MACRA Final Rule and the Quality Payment Program, Year Two — Focus on the Changes

Penny Osmon Bahr

Tony Werner

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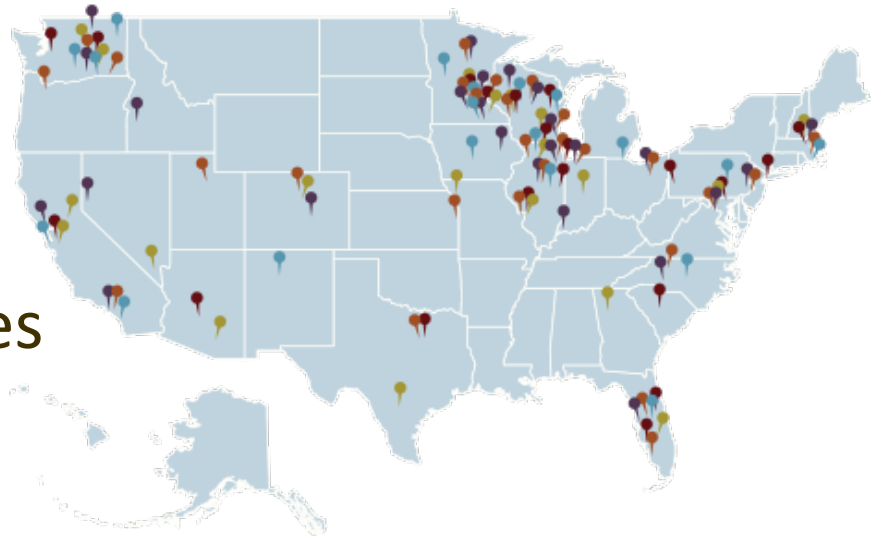

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Speaker Introductions

- **Penny Osmon Bahr**

  Penny is a health care principal at CLA with more than 20 years of industry experience and has worked across the continuum with independent physicians practices, accountable care organizations, health systems and health plans. She is an executive level health care operations specialist that works to develop business strategy, navigate regulatory impact and execute improvement across the healthcare ecosystem

- **Tony Werner**

  Tony is a health care manager at CLA with over 20 years of experience in hospital, imaging, and physician group leadership, operations, revenue cycle and technology management. He serves as an advisor on a wide array of issues, including strategic planning, leadership and governance, mergers and acquisitions, compensation models, operations and contract negotiations.

Learning Objectives

- At the end of this session, you will be able to:
  - Summarize key changes in the quality payment program (QPP) for 2018
  - Identify alternative payment models (APMs) for 2018
  - Execute a 2018 merit-based incentive program (MIPS) strategy
  - Evaluate opportunities across MIPS categories to enhance 2018 performance

