2018 Quality Payment Program Proposed Rule

Summary

On Tuesday, June 20, 2017, CMS issued the 2018 Quality Payment Program (QPP) proposed rule. Please note that these policies are subject to change based on the 2018 QPP final rule, which is expected in the fall of 2017. For information on the 2017 QPP, go to www.astro.org/qpp

The QPP encompasses the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) program, which were implemented this year to replace the sustainable growth rate. According to the proposed rule, CMS developed the QPP with the following objectives in mind:

1. Improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies;
2. Enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools;
3. Increase the availability and adoption of Advanced APMs;
4. Promote program understanding and maximize participation through customized communication, education, outreach and support that meets the diversity of physician practices and patients, especially the unique needs of small practices;
5. Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders;
6. Promote IT systems capabilities that meet the needs of users and are seamless, efficient and valuable on the front and back end; and
7. Ensure operational excellence in program implementation and ongoing development.

MIPS Highlights

In the 2017 QPP final rule comments, ASTRO, in collaboration with other medical specialty groups, urged CMS to continue a more cautious, deliberative implementation of the MIPS program, allowing eligible clinicians and their practices an appropriate amount of time to fully prepare for successful participation in the MIPS program. We are pleased that this proposed rule continues to more thoughtfully implement the MIPS program, particularly with regard to the decision to delay for another year the inclusion of the Cost Performance Category. ASTRO has urged CMS to further consider the complexities of implementing this category, particularly with regard to the development of Episode Based Cost Measures.

We are also pleased that CMS is responding to ASTRO’s concerns regarding challenges facing small radiation oncology practices as well as how the complexity of treating cancer patients could negatively impact radiation oncologists’ ability to successfully participate in MIPS. ASTRO has long argued that treatment for cancer patients is inherently costly because of its complexity. CMS is proposing the addition of a complexity bonus to account for complex patients, such as cancer patients. We are also pleased that CMS is proposing bonus points and new participation opportunities for small practices.
In the 2018 proposed rule, CMS seeks to more fully implement the reporting requirements of the MIPS program, while also extending several provisions established in the 2017 transition period, known as “Pick Your Pace.” The Agency believes this allows for iterative learning and development as physicians progress toward full implementation of the program. The 2018 performance period begins on January 1, 2018, and eligible clinician performance during the 2018 performance period will be reflected in the 2020 payment period.

Key proposed rule modifications include a proposal to increase the clinician program eligibility threshold from $30,000 in Medicare Part B payments and 100 patients to $90,000 in Medicare Part B payments and 200 patients. This expands the likelihood that many small practices will not be eligible for participation in MIPS. The Agency estimates that 3,049 radiation oncologists will be determined eligible clinicians during the 2018 performance period, far fewer than estimated for 2017. Of those expected participants, 81 percent of radiation oncologists are expected to experience a positive payment adjustment, and approximately 3 percent will experience a negative payment adjustment. CMS anticipates that the combined impact of the MIPS program on the specialty could range between 0.9 percent to 1.1 percent.

According to the proposed rule, eligible clinicians will be required to submit a full year’s worth of data for the Quality Performance Category. The weight for the Quality Performance Category will remain at 60 percent for performance year 2018. The reporting periods and weights for the Improvement Activities and Advancing Care Information Performance Categories will remain at their 2017 levels. Reporting is required for a continuous 90-days and the weights for each category will remain at 15 percent and 25 percent respectively.

Per requirements in the Medicare Access and CHIP Reauthorization Act (MACRA), CMS is proposing standards for establishing achievement and improvement scoring. Additionally, CMS is proposing the addition of a 5-point bonus for small practices of 15 or fewer clinicians and a 3-point bonus for complex patients.

APM Highlights

In the 2017 QPP final rule, CMS proposed increasing the revenue-based nominal amount standard from 8 percent to as high as 15 percent in future years. ASTRO joined other medical specialty organizations in opposition to this proposed increase, citing the complexities of APM participation and the need for time to analyze savings and outcomes in the early stages of any APM Model. ASTRO is pleased that the 2018 proposed rule contains a provision that seeks to extend the revenue-based nominal standard at 8 percent through performance year 2020.

