AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

November 8, 2017

Summary of the Quality Payment Program (QPP) Year 2 Final Rule

Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year; 42 CFR Part 414 [CMS-5522-FC and IFC] RIN 0938-AT13

On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the final rule with comment *(CMS-5522-FC)* for the second year of the Quality Payment Program (calendar year 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as well as an interim final rule with comment *(CMS-5522-IFC)* on the extreme and uncontrollable circumstances MIPS eligible clinicians may face as a result of widespread catastrophic events affecting a region or locale in CY 2017, such as Hurricanes Irma, Harvey and Maria. Below is a summary of the highlights of this rule, where applicable against our comments in response to the QPP Year 2 Proposed Rule earlier in 2017.

Merit-based Incentive Payment System (MIPS)

CMS finalized most of the proposals that were aimed at reducing reporting burden and allowing for a gradual increase in participation requirements. Note: 2017 is the first performance year in the QPP and is marked as a 'transition year' with minimal reporting requirements. **MIPS Participation Factsheet** is available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/MIPS-Participation-Fact-Sheet-2017.pdf

Final Rule Provisions	**AAOS Comments (where applicable)**
Small Practice (defined as 15 or fewer eligible clinicians) Flexibilities • **Increase in low volume threshold** Excluding individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries. **However, CMS will not include durable medical equipment (DME) and prescription medication in its count of Part B**	AAOS supported the increase in low volume threshold and additional flexibilities for small and solo practices. *(Note: the threshold for CY 2017 performance period is at less than or equal to $30,000 in Medicare Part B allowed charges or less than or*

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services at this time.[1] This definition will exclude approximately 134,000 clinicians from MIPS from the approximately 700,000 clinicians that would have been eligible based on the CY 2017 low-volume threshold. Almost half of the additionally excluded clinicians are in small practices, and approximately 17 percent are clinicians from practices in designated rural areas. • **5 bonus points** to the final MIPS scores of small practices • Continuing to award **small practices 3 points for measures in the Quality** performance category that don't meet data completeness requirements. • New hardship exception for the Advancing Care Information performance category for small practices. Resources on technical assistance are available: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf	*equal to 100 Medicare Part B patients).*
Virtual Groups: A Virtual Group is a combination of 2 or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter specialty or location) to participate in MIPS for a performance period of a year. • Solo practitioners and small groups may only participate in a Virtual Group if you exceed the low -volume threshold. • If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would have their performance assessed as part of the Virtual Group. • Components are finalized for a formal written agreement between each member of the Virtual Group. • Election process for 2018 runs from October 11 – December 31, 2017.	AAOS commented supporting the option of Virtual Groups but expressed concerns that there are significant resources needed to set up and run the virtual groups including finding potential group members, drawing up of legal contracts, expensive third party reporting as well as health information technology vendors and administrative staff to support the virtual group functioning to list just a few. Also, there may not be enough time to prepare in tiem for the election period. Further, CMS should provide technical assistance on creation of virtual groups.

[1] AAOS is pursuing legislative oversight and other regulatory options to expand the definition of Part B services in MIPS.

• CMS has developed a Virtual Groups Toolkit which can be downloaded from the CMS website. The link is available here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html	
Performance Threshold • CMS finalized the performance threshold at 15 points. (For 2017 transition year it is at 3 points). • Additional performance threshold stays at 70 points for exceptional performance. • Payment adjustment for the 2020 payment year ranges from - 5% to + 5% (x scaling factor not to exceed 3) as required by law. • Additional payment adjustment calculation is the same as in 2017.	
Quality • category weight finalized as proposed: 50% in 2020 payment year; 30% in 2021 payment year and beyond. • Data completeness finalized as proposed: 60% for submission mechanisms except for Web Interface and CAHPS. Measures that don't meet the data completeness criteria will earn 1 point, (except 3 points for small practices)	AAOS commented that the proposal to increase the data completeness threshold to 60 percent for the 2019 performance year may be too much, too soon, and too optimistic. A gradual buildup of such thresholds will reduce additional burden on MIPS participating clinicians.
• Topped out measures finalized as proposed Topped-out measures will be removed and scored on 4 year phasing out timeline; topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years will earn up to 7 points. The 7-point scoring policy for 6 topped out measures identified for the 2018 performance period.	AAOS commented this removal is likely to be a problem for specialties, such as orthopaedics, that lack outcome measures. CMS can use "topped out" measures as controls for new and developing measures. Moreover, if a measure is going to be topped out, CMS should announce the status of the measure with sufficient time lag before it is removed from service to allow clinical processes time to adjust and redirect their resources.
Cost/Resource Use	AAOS commented that CMS needs to explore all regulatory avenues to prevent the sudden jump to 30