The Burning Platform was Created for

Payment Transformation

Volume to Value

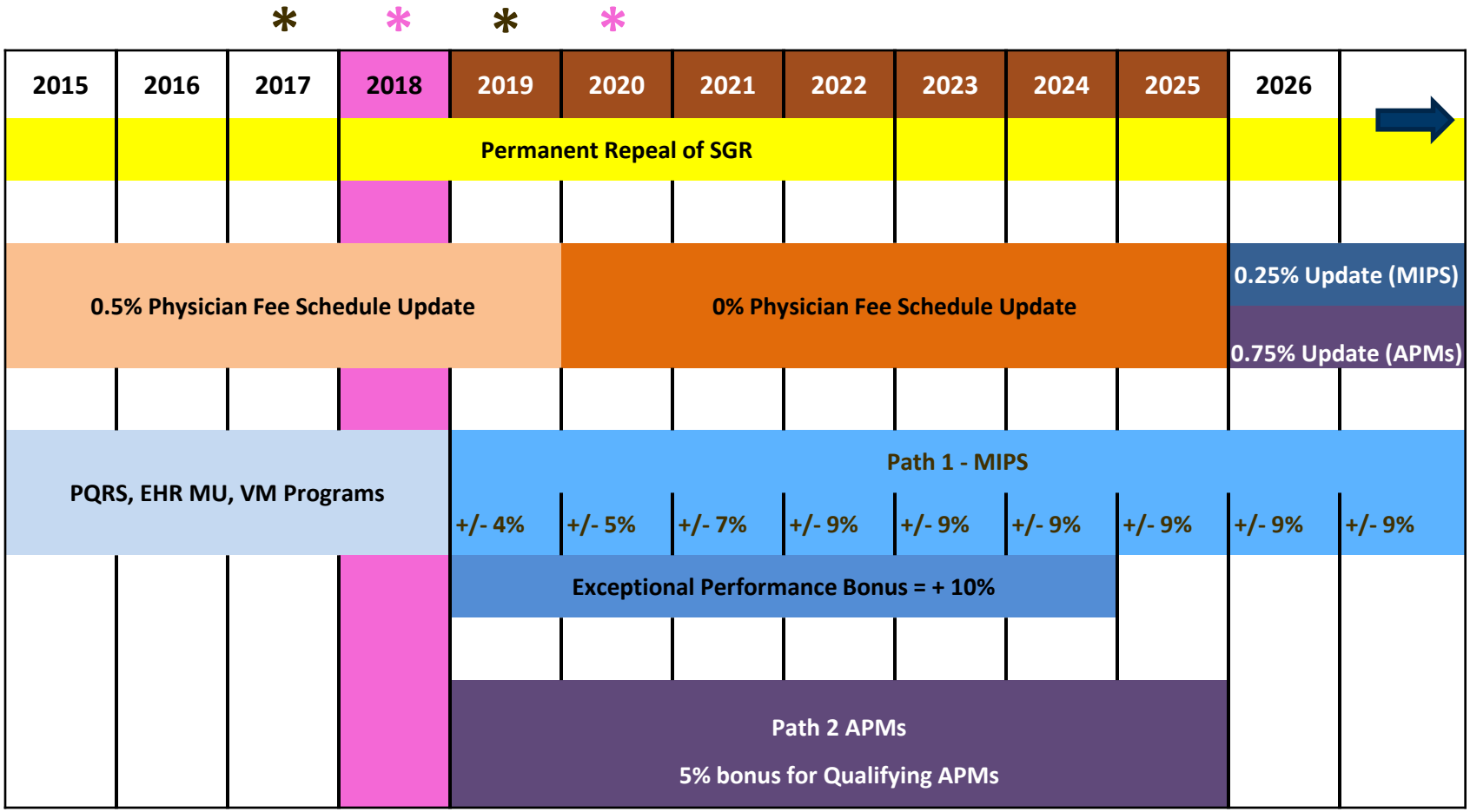
Quantity vs. Quality

MACRA – The Basics

Medicare Access and CHIP Reauthorization Act of 2105 (MACRA) – Signed April 16, 2015

- Main components
  - Repealed Sustainable Growth Rate (SGR) formula
  - Revised physician "pay for performance"
  - Extended CHIP and GME funding
  - Declared goals for interoperable EHRs by 2018
- **As a result, CMS created**
  - **The Quality Payment Program (QPP)**

