The MACRA Quality Payment Program: Who's Down With QPP?

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

November 15, 2016

Agenda

WELCOME AND INTRODUCTIONS

BACKGROUND & CONTEXT
Stephanie Glier, Senior Manager, Consumer-Purchaser Alliance

MERIT-BASED INCENTIVE PAYMENT SYSTEM
Jenny Hu, Project Coordinator, Consumer-Purchaser Alliance
Erin Mackay, Associate Director, Consumer Partnership for eHealth

ALTERNATIVE PAYMENT MODELS
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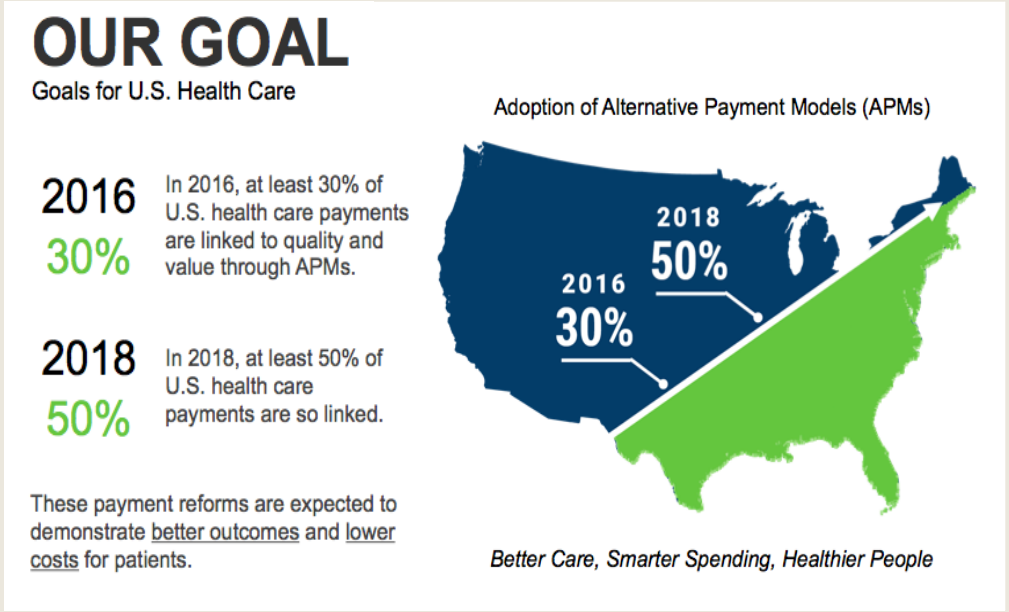
IMPLICATIONS & OPPORTUNITIES TO ACT

Q&A

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Part of a broader push towards value-based payment
- Overwhelming bipartisan support and support from docs
- General changes from proposed rule

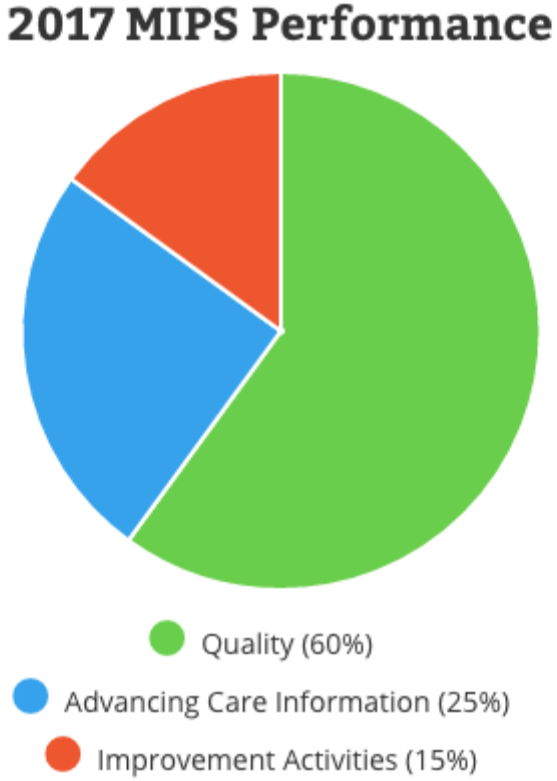


Transition Year: “Pick Your Pace” for 2017

Participate in an Advanced Alternative Payment Model

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

MIPS



payment adjustment

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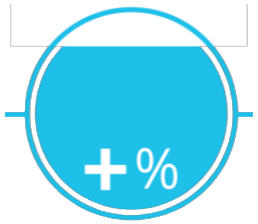
Full Year