• **Finalized at 10% weight to final score in 2020 payment year. (Note: 0% in 2019 payment year).** • 30% in 2021 MIPS payment year and beyond.	percent weight for the Cost category in 2019 performance year.[2] We believe delaying information on attribution until the ruling for 2019 will create a challenge for practices seeking to monitor and improve their cost components.
Improvement Activities • Finalized as proposed 15% for the 2020 payment year. • Finalized more activities and changes to existing activities; for a total of approximately 112 activities in the inventory.	AAOS commented that the focus should be on developing a balance in primary care and specialty care focused high-weight improvement activities.
Advancing Care Information • Finalized as proposed 25% weight No change for the 2020 payment year. • Can use either 2014 or 2015 Edition CEHRT; 10% bonus if you only use the 2015 Edition CEHRT.	AAOS asked for flexibilities in the burdensome requirement to establish good faith effort to get certification in the event of decertification mid-year. Also a requirement to reapply for hardship annually which should be made less frequent and extended to at least two years.
• Flexibilities introduced for facility based MIPS eligible clinicians: Using authority granted by the 21st Century Cures Act, CMS has finalized reweighting the Advancing Care Information performance category to 0% of the final score for ambulatory surgical center (ASC)-based ad hospital-based MIPS eligible clinicians.	

[2] AAOS is pursuing strategy to delay the statutory requirement of 'cost' category weight of 30% in 2021 payment year.

Alternative Payment Model (APM)

Final Rule Provisions	AAOS Comments (where applicable)
Nominal Amount Standard • Extended the 8% revenue-based standard for 2 additional years, through performance year 2020.	
Qualifying APM participant (QP) performance period & QP & partial QP determination • The QP performance period stays the same: January 1 – August 31 each year • The timeframe on which the payment/patient threshold calculations is based is modified for certain Advanced APMs. For Advanced APMs that start or end during the QP performance period, QP Threshold Scores are calculated using only the dates that APM Entities were able to participate in the Advanced APM, as long as they were able to participate for at least 60 continuous days during the QP performance period. • All-Payer APM option finalized.	Since the current All-Payer APM such as Medicaid and Medicare Advantage, AAOS asked for inclusion of private payer APMs in line with the efforts of the Health Care Payment Learning & Action Network (LAN).
Identifying MIPS APM participants • CMS is adding December 31 as a fourth snapshot date to determine participation in Full TIN MIPS APMs (currently applies to participation in the Medicare Shared Savings Program only). We won't use the fourth snapshot date to make QP determinations or extend the QP performance period past August 31.	

Note: AAOS' comments on the orthopaedic Advanced APMs were partially responded to in the Proposed Rule (CMS-5524-P) that canceled the Surgical Hip/Femur Fracture Treatment Model and made the Comprehensive Care for Joint Replacement Model partly voluntary.

Highlights of the Interim Final Rule for MIPS clinicians in areas affected by natural disasters

- Clinicians in affected areas that do not submit data will not have a negative adjustment.

- Clinicians that do submit data will be scored on their submitted data. This allows them to be rewarded for their performance in MIPS. Since MIPS has a composite score, clinicians have to submit data on two or more performance categories to get a positive payment adjustment.
- The policy applies to individuals (not group submissions), but all individuals in the affected area will be protect for the 2017 MIPS performance period.
- A MIPS eligible clinician who is eligible for reweighting due to extreme and uncontrollable circumstances, but still chooses to report (as an individual or group), that they will be scored on that performance category based on their results.
- This policy does not apply to APMs.