The proposed rule also contains revisions to the qualified APM participant (QP) requirements, as well as new guidance on qualifications for all-payer APMs. This includes CMS determination of “Other Payer Advanced APMS”, which would allow CMS to designate APMs developed and operationalized by private payers with Advanced APM status.

Below are more details on key provisions in the 2018 Quality Payment Program proposed rule. Comments on the proposed rule are due to CMS on Monday, August 21.

Merit-based Incentive Payment System (MIPS)
Clinician Eligibility

In the 2018 QPP proposed rule, CMS proposes to increase the low volume threshold for eligible clinicians. The current thresholds require eligible clinicians to meet both a Medicare expenditure threshold of $30,000 in Medicare Part B payments AND 100 Medicare enrolled patients. The proposed rule seeks to increase the Medicare payment and beneficiary thresholds to $90,000 in Medicare Part B payments AND 200 Medicare enrolled patients. This would exclude more physicians, including radiation oncologists, and groups from MIPS participation.

Beginning in performance period 2019, the Agency proposes to allow excluded physicians to opt-in to the program if they exceed one of the two thresholds. Additionally, CMS is considering adding a third threshold criteria that involves costs associated with items and services furnished to Medicare Part B enrolled individuals. The Agency seeks comment on allowing for an opt-in component as well as what types of items and services should be included in a third threshold group.

Additionally, beginning in the 2018 performance year, solo practitioners and groups with ten or fewer MIPS eligible clinicians may establish a Virtual Group. For the Quality and Cost Performance Categories, the performance of individual members of the Virtual Group will be combined to determine the entire groups’ performance. Virtual Groups must notify CMS of their intention to become Virtual Groups prior to the 2018 performance year.

Bonus Points for Complex Patients

For 2018, CMS proposes the addition of one to three bonus points to the overall Composite Performance Score (CPS) for complex patients based on the Hierarchical Conditions Category (HCC) risk score.

An HCC risk score would be calculated by CMS by averaging the HCC risk scores for beneficiaries cared for by the MIPS eligible clinician during the 12-month segment of the eligibility period, which spans from the last four months of a calendar year one year prior to the performance period, followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018 for the 2018 performance period). CMS proposes that MIPS eligible clinicians must submit data on at least one measure or activity in a performance category to receive the complex patient bonus. According to CMS data, the average risk score for specialties is 1.08, and the average HCC risk score for radiation oncology is 1.79, just above the average. This indicates that radiation oncologists are more likely than other physicians to receive bonus points.

In addition to the HCC score, CMS seeks comments on whether to include dual eligible patients (those enrolled in Medicare and Medicaid) as an alternative or in addition to the HCC score. According to Agency modeling, 22.7 percent of radiation oncology patients are dual eligible.

If finalized, CMS will consider continuing the complex patient bonus on an annual basis.

Small Practice Bonus
CMS proposes to add five points to the final MIPS score of small practices for the 2018 performance year to be applied to the 2020 payment year. To receive the small practice bonus, eligible clinicians must submit data on at least one performance category. This applies to group practices, virtual groups, or MIPS APM entities that consist of 15 or fewer clinicians. CMS seeks comments on whether this proposed bonus should be extended to rural practices, and if so what qualifications should be considered for rural practices.

**Quality Performance Category**

In the 2017 final rule, CMS finalized the weight for the Quality performance category at 60 percent for the 2017 performance period. The Agency proposed that the weight would decrease to 50 percent, given that the weight for the Cost category would grow from 0 percent to 10 percent for the 2018 performance period. In the 2018 QPP proposed rule, the Agency seeks to retain a weighting of 0 percent for the Cost category and a weighting of 60 percent for the quality category for the 2018 performance year. The Agency also proposes a full calendar year performance reporting period for 2018.

