Quality Payment Program Year 2
Final Rule Analysis

January 2018

We continue to monitor and shape the implementation of the Medicare Access and Chip Reauthorization Act (MACRA) to drive health system transformation that results in authentic person- and family-centered care.

In November 2017, the Centers for Medicare & Medicaid Services (CMS) released the final rule on the second year of the Quality Payment Program (QPP) created by MACRA. Earlier in 2017, the Consumer Partnership for eHealth (CPeH) and the Coalition for Better Care (CBC) submitted comments in response to the proposed rule expressing our concern that the proposed requirements would have a chilling effect on the transition to a health care system that rewards quality and value over volume.

Below, we summarize key aspects of the final rule and offer a side-by-side comparison of our recommendations and the final rule for the 2018 performance year.

2018 Merit-Based Incentive Program (MIPS) Final Score

- Quality: 50 percent
- Cost: 10 percent
- Improvement Activities: 15 percent
- Advancing Care Information (ACI): 25 percent

Big Wins

- Cost weighted at 10 percent (increased from 0 percent as originally proposed for 2018).
- Added two criteria for proposing new improvement activities:
    - Activities that focus on meaningful actions from the person and family's point of view; and
    - Activities that support the patient's family or caregiver.
- Finalized changes to a quality improvement-related improvement activity encouraging "activities in which clinicians act upon patient experience data."

Proposals Finalized with Consumer Support

- Increased complex patient bonus from 3 percent to 5 percent.
- Established 10 percent bonus points in the ACI category for providers who use the 2015 Edition certified electronic health record technology (CEHRT).
- Added "Health Status and Functional Status" Summary Survey Measure (SSM) to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey.
- Added new "Achieving Health Equity" subcategory for Improvement Activities.
- Added five new Improvement Activities, and made patient-centered changes to several existing Improvement Activities.

Partial Wins

- CMS is likely to reject measures that are not outcomes-based in future rulemaking with limited exceptions.
- CMS is likely to include narrative questions in future iterations of the CAHPS survey.
- CMS voiced general support for:
  - Sharing provider performance data that is stratified by social risk factors with consumers.
  - Making performance data at provider and practice levels available to consumers; and
  - Incorporating improved cross-cutting measures.

	Issue	CBC/CPeH Comments on Proposed Rule	MACRA Final Rule
	MERIT-BASED INCENTIVE PAYMENT SYSTEM		
Eligibility	Delaying transitions and exempting more providers	Encouraged CMS not to delay the move to a value-based system by extending transition year policies. Discouraged CMS from exempting more providers from participating.	Finalized exemptions, including: • Non-patient facing clinicians • Hospital-based clinicians • Ambulatory surgical center-based clinicians • NPs, PAs, CRNAs, CNSs • Significant hardship (broadband access, etc.) • Decertified EHR • Small practices Raised the patient quantity and billing low-volume thresholds for participation. Not allowing opt-in for clinicians that meet one, but not both, of the thresholds.
	Financial support and technical assistance	Offer direct support to groups of providers that may have a difficult time reporting; help clinicians fully participate in the QPP (rather than exempting them).	Finalized proposed exemptions. Cited the technical support provided through the Small, Underserved, and Rural Support initiative.
	Additional notes		• Areas with extreme and uncontrollable circumstances (e.g., hurricanes) are exempt from reporting. • Finalized virtual groups.
Scoring	Demographically stratified data	Collect and publicly report demographically stratified data at individual and practice levels.	Voiced support for stratified public reporting by risk factors (income, education, race and ethnicity, employment, disability, community resources and social support) on Physician Compare; hope to finalize in future rulemaking.

	Bonus for complex patients	Support bonus points for treating patients with complex situations that take into account health status, medical conditions and social risk factors.	Finalized their proposal to increase from 3 percent to 5 percent bonus, based off dual eligibility ratio and average Hierarchical Condition Category (HCC) risk score.
Cost	Weight of cost category	Weight cost at 10 percent (instead of 0 percent as proposed) to provide a ramp to 30 percent for the next reporting period.	Reversed course and finalized 10 percent cost weighting.
	Additional cost notes		• Part D drug costs still excluded, did not elect to also exclude Part B drugs. • Will not adopt episode-based measures at this time. • Will consider risk adjustment by social determinants of health in future years.
Quality	Quality tracking	• Provide more quality information (at the provider level as well as the system level) to patients. • Identify health equity measures for future development and inclusion in MIPS.	• Cited efforts to continue to advance the Physician Compare launch and test interface/usability with consumers.
	Menu of options	• Encouraged CMS to retire the menu approach to quality measure selection (clinicians choose any six measures, at least one outcomes measure when possible, vs. a standardized measure set). Menu approach too lenient – makes it easy to skirt key measures, and makes it harder to tell when measures are topped out. • Finalize a core set of high-value measures for each specialty/sub-specialty with an emphasis on outcomes measures and patient-reported outcome measures (PROMs).	• Maintained the menu option for clinical quality measure selection. • Proposed four-year removal process for topped out measures. Listed six measures as topped out for this year. • Outcomes measures are going to be given high priority, intend to reject future proposed measures that are not outcomes measures.
	Cross-cutting measures	Keep the requirement to report on cross-cutting quality measures and continue to develop more meaningful cross-cutting measures.	• Removed from most specialty sets, kept only for primary care, pediatrics and family medicine. • Cited general support for better incorporating cross-cutting measures in future rules.