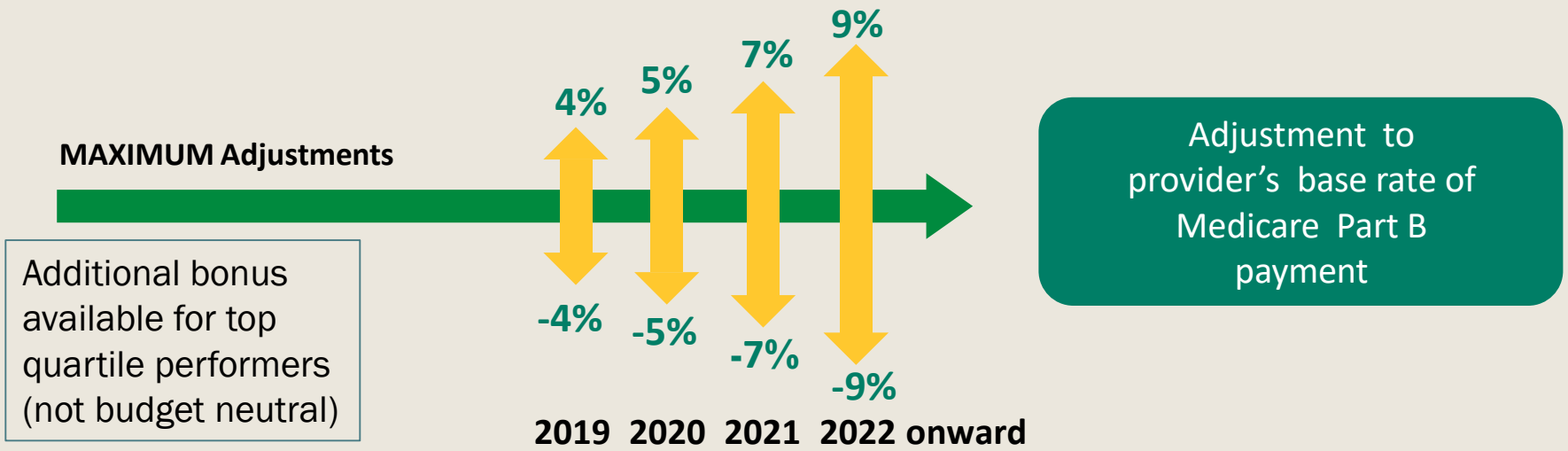
Submit a Full Year

- 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.

How Much Can MIPS Adjust Payments?

- 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.



Merit-Based Incentive Payment System **(MIPS)**

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

Scope of Quality Payment Program, 2017

- More than 600,000 clinicians included
- Advanced APMs: estimated 70k – 120k QPs in 2017; 125k – 250k QPs in 2018
- Half of Medicare clinicians will be excluded from MIPS, representing a quarter of total Part B allowed charges
- Estimated 90% of MIPS ECs will receive a positive or neutral MIPS payment adjustment (80% for clinicians in small and solo practices)

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Resource Use

Replaces Physician Value-Based Payment Modifier (VM) program

Cost Measures:

- *10 existing episode-based measures*
- *1 total per capita cost measure for all attributed beneficiaries*
- *Medicare Spending Per Beneficiary (MSPB) measure*

No reporting burden -- measures are all based on administrative claims data

- Weighting lowered to 0% for MIPS performance year 2017
- Category weighting will increase to 10% in 2018, and then to 30% for 2019 and beyond
- In the transition year, cost data will still be collected and reported back to eligible clinicians

Recommendations for the Resource Use Performance Category

- Maintain timeline for ramping weight to equal quality category
- Don’t let the perfect be the enemy of the good

Quality

Replaces Physician Quality Reporting System (PQRS)

Accounts for 60% of total 2017 MIPS performance score

Final rule removed cross-cutting measure requirement

CAHPS for MIPS rewarded in two QPP performance categories

- Submission Criteria
  - *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*

High-Priority Measures

outcome, patient experience, appropriate use, patient safety, efficiency, care coordination

- Quality performance category weight will decrease from 60% to 30% by the 3rd performance year