CMS is proposing to maintain the 20 Medicare Part B patient case requirement for each measure, as well as the transition year data completeness threshold at 50 percent for 2018. Beginning in 2019, the Agency proposes to increase the requirement to 60 percent. Practices that do not meet data completeness requirements currently receive three points toward their Quality score. CMS proposes to modify the scoring so that practices will only receive one point if they do not achieve data completeness beginning in 2019. This policy will not apply to small practices who will continue to earn three points.

Beginning with the 2018 performance year, CMS will begin to score achievement as well as improvement, if sufficient data is available. The Agency proposes measuring improvement in the Quality performance category based on changes in the achievement percent score from one performance year to the next performance year. Achievement percent scores are calculated for the Quality category, rather than on a measure specific basis, in each performance period. CMS proposes an overall calculation 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 percent score that is added into the Quality score. CMS proposes to cap the size of the improvement award at 10 percentage points.

Additionally, CMS is proposing a 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. Special scoring, featuring a 6-point measure cap, will be applied in years one through three, then in year four the measure is finalized for removal and no longer available for use. If during one of the three performance periods, the measure benchmark is not topped out, then the cycle would start again at year one. CMS seeks comment on this proposed mechanism for removing topped out measures.

**Cost Performance Category**
CMS proposes a zero percent weight for the Cost category for performance periods 2018 through 2020. In the 2017 final rule, CMS had established a weight of 10 percent for the Cost category in 2020 before the MACRA-mandated weight of 30 percent becomes effective in 2021. The Agency is seeking comments regarding whether it should move forward with a weight of 10 percent in 2020 to allow for some transition to the higher weighted amount in 2021.

Cost measures include Medicare Spending Per Beneficiary (MSPB) and total per capita cost for all attributed beneficiaries. The Agency proposes to provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018. Additionally, the Agency proposes to replace the 10 episode-based cost measures with those that are under development with specialty groups. The Agency plans to provide a new set of episode-based cost measures in 2018 for public consideration.

Similar to the Quality performance category, CMS will begin measuring improvement in the Cost category. Because cost measures are calculated based on Medicare administrative claims data, measuring Cost category improvement can be done at the measure level rather than at the performance category level, as proposed for the Quality category. Improvement will be based on statistically significant changes but would not be effective until 2021, if the category is weighted at zero through 2020 as proposed.

**Improvement Activities Performance Category**

CMS does not propose any changes in weighting for the Improvement Activities performance category and retains the 90-day minimum performance period. The category will remain weighted at 15 percent, based on a selection of medium and high weighted activities. Evidence indicators required by APEx already map to 16 Improvement Activities. CMS is adding several new Improvement Activities, including Accredited Safety or Quality Improvement Program (such as APEx); clinician leadership in clinical trials or community-based participatory research; and CDC training on CDC guidelines for prescribing opioids for chronic pain. The Agency is seeking comment on the concept of applying a participation threshold on eligible clinician groups. Currently, if one eligible clinician in a group completed an improvement activity, the entire group receives the same score for the Improvement Activities category. CMS is not proposing changes to this policy for 2018, but seeks comment regarding a future requirement that 50 percent of the eligible clinicians complete an improvement activity for the entire group to receive credit for the category.

CMS is also seeking comment on how the Agency should measure performance and improvement in the Improvement Activities category. Currently, scores are based on simple attestation.

**Advancing Care Information Performance (ACI) Category**

CMS is proposing to extend the use of 2014 Edition CEHRT for 2018. CMS proposes 10 bonus points for those eligible clinicians who report the ACI objectives and measures for the 2018 performance period utilizing only 2015 Edition CEHRT. Additionally, the Agency retains the 25
percent weight for the ACI category as required by MACRA and extends the 90-day minimum performance period through 2018.

The ACI standard measures remain unchanged for the 2018 performance period. The Agency proposes to establish a 5-point bonus for reporting on any one of four Public Health and Clinical Data Registry reporting objectives:

1. Syndromic Surveillance Reporting or Specialized Registry Reporting
2. Electronic Case Reporting
3. Public Health Registry Reporting
4. Clinical Data Registry Reporting

In the 2017 final rule, CMS established a 10-point bonus for eligible clinicians who attest to completing at least one specified improvement activity using CEHRT. The Agency proposes to expand this policy by identifying additional improvement activities that qualify for the bonus. The list of eleven activities includes the provision of clinical-community resources and advance care planning among others.

