The MACRA Quality Payment Program CY 2018 Proposed Rule

Hosted by the Coalition for Better Care, Consumer Partnership for eHealth, and Consumer-Purchaser Alliance

July 11, 2017

Agenda

WELCOME AND INTRODUCTIONS

QPP REFRESHER AND THEMES

Stephanie Glier, Senior Manager, Consumer-Purchaser Alliance

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Jenny Hu, Policy Analyst, Consumer-Purchaser Alliance

Erin Mackay, Associate Director, Consumer Partnership for eHealth

ALTERNATIVE PAYMENT MODELS

Stephanie Glier, Senior Manager, Consumer-Purchaser Alliance

Q&A

THE QUALITY PAYMENT PROGRAM

Program Year 2

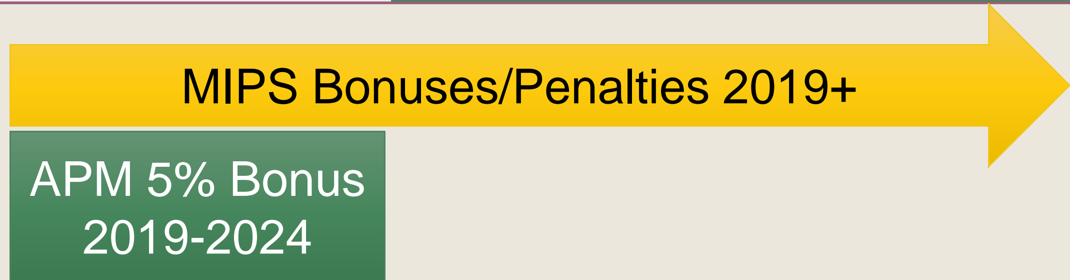
Goals and Importance of the QPP

- Landmark legislation guiding clinician payment under Medicare, replaced sustainable growth rate and reset annual updates to clinician payment rates
- Major channel to promote payment and delivery system reform, including alignment with the private sector
- Two program tracks provide a “ramp” for clinicians to move from fee-for-service to value-based payment

QPP Refresher: Two Tracks

	2016-2019	2020-2025	2026+
Impact on Physician Fee Schedule: Annual Updates	0.5%	0.0%	0.25% MIPS 0.75% APMs

Pre-MACRA programs:
PQRS, Physician Value Modifier, MU Bonuses/Penalties through payment year 2018 (performance year 2016)



MIPS

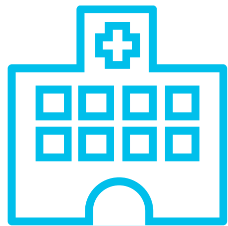
- Fee-for-service with bonuses and penalties for performance (budget neutral)
- Additional bonuses for "exceptional performance"
- Default track

APMs

- Payment model that rewards high quality, requires use of HIT, and is an enhanced Medical Home model or requires participants to bear risk
- Minimum payment and patient thresholds to qualify
- 5% bonus on all Part B payments through 2024

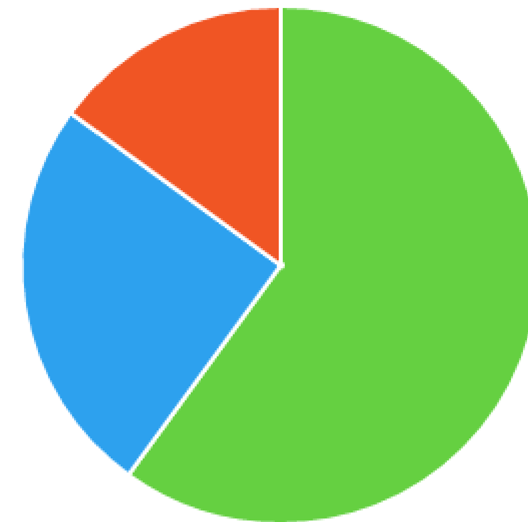
QPP Transition Year 2017: “Pick Your Pace”

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

2017 MIPS Performance



Quality (60%)
Advancing Care Information (25%)
Improvement Activities (15%)

adjustment

MIPS

Year

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90-day
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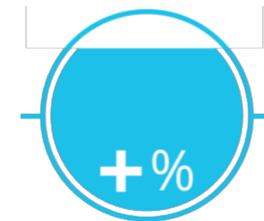
Full Year



Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

Proposed Rule: Themes & Key Takeaways

- Reduce burden on clinicians, particularly for small and/or rural practices
  - *Continued transition year policies*
  - *More excluded clinicians*
  - *More flexibility available for participation (e.g., virtual groups)*
  - *More opportunities to score well, including new bonus points, facility-based performance measurement, and new improvement scoring methodology*
- Payment and delivery system reforms continue
  - *Scoring changes impact attractiveness of MIPS vs APM tracks for high performers*
- What does this mean for consumers and purchasers?
  - *Slower move toward a high-value system*
  - *Little progress on accessing meaningful information*
  - *Further delay in health IT functions that are a priority for consumers and purchasers*

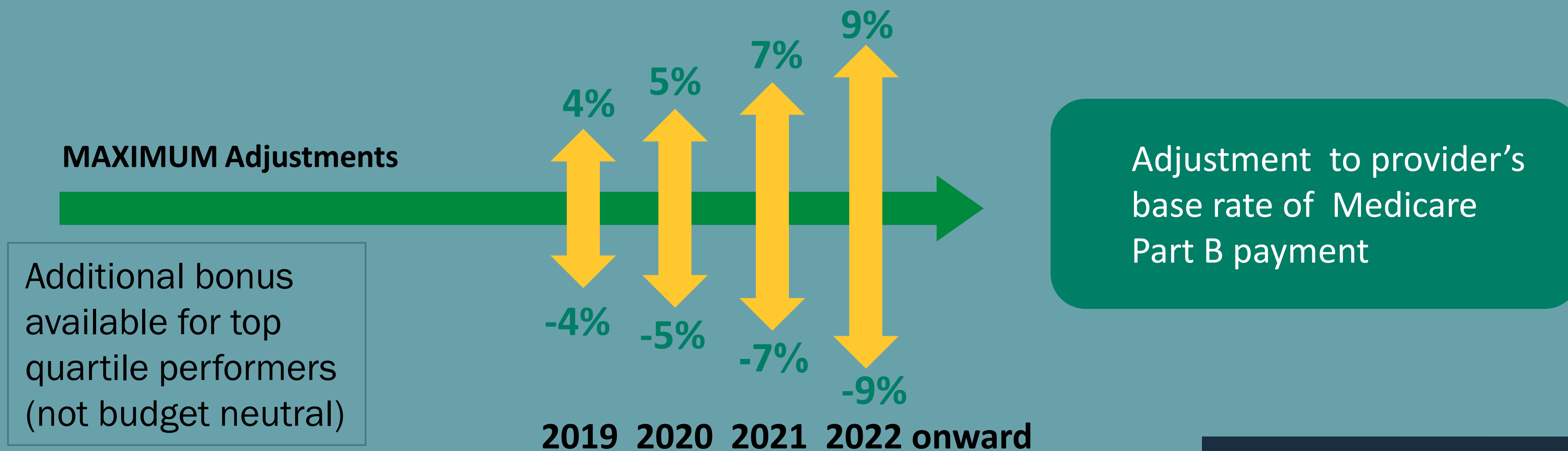
QPP CY 2018 Timeline

- Comments on proposed rule due August 21, 2017
- Anticipate Final Rule published by October 2017
- Performance year will be calendar year 2018; payment adjustments will be applied to care delivered in calendar year 2020

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS Overview

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below
- MIPS adjustments are **budget neutral** -- a **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal



Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

Participation

Types of MIPS Eligible Clinicians (ECs)