MACRA Changes Physician Payment

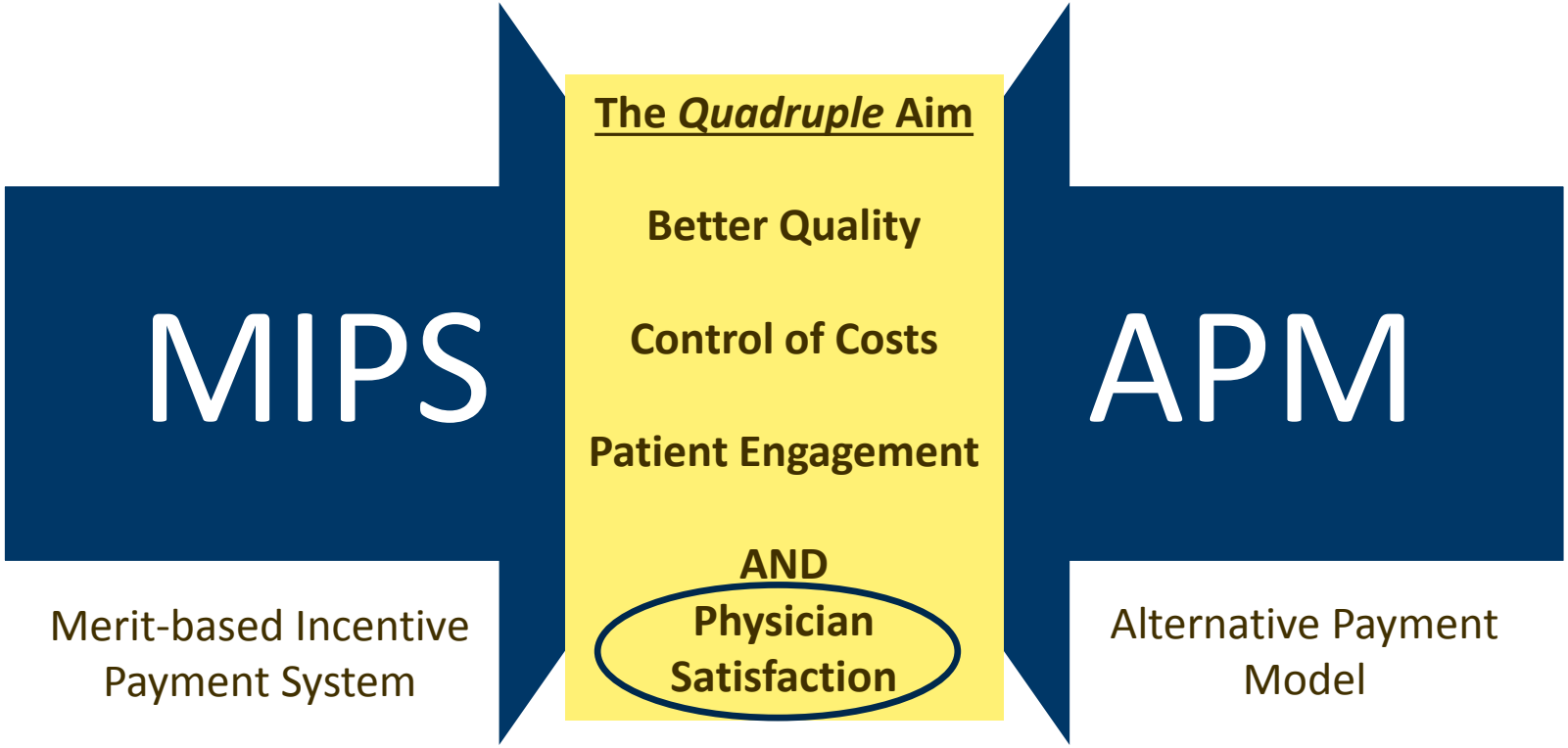


*Measurement year is followed by a year of analysis prior to the payment year. Measure, analyze, apply.

* QPP Year 2.

MACRA QPP Paths

Medicare Participating Physicians



Complex, yet flexible reporting requirements

Requires technical infrastructure and appetite for risk

MACRA Influences the Care Continuum

- Hospitals
- Physician groups (all specialties)
- Health systems
- Skilled nursing facilities
- Home health agencies
- Patients

Key changes in the QPP program for 2018

CMS Comments

"There are more outcomes measures in the MIPS portfolio than I think people realize, but it is still too heavily weighted on process measures… we will be asking for feedback on how to incorporate more outcome measures."

Dr. Kate Goodrich, CMO Division of Quality and Standards, CMS – October, 2017

CMS Comments

"We've heard the concerns that too many quality programs, technology requirements, and measures get between the doctor and the patient," said CMS Administrator Seema Verma. "That's why we're taking a hard look at reducing burdens. By proposing this rule, we aim to improve Medicare by helping doctors and clinicians concentrate on caring for their patients rather than filling out paperwork. CMS will continue to listen and take actionable steps towards alleviating burdens and improving health outcomes for all Americans that we serve."

QPP Final Rule, November 2, 2017

QPP Year 2 - Highlights

- More options for small practices
- Low volume threshold increased; estimating 518,000 exempt clinicians
- Changes to MIPS scoring in cost and quality
- Exemptions for extreme and uncontrollable circumstances
- Continued gradual transition to year three
- New opportunity for reporting as virtual groups
- Increased ease to participate in advanced APMs

No Changes

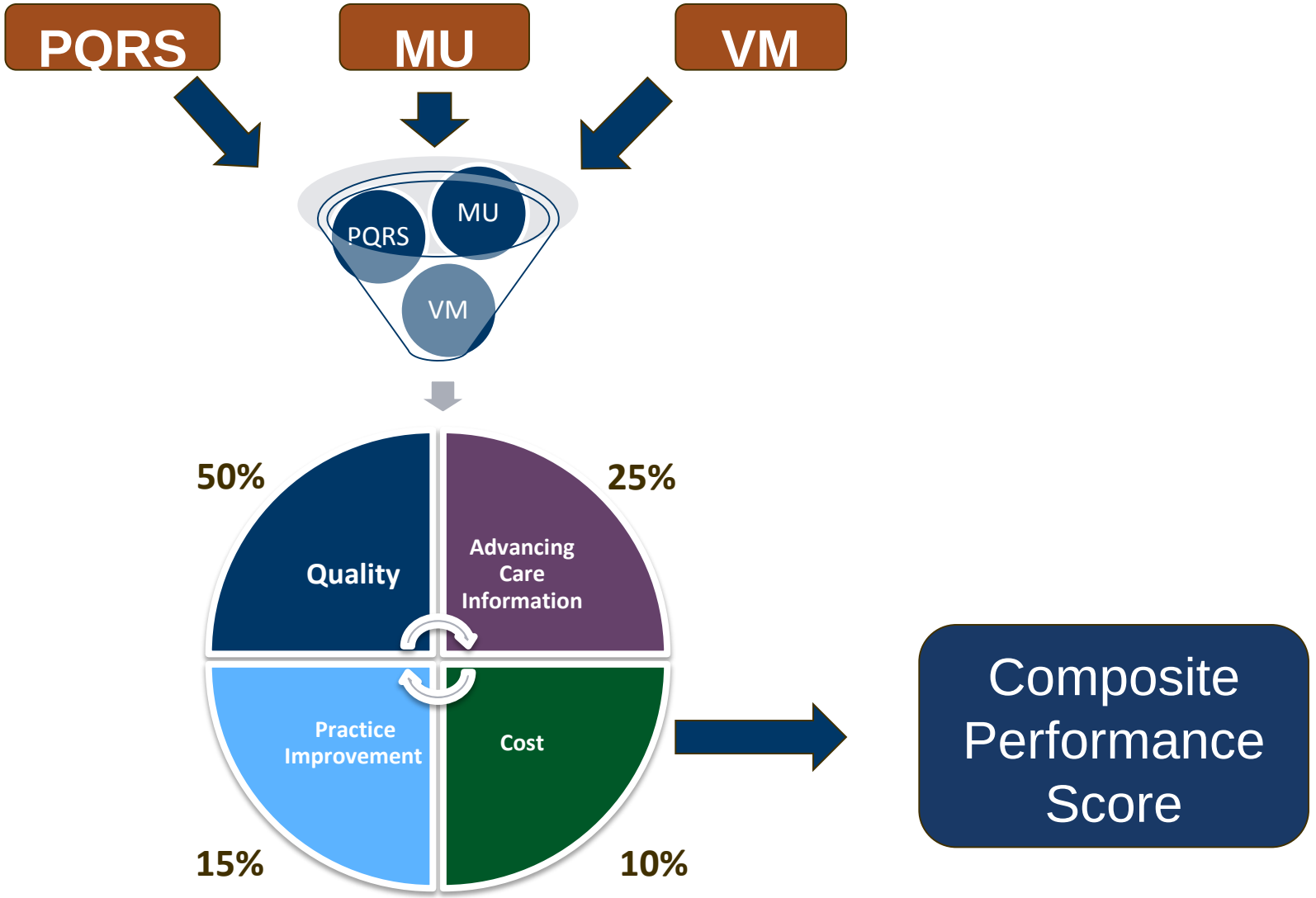
- Submission methodologies
  - Claims, registry, web interface, EHR, QCDR
- Length of measurement period
  - Improvement activities and ACI = 90 days
  - Cost = full year
- Reweighting of ACI, when appropriate, to quality
- >26 ECs or more can report using the web interface
- All cause readmission (ACR) measure collected via claims data for groups >16 eligible clinicians
- Types of eligible clinicians