Quality Performance Score Components

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

Calculating Scores for Required Measures

- Performance is evaluated via comparison to baseline benchmarks
  - *Benchmarks calculated using data from 12-month calendar year, two years prior*
- Scores on reported measures will be converted using a 10-point scoring system

Changes from NPRM

- Bonus points for both high-priority measures and CEHRT Use now capped at 10% of total possible points
- Originally proposed 3 global- and population-based measures; AHRQ's Acute and Chronic PQI Composites no longer required

Recommendations for the Quality Performance Category

1) To provide a complete and accurate assessment of the quality and outcomes of care provided
2) To enable comparisons of providers on quality performance
3) To capture quality of care using patient-generated data, in addition to clinical data and health system-generated data

Key Levers

- Mandatory Core Measure Sets, by specialty
- Cross-cutting measure requirement
- Patient Experience and Patient-Reported Outcome Measures

Advancing Care Information

Replaces the Electronic Health Record (EHR) “Meaningful Use” Incentive Program for eligible Medicare clinicians

Accounts for 25% of MIPS performance score for 2017

Rewards providers for specific uses of technology that improve patient care

- ACI Score = Base score + Performance score + (possible) bonus points
- Bonus Points, up to 15% of total ACI score, available for:
  - *Reporting on Public Health and Clinical Data Registry Reporting measures*
  - *Reporting measures using certified EHR technology to complete certain improvement activities in the CPIA performance category*
- The reporting period for 2017 is 90 days
- Secretary has discretion to reduce the weight of the ACI performance category (not below 15%) if > 75% of clinicians are “Meaningful Users”

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*

BONUS POINTS available for:

- Reporting on Public Health and Clinical Data Registry Reporting measures
- Reporting measures using certified EHR technology to complete certain improvement activities in the CPIA performance category

2017 Advancing Care Information Transition Objective (2017 only)	2017 Advancing Care Information Transition Measure* (2017 only)	Required/ Not Required for Base Score (50%)	Performance Score (Up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	E-Prescribing	Required	0	Numerator/ Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	Numerator/ Denominator
	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Numerator/ Denominator
Patient-Specific Education	Patient-Specific Education	Not Required	Up to 10%	Numerator/ Denominator
Secure Messaging	Secure Messaging	Not Required	Up to 10%	Numerator/ Denominator
Health Information Exchange	Health Information Exchange	Required	Up to 20%	Numerator/ Denominator
Medication Reconciliation	Medication Reconciliation	Not Required	Up to 10%	Numerator/ Denominator
Public Health Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	Bonus	Yes/No Statement
	Specialized Registry Reporting	Not Required	Bonus	Yes/No Statement
Bonus up to 15%				
Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure			5% bonus	Yes/No Statement
Report improvement activities using CEHRT			10% bonus	Yes/No Statement

What's New

- Changes to base score
  - *Reduced the number of required measures from 11 to 5 required measures*
  - *Loss of patient-facing requirements for calculating base score*
- Changes to performance score:
  - *Increased number of measures eligible clinicians can earn performance score credit from 8 to 9*
  - *Increased the number of percentage points available for the performance weight of the Provide Patient Access and Health Information Exchange measures (up to 20% for each measure)*
- Bonus points available for:
  - *Completing at least one of the improvement activities using CEHRT functionality (10% bonus)*
  - *Reporting to public health or clinical data registries*
- Definition of "Meaningful User"
  - *CMS will define meaningful users as those MIPS eligible clinicians who earn a score of 75 in the ACI performance category (rather than 50 points)*

Recommendations for the ACI Performance Category

- Support performance score measures focused on patient/family engagement and health information exchange
- Advance patient-facing uses of CEHRT:
  - *View/download/transmit of data*
  - *Secure messaging*
  - *Patient-generated health data & data from non-clinical sources*
- Increase stringency of ACI measures in future years
  - *Implement minimum thresholds for base score measures*
  - *Increase weight of performance score relative to base score*
- Advance a holistic approach to health IT
  - *Align with other performance categories (quality, improvement activities) to achieve unified goal of quality improvement*

Improvement Activities

New performance category that includes a broad swath of activities designed to reward clinicians for care focused on beneficiary engagement, care coordination and patient safety

Accounts for 15% of MIPS performance score in 2017

Providers will choose from a list of nearly 95 activities.