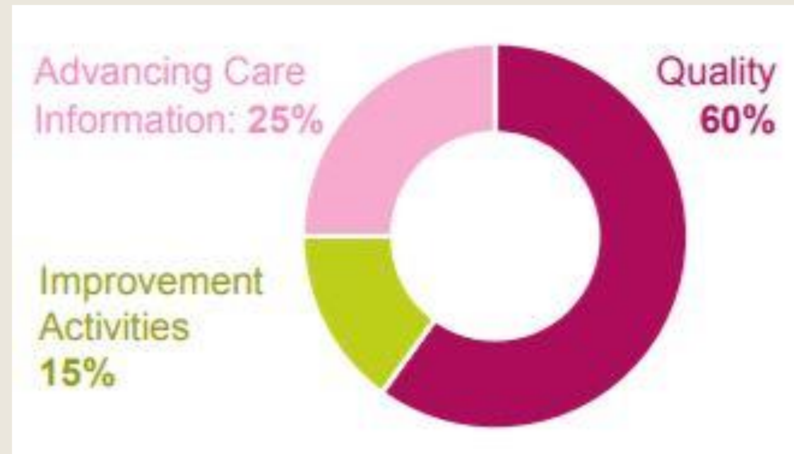
- Physician, physician assistance, nurse practitioner, clinical nurse specialist, and certified registered nurse anesthetists

Exclusion Criteria for MIPS ECs

- Qualifying Participants (QPs), Partial QPs, newly Medicare-enrolled ECs, and ECs who do not exceed the low volume threshold are exempt from MIPS payment adjustments

Low Volume Thresholds	Performance Year	Medicare Part B Allowed Charges	# Medicare Beneficiaries Served	Total % Clinicians Excluded *Total % Part B Charges Excluded* (estimated)
	2018 (proposed)	**Less than or equal to $90,000**	**200 or fewer**	**64% of clinicians** *42% of Part B charges*
	2017	Less than or equal to $30,000	100 or fewer	53% - 57% of clinicians *22% - 27% of Part B charges*

MIPS Final Scoring Methodology



- Multiple pathways to avoid a negative payment adjustment
- Complex patient bonus (1-3 points)
- Small practice bonus (5 points)
- Quality (and cost) score will account for improvement

Facility-Based Measurement Option for Quality (and Cost)

- Allows facility-based MIPS ECs to be scored based on their facility's performance in the Hospital Value-Based Purchasing (HVBP) program -- 13 quality and cost measures

Quality

Accounts for 60% of total 2018 MIPS performance score

Removes majority of cross-cutting measures from specialty sets

No changes to the Global and Population-based measures (i.e., continue to use All-cause Readmission Measure)

High-Priority Measures: outcome, patient experience, appropriate use, patient safety, efficiency, and care coordination

Submission Requirements

- Choose 6 measures to report, including at least one outcome or high-value measure
  - *OR*
- Report all measures in a “specialty set”
  - *OR*
- Use Group reporting website and report all 15 measures required on website

Proposing to allow quality measures to be submitted via multiple submission mechanisms

Data Completeness Criteria

- Maintains 50% threshold rather than increasing to 60% as was previously finalized
- Lowers points assigned to measures that do not meet the criteria, from 3 points to 1 point (does not apply to small practices)

Reporting Period

- Increases the reporting period from a minimum of 90 continuous days to the full 12-month calendar year

Quality, continued…

Topped Out Measures
Measures for which performance is so high and unvarying that meaningful distinctions/improvement in performance can no longer be made

Proposal to remove topped out measures

- Approximately 45% of quality benchmarks currently meet the definition of topped out
- Transition year(s) scoring: a 6-point cap applied to identified measures
- Three-year timeline for removal: measure must be identified as topped out for two consecutive years to be proposed for removal in the third year (effective in 4th year)
  - *Six long-topped out measures identified for removal in 2018 performance year*

CAHPS for MIPS

- Reduces minimum reporting period from 4 months to 2 months of performance year
- Removes two Summary Survey Measures (SSMs): “Helping You to Take Medication as Directed” SSM and “Between Visit Communication” SSM
- Proposing not to score two Summary Survey Measures (SSMs): “Health Status and Functional Status” and “Access to Specialists”

Scoring Quality

$$\text{Quality Performance Score} = \frac{\text{Sum of Points Assigned to Req. Measures} + \text{'High Priority Measure' Bonus Points} + \text{'CEHRT Use' Bonus Points}}{\text{Total Possible Points on Req. Measures}} + \left(\frac{\text{Points Assigned to All-Cause Readmission Measure*}}{10} \right) + \text{Improvement Percent Score}$$

* *Applies to groups of 16+ clinicians who have at least 200 cases*

Scoring Achievement

- Performance is evaluated via comparison to baseline benchmarks
- Scores on reported measures will be converted using a 10-point scoring system
- Achievement denoted as 'Sum of Points Assigned to Req. Measures'