CMS plans to continue the ACI hardship exemption. The Agency believes this is particularly important for small practices (those with 15 or fewer clinicians). A new exemption for small practices would re-weight the ACI category to zero, shifting an additional 25 percent to the Quality category, similar to ACI exemptions in the 2017 performance year. CMS proposes changing the deadline for the exemption application for 2017 and future years to December 31 of the performance year. The Agency also seeks comment on whether there are other types of eligible clinicians or groups that should be given special consideration for an ACI exemption.

**MIPS Scoring Methodology**

For 2018, CMS is proposing the following weights for the four MIPS Performance Categories:

- Quality – 60%
- Improvement Activities – 15%
- Advancing Care Information – 25%
- Cost – 0%
- Additionally, up to five bonus points for small practices and up to three bonus points for complex patients could be added to the MIPS overall score, known as the Composite Performance Score (CPS).

For 2018, CMS proposes to increase the performance threshold needed to avoid the payment penalty from 3 to 15 CPS points. The agency seeks comments on whether the threshold should be higher or lower. The exceptional performance threshold is proposed to remain at 70 points for 2018.

The payment adjustment for 2020 (based on 2018 performance) is set to range from -5% to +5%, plus any scaling to achieve budget neutrality as required by MACRA.

For MIPS performance year 2018 and future years, the performance period for the Quality and Cost performance categories will be one calendar year. The performance periods for
Improvement Activities and Advancing Care Information will be a minimum of a continuous 90-day period within the calendar year. CMS seeks comments on the proposed performance periods for 2021 and future years.

Other MIPS Provisions

Performance Feedback

CMS proposes to provide eligible clinicians with QPP performance feedback on an annual basis. The Agency commits to providing more frequent feedback in future years.

Data Submission Requirements

CMS is proposing to allow eligible clinicians to continue to submit measures using Qualified Clinical Data Registries (QCDRs), qualified registries, EHRs or Medicare Part B claims. The Agency proposes to modify its requirement that data be submitted using only one of the various reporting mechanisms within a category. This would allow eligible clinicians to submit data within a category using one or more reporting mechanisms, increasing flexibility and measures reporting options. The Agency cannot aggregate data on the same measure across submission mechanisms, so to address the potential for double counting data, the Agency will count the submission with the higher performance score.

QCDRs

CMS proposes revisions to the QCDR nomination process. The Agency wants to eliminate the self-nomination submission method and establish a web-based tool beginning in 2019 that will allow QCDRs to continue participation in the MIPS program. Additionally, the Agency proposes to replace the term “non-MIPS measures” with “QCDR measures”.

Facility-Based Measurement

CMS is proposing to implement facility-based measures for the 2018 performance period and future performance periods that applies to physicians practicing in inpatient or emergency room settings, not outpatient settings. The Agency believes this will add more flexibility for clinicians practicing primarily in a hospital to be assessed in the context of the hospital. Clinicians are eligible to participate in the facility based payment methodology if they meet one of the following criteria:

1. The eligible clinician furnishes 75 percent or more of their services in an inpatient hospital setting or emergency room setting.
2. The eligible clinician group furnishes 75 percent or more of services in an inpatient hospital setting or emergency room setting.

Facility-based measurement would apply to the performance in the Quality and Cost performance categories. For those eligible clinicians who opt to participate in the facility-based measurement program, their quality and cost measures would be tied to the hospital’s Value Based Purchasing (VBP) Program performance. FY 2019 VBP program measures will apply to the eligible clinician’s 2018 performance period.
Definition of “Small Practice” and Qualifications for Rural or HPSA Designation

CMS defines a “small practice” as a practice consisting of 15 or fewer clinicians and solo practitioners. CMS recognizes that it must account for small practice size in advance of the performance period and proposes to identify small practices through claims data. A 12-month determination period would span the last four months of the calendar year two years prior to the performance period through the first 8 months of the next calendar year. Practices that meet the small practice definition would then be eligible for the reduced reporting requirements in the Improvement Activities performance category; exempt from the ACI performance category; and be eligible for the small practice bonus. CMS seeks comments on this approach to identifying small practices in 2018.