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

- Most participants will attest to completing up to 4 improvement activities for a minimum of 90 days.
- Reduced requirements for groups with fewer than 15 participants or in a rural or health professional shortage area.
- Providers participating in a certified patient-centered medical home (PCMH) will receive the highest possible score.
- Providers participating in an APM will automatically receive half the points toward full credit in this category; some providers in APMs may be eligible for full credit

Improvement Activity Examples

- Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge
  - *e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).*
- Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.
- Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following:
  - *Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or Provide a guide to available community resources.*
- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.

What's New and Recommendations for the Improvement Activities Category

What's New?

- Reduced number of activities required to achieve full credit from 6 medium-weighted or 3 high-weighted activities to 4 medium-weighted or 2 high-weighted activities
- For small and rural practices, HPSAs and non-patient-facing clinicians, requirement is reduced to 1 high-weighted or 2 medium-weighted activities
- Expanded definition of how CMS will recognize a certified patient-centered medical home

Recommendations

- More specificity around the descriptions to ensure improvement activities result in continuous quality improvement and better care delivery
- Meaningful beneficiary and family engagement
- Align improvement activities to promote data-driven quality improvement

ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

Criteria for Advanced APMs

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

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

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

Criteria for Advanced APMs

Based on the above criteria, CMS determined the following are qualifying Advanced APMs:

- Comprehensive ESRD Care (CEC) with two-sided risk;
- Comprehensive Primary Care Plus (CPC+);
- Oncology Care Model (OCM) with two-sided risk;
- Next Generation ACO Model; and
- Shared Savings Program - Tracks 2 and 3.

Final list to be published by January 2017

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

Additional Advanced APMs for 2018

CMS anticipates adding additional Advanced APMs for 2018:

- Comprehensive Care for Joint Replacement (CJR) Payment Model
- ACO Track 1+
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer Model)
- Advancing Care Coordination through Episode Payment Models Track 1
- New Voluntary Bundled Payment Model

Physician-focused Payment Model Technical Advisory Council (PTAC) Recommendations to Secretary of HHS

- PTAC is an 11-member independent federal advisory committee and is 1 of 6 currently active GAO Healthcare Advisory Committees
- Opportunity for public comment (3 week window)

Stay tuned for more information on these proposals! We expect to learn more in the coming months.

Recommendations for Advanced Alternative Payment Models

- Create care delivery requirements for Advanced APMs
  - *Add an additional criterion for Advanced APMs that requires them to demonstrate that their payment approach reinforces the delivery of patient- and family-centered care, with a strong grounding in primary care.*
- Ensure multi-stakeholder input into determining qualification for Advanced APM designation
  - *Ensure consumers and purchasers are involved in the development of the underlying models that are categorized as Advanced APMs.*

THE QUALITY PAYMENT PROGRAM

Implications and Opportunities to Act

Summary

- Changes between the NPRM and the Final Rule reflect CMS's goal to maximize clinician success and early participation in the Merit-Based Incentive Program (MIPS) via transition year timeline and reporting requirements
  - *We support this effort but reiterate the importance of strengthening QPP requirements in later years for achieving meaningful quality improvement*

- Our recommendations for future changes to the program:
  - *Quality: focus on emphasizing high-value measures like patient-reported outcomes, cross-cutting measures*
  - *ACI: strengthen the patient-facing requirements*
  - *CPIA: room for improvement in creating structures and incentives for meaningful patient and family engagement*
  - *APMs: create care delivery requirements for qualifying models and build in greater consumer and participation in the design and implementation of models*

Impact of Election Results

What does this mean for consumers and purchasers?

- Continuing overall movement toward value-based payment system-wide
- Need for strong voice supporting meaningful requirements and incentives for MIPS categories, and for APM criteria and model design
- Watch out for potential extension of transition periods

What's Next?
Comment and advocacy opportunities

- Current comment period on the final rule open through December 19.
- Additional advanced APM models will be released with comment opportunities.

  Remember: Advanced APMs are only as strong as the underlying models, so weighing in on the proposed models will be critical for consumer, patient, and purchaser priorities to be addressed.

- Quality measures published annually by November 1; Measure Applications Partnership 2016-17 cycle (for 2017 rulemaking) kicks off by December 1.
- Measure Development Plan progress report will be out by May 2017.
- Future rulemaking, changes to MIPS performance categories likely.

THE QUALITY PAYMENT PROGRAM

Q&A