Scoring Improvement

- Improvement evaluated at the category level
- Capped at 10 percentage points of the quality category

$$= \frac{Achievement\ \%\ score\ - Previous\ Year\ Achievem.\%\ score}{Previous\ Year\ \%\ score\ x\ 10}$$

- *Bonus points for high-priority measures and for CEHRT Use are each capped at 10% of total possible points*

Cost

Weighting finalized at 0% for 2017 performance year

Keeps total cost measures: Total Per Capita Cost & Medicaid Spending Per Beneficiary (MSPB)

Removes all current episode-based measures

No cost measures will be applied to non-patient facing MIPS ECs

Measures are calculated based on administrative claims data (i.e., no reporting burden)

Weighting

- Proposing to maintain the transition year weighting – seeking comment on whether 10% would be more appropriate
- Cost data still collected and shared confidentially with eligible clinicians
- By statute, the cost category must be assigned a weight of 30% of the MIPS final score beginning in the 2019 performance year

Episode-based Measures

- Proposing to remove the 10 episode-based measures adopted for the 2017 performance period
- No replacement measures, but plan to introduce new episode-based measures currently under development

Advancing Care Information

Rewards providers for specific uses of technology that improve patient care

Accounts for 25% of MIPS performance score in 2018

New performance category exemptions proposed (per 21st Century Cures Act)

More bonus points proposed for 2018, up to 25% of total ACI score

Delayed transition to 2015 Edition certified EHR technology (CEHRT)

- ACI Score = Base score + Performance score + (possible) bonus points
- MIPS clinicians can use technology certified to either 2014 or 2015 Edition certification criteria, or a combination of the two
- 90-day reporting period previously finalized for 2018
  - *Proposed for 2019 as well*
- New proposal for determining the proportion of meaningful EHR users for purposes of reweighting the ACI performance category (not below 15%)

ACI Performance Score Components

- **BASE SCORE** – Required Reporting on five measures:
  1) Protecting patient health information;
  2) Electronic prescribing;
  3) Providing patient access to health information;
  4) Sending a summary of care document; and
  5) Requesting/accepting a summary of care document.

- **PERFORMANCE SCORE** – Determined by performance on high-priority measures
  - Providers can choose from nine high-priority measures in the areas of patient engagement, care coordination and health information exchange
  - Minor (non-substantive) changes proposed to ACI objectives and measure specifications for 2018

- **BONUS POINTS** – Up to 25 bonus percentage points available for:
  - Reporting on Public Health and Clinical Data Registry Reporting measures (*5 percentage points*)
  - Reporting measures using CEHRT to complete certain improvement activities; new activities available (*10 percentage points*)
  - Reporting using only 2015 Edition CEHRT (*10 percentage points; 2018 only*)

Scoring Methodology

Performance Category Exemptions:
Per the 21st Century Cures Act, CMS proposes to reweight ACI performance category to ZERO for:

- Hospital-based clinicians
- Ambulatory surgical center-based clinicians
- Clinicians facing a significant hardship (demonstrated through an application process)
- Clinicians using decertified EHR technology (demonstrated through a reporting process)
- Small practices (15 or fewer clinicians and solo practitioners)

Measure Exclusions:
CMS proposes exclusions to measures associated with objectives required for the base score:

- Electronic Prescribing: Fewer than 100 permissible prescriptions
- Health Information Exchange (send summary of care): Fewer than 100 patient transfers/referrals
- Health Information exchange (accept summary of care): Clinician receives fewer than 100 transfers/referrals

Advancing Care Information, continued…

- Certification Requirements: Clinicians can use technology certified to either 2014 or 2015 Edition certification criteria, or a combination of the two.
- 2015 Edition Highlights:
  - **Health Information Exchange**: New certification standards and implementation specifications for interoperability
  - **Patient Engagement**: Use of Application Programming Interfaces (APIs) to support consumers' ability to view, download and transmit their health information to a third party (such as a mobile health application)
  - **Patient Generated Health Data**: New certification standards
  - **Transitions of Care**: Certification criterion assesses EHRs ability to create / receive C-CDA formatted documents
- ACI performance category weighting
  - Background: HHS secretary can reduce weight of ACI category (not below 15%) when 75% of clinicians are meaningful EHR users
  - New Proposal: Estimate meaningful EHR users based on data from the performance period that occurs four years before the MIPS payment year.
    - i.e., Use data from 2017 performance category period to estimate proportion of physicians who are meaningful users for 2021 payment year.