Registry Issues

(1) Self-nomination streamlining (p. 849):

"Beginning with the 2019 performance period existing QCDRs that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the upcoming performance period. CMS may allow existing QCDRs in good standing to submit minimal or substantial changes to their previously approved self-nomination form, from the previous year, during the annual self-nomination period, for CMS review and approval without having to complete the entire QCDR self-nomination application process."

-**This was in the proposed rule and something that we encouraged.**

- CMS gave some clarification on what "minimal changes" means: "include, but are not limited to: limited changes to performance categories, adding or removing MIPS quality measures, and adding or updating existing services and/or cost information."

- They rejected the idea of expanding the approval window from 1 year to 2 (or more) years - we asked for an expansion of this type. **But they are asking for comment on how their concerns with this expansion could be adequately addressed** (p. 852-53).

- CMS proposed a Web-Based Submission of Self-Nomination Forms -- They finalized that self-nomination submissions will occur via a web-based tool rather than email. We supported the implementation of a web-based tool.

- These attestation/"minimal changes"/Web-based submission proposals also were finalized for qualified registries.

(2) The term “non-MIPS measures” will be replaced with the term “QCDR measures” (p. 865)

- This was in the proposed rule, not a significant change

(3) Use of another QCDR's measure (p. 873)

- In our comments on the proposed rule, we requested that CMS provide clarification on what form "proof of permission" (to use another QCDR's measure) should take.

- **CMS responded directly** by explaining that for the 2018 self-nomination period and for future performance periods, the self-nomination form that is available through the web-based tool, will include two additional fields: one that questions whether the QCDR measure is owned by another QCDR, and another that asks the secondary QCDR to attest that it has received written permission to use another QCDR’s measure.

- Approved measures will be assigned a measure ID that each subsequent user of that measure must provide in their own self-nomination application. The self-nomination form that is available via the web-based tool will be modified to include a field that will request QCDR measure IDs if the measure has been previously approved and assigned a MIPS QCDR measure ID.

- CMS is also clarifying that the QCDR must publicly post the measure specifications no later than 15 calendar days (not business days) following its approval of these measures specifications for each approved QCDR measure.

(4) Full Development and Testing of QCDR Measures by Self-Nomination (p. 870)

- In our comments, we cautioned CMS to consider the burdens extensive pre-submission testing may put on many smaller, sub-specialty, or nascent QCDRs.

- Their response: As this was a request for comment only, we will take the feedback provided into consideration for possible inclusion in future rulemaking.

- No proposed changes to this effect at the time.

(5) Expansion of Third Party Intermediary Submissions to Virtual Groups (p. 844)

- This was in the proposed rule - finalized (i.e. QCDRs/QRs can submit for virtual groups, just as they could submit for other MIPS participants previously)

(6) Certification by Third Party Intermediaries (p. 845)

- The proposed rule provided that "all data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group or virtual group must be certified by the third party intermediary to the best of its knowledge as true, accurate, and complete"

- This was in the proposed rule - finalized

(7) QCDR Criteria for Data Submission

- The proposed rule included no changes, but provided some clarifications.

- While CMS does, on a case-by-case basis, allow QCDRs and qualified registries to request review and approval for additional MIPS measures throughout the performance period, this flexibility would only apply for MIPS measures; QCDRs will not be able to request additions of any new QCDR measures throughout the performance period.

(8) Records Retention for Third Party Intermediaries (p. 889)

- The proposed rule included that "any third-party intermediary (incl. QCDR, qualified registry) must comply with the following procedures as a condition of their qualification and approval to participate in MIPS as a third party intermediary: (1) The entity must make available to us the contact information of each MIPS eligible clinician or group on behalf of whom it submits data. The contact information will include, at a minimum, the MIPS eligible clinician or group's practice phone number, address, and if available, email; (2) The entity must retain all data submitted to us for MIPS for a minimum of 10 years; and (3) For the purposes of auditing, we may request any records or data retained for the purposes of MIPS for up to 6 years and 3 months."

- The Final Rule modifies this to require record retention for only 6 years and to allow CMS to request any records or data retained for the purposes of MIPS for up to 6 years from the end of the MIPS performance period.

More details on QCDR self-nomination, measure template and factsheet are available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

Reference

The CMS factsheet: https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf