higher combined Quality and Cost score. There would be no submission requirements for individual clinicians in facility-based measurement, but a group must submit data in the IA or PI performance categories to be measured as a group under facility-based measurement.

In the case of an eligible clinician providing services at multiple facilities, attribution is to the hospital at which they provide services to the most Medicare patients. A facility-based group is attributed to the hospital at which a plurality of its facility-based clinicians is attributed. If a clinician's performance cannot be attributed to a facility with a VBP score, then that clinician is not eligible for facility-based measurement and will have to participate in MIPS by other methods.

For those hospitals that do not receive a Total Performance Score in the VBP program, CMS would not be able to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would be required to participate in MIPS via another method.

#### Qualified Clinical Data Registry (QCDR)

CMS finalized the definition of a QCDR to require that an approved entity have clinical expertise in medicine and quality measure development, starting in the 2020 MIPS performance year. Entities may also meet this definition through a signed, written agreement with an external organization with expertise in medicine and quality measure development. This is in light of CMS's observations that certain entities that have a predominantly technical background with limited understanding of medical quality metrics or the process for developing quality measures are seeking approval as a QCDR. CMS does not believe that these types of entities, in the absence of clinical expertise in quality measurement, meet the intent of QCDRs.

Beginning with the 2020 MIPS performance year, QCDRs must have at least 25 participants by January 1 of the year prior to the performance period. In this case, the 2019 performance year. These participants do not need to use the QCDR to report MIPS data; rather, they need to submit data to the QCDR for quality improvement.

### **Alternative Payment Models (APMs)**

#### Advanced APMs

CMS has finalized several key modifications to the Advanced APM requirements. First, the Agency is increasing the Advanced APM CEHRT threshold to 75 percent of eligible clinicians

from the previous threshold of 50 percent. The Agency believes this change aligns with increased adoption of CHERT among providers and suppliers that is already taking place.

CMS also finalized revisions to the definition of a MIPS comparable measure in the Advanced APM criteria to reduce confusion and reporting burden. Specifically, the Agency is requiring that at least one of the quality measures upon which an Advanced APM bases payment must be finalized on the MIPS final list of measures, be endorsed by a consensus-based entity; or otherwise determined by CMS to be evidence-based, reliable and valid.

In past rulemaking, CMS required outcomes measures, when they are available, for Advanced APMs but has not provided explicit qualifiers for outcomes measures. In the 2019 final rule, CMS explicitly requires the use of at least one outcome measure that must be evidence-based, reliable, and valid. The Agency will continue to recognize that outcomes measures are not available or applicable to all APMs.

CMS is expanding Qualified APM Participant status (QP), by allowing QP determinations under the All-Payer Option to be requested at the TIN level, in addition to the APM Entity and individual eligible clinician level. This allows eligible clinicians who have assigned their billing rights to a TIN to be counted as QPs in an APM entity.

Finally, CMS finalized its decision to retain the 8 percent revenue-based nominal amount standard for Advanced APMs through performance year 2024 that was initially established in the 2017 QPP final rule. CMS believes that 8 percent of APM entity Medicare Parts A and B revenues represents an appropriate standard for more than a nominal amount of financial risk.

#### Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

In an effort to encourage greater participation in alternative payment arrangements, CMS has finalized its decision to launch the MAQI Demonstration in 2018. Currently, MIPS eligible clinicians are required to comply with MIPS reporting requirements, even if they are participating in an alternative payment arrangement with a Medicare Advantage Organization (MAO).

The MAQI demonstration exempts MIPS eligible clinicians from MIPS reporting requirements and is designed to test whether excluding MIPS eligible clinicians from MIPS reporting requirements will result in increased or continued participation in other payment arrangements similar to Advanced APMs. MIPS eligible clinicians seeking to participate in the MAQI demonstration must become a designated Qualified Participant (QP). To become an eligible QP the clinician must meet 1) either the patient or payment thresholds required for Advanced APM QP status and 2) submit required documentation regarding the MAO alternative payment arrangement.

The requirements for qualifying payment arrangements under the MAQI demonstration will be the same as the Advanced APM requirements, which include the use of CEHRT, MIPS comparable measures, and the establishment of two-sided risk that involving a nominal amount at risk.



### MIPS APMs

In the 2019 MPFS final 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 final rule, CMS finalized 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 is modifying 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.

For more information on these and other payment issues, please join us for ASTRO's 2019 MPFS and HOPPS Final Rules [webinar](#) on December 5, 2018.

For a fact sheet on the CY 2019 Quality Payment Program proposed rule, please visit: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Year-3-Final-Rule-overview-fact-sheet.pdf>

To view the CY 2019 Quality Payment Program proposed rule, please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>

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