Improvement Activities

Activities identified as improving clinical practice or care delivery and when effectively executed is likely to result in improved outcomes

Each activity is either “medium-weighted” or “high-weighted.”

Accounts for 15% of MIPS performance score in 2018

Expanded inventory of activities, including new high-weighted activities and new activities eligible for ACI bonus

- Most participants will attest to completing up to 4 improvement activities for a minimum of 90 days
- Exceptions for small practices, practices in a rural or health professional shortage area and non-patient facing clinicians
- Providers participating in a certified / recognized patient-centered medical home (PCMH) will receive the highest possible score
- Providers participating in an APM receive at least one-half of the highest score applicable (entity can submit additional improvement activities to achieve maximum score)

Improvement Activities Inventory

- Changes to activities (Table G)
- New activities, including more high-weighted activities (Table F)
- New activities eligible for ACI bonus score (Table 6)
- Annual call for activities: proposed approach for adding new activities suggested by clinicians and other stakeholders (similar to the Annual Call for Measures)
  - Submit activities by March 1 to be considered for performance period in the following CY
  - Clinicians and other stakeholders can also nominate additional activities
  - CMS will also establish process for removing activities from inventory
- Subcategories: No changes for CY 2018
  - CMS invited comments on a separate health IT subcategory

Submission and Scoring

- **Exceptions:** Small, rural, non-patient facing practices must submit:
  - 1 high-weighted or 2 medium-weighted activities to achieve highest score;
  - 1 medium-weighted activity to receive at least one-half of highest score.
- **Submission Mechanisms:** Propose to allow clinicians and groups to submit measures and activities via as many submission mechanisms as necessary to meet the requirements
  - For all MIPS performance categories
- **Patient Centered Medical Homes:** More stringent requirements for PCMHs to receive full credit in Improvement Activities performance category.
  - At least 50% of practice sites must be recognized as a PCMH or comparable specialty practice for 2020+ payment years
  - CPC+ design satisfies requirements to be designated as a medical home model
- **Measuring Improvement:** CMS reiterated intention to move from scoring IA category based on simple attestation to measuring performance and improvement.
  - REQUEST for COMMENT: How to measure performance and improvement (without imposing additional burden on clinicians), such as by using data captured in eligible clinician's daily work?

MIPS – Key Changes

- More clinicians exempt from the program
- More flexibility to help clinicians succeed in the program
- Quality (and Cost) performance categories will account for year over year improvement in scoring, in addition to achievement
- Increased performance period requirements for the Quality and Cost performance categories from 90 days to a full year of data
- Advancing care information performance category exemptions and measure exclusions; additional bonus points available
- Delay in transition to 2015 Edition
- Expanded inventory of improvement activities, including new high-weighted activities and new activities eligible for ACI bonus

ALTERNATIVE PAYMENT MODELS (APMs)

Alternative Payment Models (APMs)

Four ways for clinicians to participate in APMs:

- MIPS APMs
- Partial Qualifying Participant for Advanced APMs
- Advanced APMs
- All-Payer APMs

Criteria for APMs: MIPS APMs

Under the QPP, a MIPS APM must meet three criteria:

- Participate under an APM agreement with CMS (i.e., Medicare APMs);
- Have at least one MIPS clinician participating (i.e., not just facilities); and
- Tie payment incentives to quality and cost/utilization performance at the APM Entity or clinician level

Full list of all MIPS and Advanced APMs for 2017:
https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

MIPS APMs

For clinicians who participate in APMs but don't meet the requirements to be a Qualifying APM Participant (QP):

- APM-specific rewards (e.g., shared savings)
- APM scoring standard for MIPS performance score reflecting APM entity's combined performance
- MIPS payment adjustments