New Terms

- Ambulatory surgical center (ASC)-based MIPS eligible clinician
- CMS multi-payer model
- Facility-based MIPS eligible clinician
- Full TIN APM
- Improvement scoring
- Other MIPS APM
- Solo practitioner
- Virtual group

The Merit-Based Incentive Payment System (MIPS)

MIPS Potential Components



Am I Exempt from MIPS?

- Do any of the following apply to your organization:
  - Anticipate billing less than $90,000 in allowed charges to Medicare Part B in 2018?

  Or

  - Will see less than 200 unique Medicare beneficiaries in 2018?

  Or

  - Are within the first year of Medicare participation?

- If you answer yes to either of these, and you are not participating in an APM, you are exempt from MIPS in 2018.

Small Practice Information

- Small practice = <16 Eligible (for MIPS) clinicians
  - Pre-determined during the **"small practice size determination period"** by assessing claims data across a 12 month period
  - **September 1, 2016 to August 31, 2017**
  - HPSA threshold set at 75%

- Small practice bonus of 5 points added to any eligible clinician or group that submits data in at least one performance category

Non-Patient Facing Eligible Clinicians

- An eligible clinician which 100 or fewer patient facing encounters (E & M, surgical and procedural data analyzed) during the non-patient facing determination period (**September 1, 2016 to August 31, 2017)**
  - Includes groups and virtual groups

FQHC, RHC, CAH, and more

- FQHC and RHCs
  - Can voluntarily report data, but are not required
- CAHs
  - Method 1 – will not apply to the facility payment
  - Method 2 – will only apply to payments by eligible clinicians which have reassigned billing rights to the facility
- ASCs
  - No implication to ASC facility payment, but Part B reimbursed services to eligible clinicians performed in an ASC are subject to MIPS

Virtual Groups – *new for 2018*

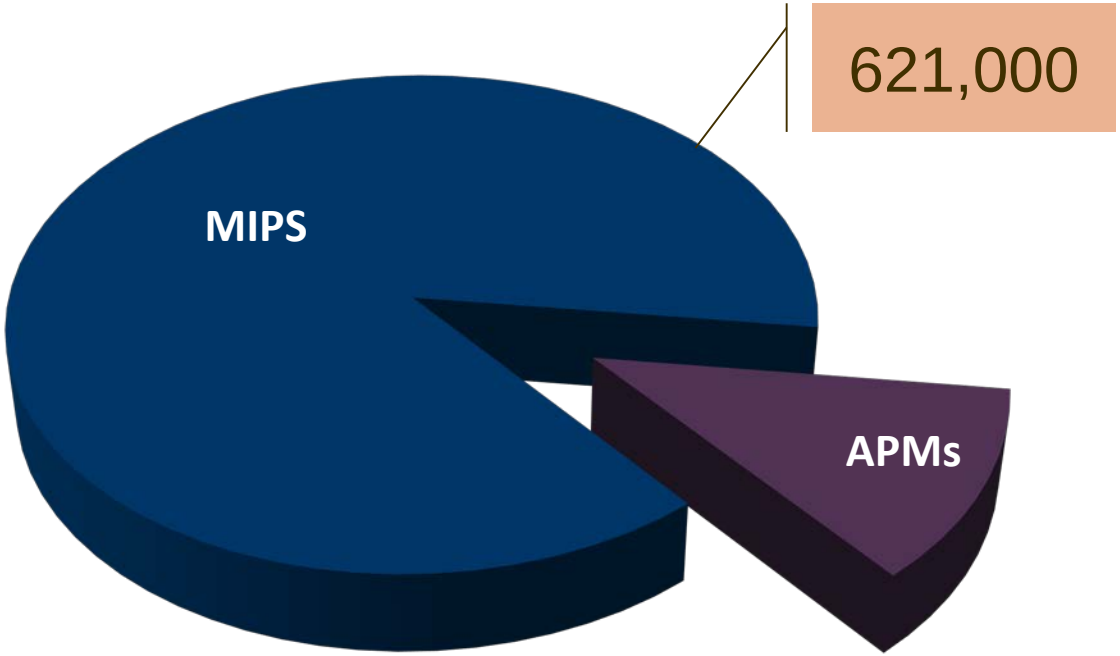
CMS allows for small groups to participate via virtual groups.