CMS proposes to modify the rural practice designation. The modified determination would require that more than 75 percent of clinicians in a practice be located in a Rural and Health Professional Shortage Area (HPSA) designated zip code.

Alternative Payment Model (APM) Program

In the proposed 2018 QPP, CMS seeks to clarify and modify some of the policies finalized in the 2017 final rule related to the establishment of APMs. The proposed rule also seeks to provide additional information regarding the establishment of an All-Payer APMs.

Nominal Revenue at Risk

CMS proposes to retain the nominal revenue at risk requirement for Advanced APMs at 8 percent for another two years (through performance year 2020). In the 2017 QPP rule, CMS stated that it was considering incremental increases up to 15 percent in future years. Based on stakeholder feedback, the Agency has delayed increases.

Qualified APM Participant (QP) Performance Period and Status Determination

The 2017 final rule, established the definition of qualified APM participants (QPs), as those eligible clinicians who have met the established patient or Medicare expenditure thresholds for participation in an Advanced APM, thus exempting them from MIPS participation. CMS is proposing to replace the term “QP Performance Period” with a definition for an “All Payer QP Performance Period” and a “Medicare QP Performance Period”. The All Payer QP Performance Period begins January 1 and ends on June 30 of the calendar year that is two years prior to the payment year. The Medicare QP Performance Period begins on January 1 and ends on August 31 of the calendar year that is two years prior to the payment year.

The Agency is proposing to modify its policy regarding the timeframe for which payment amount and payment count data are included in the QP threshold determination for Advanced APM status. CMS recognizes that not all APM entities can participate in Advanced APMs within the full January 1 to August 31 performance period, so the Agency is proposing that if entities are able to participate in an Advanced APM for a continuous 60-day period, that will be sufficient to determine QP status. This policy would not apply to those APM Entities that had an
opportunity to participate in an Advanced APM during the full performance period but chose not to do so.

CMS also provided clarification in the proposed rule that it will use the entire performance period to make QP determination for those eligible clinicians participating in multiple Advanced APMs. Additionally, should an APM Entity, either voluntarily or involuntarily, terminate from the Advanced APM, then the eligible clinicians will no longer be designated QPs.

All-Payer APM Arrangements

Beginning in payment year 2021 (performance period 2019), eligible clinicians may participate in All-Payer APM arrangements. QPs must meet specific payment amount and patient count thresholds to participate in All-Payer APM arrangements. Effective 2021, the QP payment amount determination threshold is set at 50 percent of total payments, of which 25 percent must be Medicare payments. The patient threshold is set at 35 percent of total patients, of which 20 percent must be Medicare patients. The threshold requirements for QP status determination incrementally increase over a four-year period, topping out at 75 percent total/25 percent Medicare payment and 50 percent total/20 percent Medicare patients in 2024 and future years.

Because CMS cannot verify the payment amounts or patient counts attributed to other payer APMs, the Agency requires that eligible clinicians submit to CMS the information on all relevant payment arrangements with other payers.

Other Payer Advanced APM Criteria

In the 2017 final rule, CMS determined that other payer Advanced APMs meet the following criteria: 1) require at least 50 percent of participating eligible clinicians in each APM entity to use CEHRT to document and communicate clinical care; 2) utilize quality measures that are comparable to MIPS quality measures; and 3) require APM Entities to bear more than nominal financial risk if the actual aggregate expenditures exceed the expected aggregate expenditures.

The 2017 final rule established the nominal risk requirement for other payer Advanced APMs. The requirement contains three components: 1) Marginal risk of at least 30 percent; 2) Minimum loss rate of no more than 4 percent; and 3) Total risk of at least 3 percent of the expected expenditures for which the APM entity is responsible. In the 2018 QPP proposed rule, CMS is seeking to add a revenue-based, generally applicable nominal risk amount similar to the Medicare Advanced APM requirement. CMS proposes that the revenue-based nominal amount that an APM Entity potentially owes the payer or forgoes is equal to at least 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM entities. This methodology would apply to the 2019 and 2020 performance periods and it would only be applicable in arrangements in which the risk is explicitly defined in terms of revenue, as specified in an agreement covering the other payer arrangements.