APM Scoring Standard

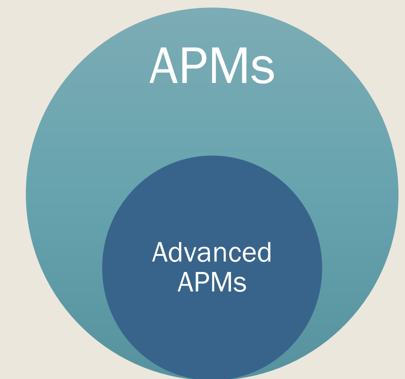
	Transition Year		Proposed Year 2
Domain	SSP and Next Gen ACO	Other MIPS APMs	All MIPS APMs
Quality	50%	0%	50%
Cost	0%	0%	0%
CPIA	20%	25%	20%
ACI	30%	75%	30%

Criteria for APMs: Advanced APMs

Under the QPP, an Advanced APM must:

- Tie payment to quality performance using measures comparable to MIPS quality measures, including at least one outcome measure in the set;
- Use certified EHR technology; and
- Bear financial risk, or be an expanded medical home model

Advanced APMs are a subset of APMs



Advanced APM Volume Requirements

	2017	2018	2019*	2020	2021	2022
% Medicare $ through APM	25%	25%	50%	50%	75%	75%
% Medicare patients in APM	20%	20%	35%	35%	50%	50%

*All-payer APM option begins in PY 2019 for volume calculations

Advanced APMs
Advanced APM-specific rewards (i.e., program design) + 5% lump sum incentive

Advanced APMs

Qualifying Advanced APMs for CY 2017:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

Additional proposed Advanced APMs for CY 2018:

- Shared Savings Program – Track 1+
- Reopening applications for Next Gen ACO, CPC+

Advanced APMs
Advanced APM-specific rewards (i.e., program design) + 5% lump sum incentive

“More than Nominal” Financial Risk

Financial Risk

Bearing financial risk means that the Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians
- Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians
- Require direct payments by the APM Entity to CMS

Total Amount of Risk

Transition year final policy: total potential risk under the APM must be at least:

- 8% of average estimated Parts A and B revenue of the APM entities, OR
- 3% of the expected expenditures an APM entity is responsible for
- Proposed rule: extend the 8% revenue standard to apply for two more years, through 2020

Medical Home Financial Risk Standard

Financial Risk

Bearing financial risk means that the Medical Home Model may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to CMS
- Cause the APM Entity to lose the right to all or part of otherwise guaranteed payment

Total Amount of Risk: Transition Year

The amount of risk under a Medical Home model must be at least:

- 2.5% of the estimated average total Parts A and B revenue of participating APM Entities for 2017
- 3% for 2018
- 4% for 2019
- 5% for 2020

Medical Home Financial Risk Standard

Financial Risk

Bearing financial risk means that the Medical Home Model may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to CMS
- Cause the APM Entity to lose the right to all or part of otherwise guaranteed payment

Total Amount of Risk: Proposed Rule

The amount of risk under a Medical Home model must be at least:

- 2.5% of the estimated average total Parts A and B revenue of participating APM Entities for 2017
- ~~3%~~ 2% for 2018
- ~~4%~~ 3% for 2019
- ~~5%~~ 4% for 2020
- 5% for 2021 and after

All-Payer APM Combination Option

What counts?

- 50%+ eligible clinicians use CEHRT
- Payments based on MIPS-comparable quality measures
- Either Medicaid Medical Home model comparable to qualifying Medicare Medical Home models, or requires participants to bear more than nominal financial risk

Nominal Risk Standards

- Marginal risk of at least 30%
- Minimum Loss Rate of no more than 4%
- One of:
  - *Total Risk of at least 3% of expected expenditures APM Entity is responsible for under APM*

    OR
  - *Total Risk of at least 8% of revenue of APM Entity (new proposal)*

APMs – Key Changes

- Updates to APM Scoring Standard for MIPS APM participants
- Nominal risk definition: extends 8% threshold for two years, through 2020
- Slower ramp for nominal risk standard for Medical Home models
- Sets parameters for All-Payer Combination qualification that begins in 2019

THE QUALITY PAYMENT PROGRAM

Q&A

Proposed Rule: Themes & Key Takeaways

- Reduce burden on clinicians, particularly for small and/or rural practices
  - *Continued transition year policies*
  - *More excluded clinicians*
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