	CAHPS	• Keep "Functional and Health Status" Summary Survey Measure. • Increase reporting period to at least 12 weeks. • Require standardized patient experience measure for all MIPS clinician groups of two or more. • Add narrative questions to patient experience survey.	• Finalized "Health Status and Functional Status" SSM, removed two: Communication Between Visits and Taking Medication as Directed (p. 231). • Finalized the minimum reporting period at eight weeks. • Beta-testing five narrative questions with AHRQ; CMS will consider them for future rulemaking.
Advancing Care Information (ACI)	Exemptions	Concerned with the number of clinicians that will be exempt from the requirements of the ACI performance category, including: • Non-patient facing clinicians • Hospital-based clinicians • Ambulatory surgical center-based clinicians • NPs, PAs, CRNAs, CNSs • Significant hardship • Clinicians using decertified EHR • Small practices	Finalized proposal to reweight the ACI category to 0 percent of the final score for stated groups of clinicians. Five-year limit on performance exceptions will not apply to clinicians facing a significant hardship.

	2015 EHR Certification Standards	• Implement 2015 certification requirements as planned; no more delay.
		• Finalize the proposed bonus points for using solely 2015 CERHT, registry reporting, leveraging HIT
			• Finalized delay, allowing clinicians to use both 2014 and 2015 CEHRT.
			• Finalized 10percent bonus points for use of 2015 CEHRT to:
			  o Report ACI measures;
			  o Report to registries (5percent for each registry, up to 10percent); or
			  o Report an Improving Activity.

	Reporting period	Require full-year reporting; 90 days is not long enough.	Finalized reporting period at 90 days.
	Meaningful EHR users	Decrease the proposed four-year look back for determining meaningful users; four years is unreasonable given the rapid pace of technology.	Finalized four-year look back period. Long look back period is necessary for providers to have sufficient time to adjust and for CMS to collect performance data.

Improvement Activities			
	Reporting period	Require full-year reporting period.	Finalized reporting period at 90 days, no response to comments.
	Informed activity selection	CMS should support practices in making decisions about how and where to target improvement activities based on the specific needs of their patient population.	*No response*.
	Score of performance and improvement	• Attestation is not sufficient to measure performance with PROs and patient experience measures. • To allow comparison, providers should complete each activity for at least two years.	• Finalized the attestation method for improvement activity submission. • No response on continuity issue.
	"Achieving health equity"	• Finalize this subcategory, add new activities to it and assign them high weights. • Add limited English-speaking patients as an underserved group, add a high-weighted activity of providing language support.	Finalized "Achieving Health Equity" subcategory and will take comments about new activities into account in future rulemaking.
	New activity submission	Criteria for new activities should include importance or relevance to patients and families. Criteria list for reference: • Relevance to existing activities • Importance for health outcomes • Importance for reducing health disparities • Related to patient-centered medical homes • Related to ACI bonus • Applicable to specialty and primary care • Feasible with minimal burden for many groups • Evidence-based or CMS is able to validate	Finalized more activities and changes to existing activities; for a total of approximately 112 activities in the inventory. Finalized additional criteria for submitting a new Improving Activity: 1) Improvement activities that focus on meaningful actions from the person and family's point of view; and 2) Improvement activities that support the patient's family or personal caregiver.
	ACI bonus	Finalize the ACI bonus.	Finalized the 10 percent bonus for completing activities using CEHRT. CMS will continue to designate activities that will also qualify for bonus points under ACI.

	Additional notes		• Finalizing 60 percent data completeness threshold instead of 50percent as proposed. • In a group, only one NPI in the TIN has to complete an IA for the whole group to get credit.
	ADVANCED ALTERNATIVE PAYMENT MODELS (A-APMS)		
Advanced APMs	Patient-centered standards	• A-APMs should have requirements that ensure the delivery of high-quality, patient-centered care (not just value). • Require proposals to demonstrate how it reinforces patient- and family-centered care.	No changes to criteria for PFPMs. In response to our comment, CMS cited the "Integration and Care Coordination" and "Patient Choice" criteria, saying they ensure APMs are sufficiently patient-centered (p. 1159).
	Public input in development of APMs	• Include patients and consumers in a meaningful way, especially with commercial models. • Convene a Technical Expert Panel of patient/consumer advocates for A-APM approval.	In response to comments that requested specific representation on the PTAC, CMS said that such changes were outside of their scope and instead up to the Government Accountability Office (p. 1156). No mention of an additional consumer panel.