CMS Multi-Payer Models

CMS-Multi Payer Models are defined as Advanced APMs that CMS determines has at least one other payer arrangement that is designed to align with the terms of the Advanced APM. A
current example of a CMS-Multi Payer Model is the Oncology Care Model (OCM). Advanced APM determination of other payer arrangements is performed during the first performance period, CMS does not automatically confirm Advanced APM status on other payer arrangements participating in an CMS-Multi Payer Model.

Physician Focused Payment Models (PFPMs)

CMS established the parameters around the development of Physician Focused Payment Models and the process by which they are considered and approved for recommendation to CMS by the Physician Focused Payment Model Technical Advisory Committee (PTAC) in the 2017 final rule. In this proposed rule, the Agency seeks comment on whether additional consideration should be given to PFPMs that include Medicaid or the Children’s Health Insurance Program (CHIP) as payers.

MACRA does not require PFPMs to meet APM standards. In this proposed rule the Agency is seeking to modify that requirement, suggesting that PFPMs meet APM standards. Additionally, the Agency seeks feedback on PFPM criteria as outlined in the 2017 final rule, as well what additional information or resources stakeholders are required to submit for consideration by PTAC.

Small and Rural Practices

CMS seeks comments on whether it should consider a different, potentially lower, revenue-based nominal amount standard for small practices and those in rural areas. The Agency also seeks comment on whether such an exception should be expanded to small or rural practices that are joining with a larger APM entity to participate in an APM. This type of arrangement might involve a satellite practice that participates in an Advanced APM with a practice that serves as the satellite headquarters.

MIPS APMs

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.

An APM scoring standard is applied to MIPS APMs that recognizes the unique arrangements of MIPS APMs. In the 2017 final rule, CMS determined that the MIPS Quality and Cost categories did not apply to MIPS APMs because participation in an APM inherently include improvements in quality and reduced costs. For the 2018 performance period, the Agency proposes to continue weighting the Cost component at zero for MIPS APMs. MIPS APMs will still be required to report on Improvement Activities and ACI category measures.

CMS proposes modifying the Quality performance category by establishing a MIPS APM quality measures list for use in the APM scoring standard. The quality measures sets for each MIPS APM are unique. The MIPS APM quality measures set for the Oncology Care Model
includes three radiation oncology specific measures: 1) Medical and Radiation – Pain Intensity Quantified; 2) Medical and Radiation – Plan of Care for Pain; and 3) Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer. The measures are tied to payment as described by the terms of the APM; are available for scoring near the close of the MIPS submission period; require a minimum of 20 reportable cases; and have a benchmark.

MACRA requires the Agency to begin scoring for improvement in the Quality category beginning in the 2018 performance year, if a sufficient amount of data is available to calculate quality improvement. The addition of the MIPS APM quality measures allows for improvement measurement over time in compliance with MACRA.

APM entities are eligible for additional bonus points if they report on high priority measures or measures submitted via CEHRT. The total number of awarded bonus points may not exceed ten percent of the APM entity’s total available achievement points for the MIPS Quality performance score.

CMS proposes to weight the Quality performance category at 50 percent, the Improvement Activities performance category at 20 percent, and the ACI category at 30 percent of the final score for MIPS APMs. The Agency recognizes that there may be instances where a MIPS APM may not have measures available to score for the performance category. Under these circumstances the Agency proposes to reweight the Quality performance category to zero, the Improvement Activities category to 25 percent and the Advancing Care Information category to 75 percent.

Finally, the Agency also proposes adding a fourth snapshot date to the series of dates for which physicians can be considered part of, and benefit from participating in, a MIPS APM. In addition to March 31, June 30 and September 30, CMS proposes to add December 31.