- Virtual groups are required to make an election to participate in MIPS as a virtual group prior to the start of an applicable performance period
  - The election deadline is December 31
- Two-stage virtual group election process.
  - The first stage is optional (virtual group pre-determination of eligibility)
  - The second stage is the virtual group formation stage
  - Virtual groups must have a formal written agreement among each party of a virtual group

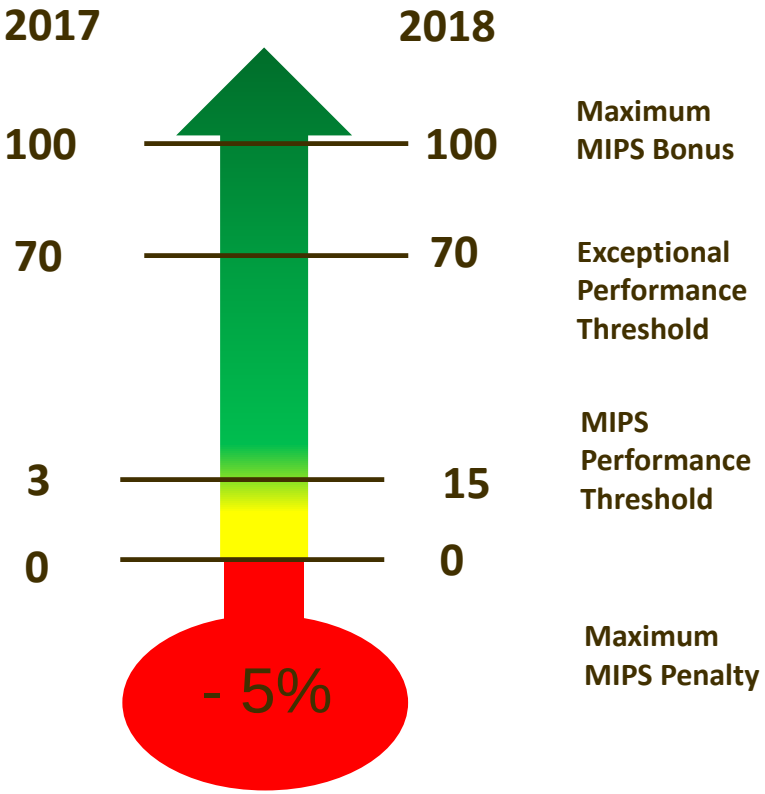
Virtual Groups – *new for 2018*

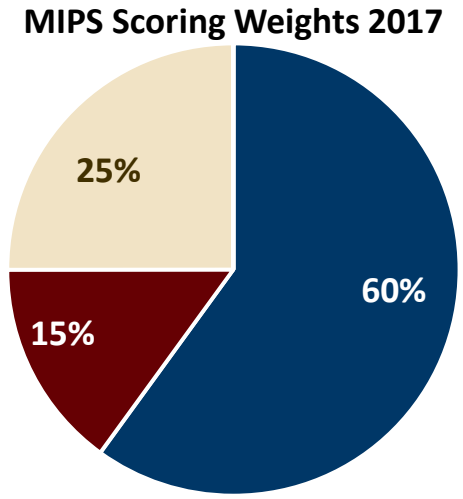
- Combination of one or more solo practitioner (eligible clinician) and groups of <11 eligible clinicians form a virtual group and report aggregated data.
  - Must exceed the performance threshold
- May only participate in one virtual group in a performance period
  - Most group reporting policies also apply to virtual groups

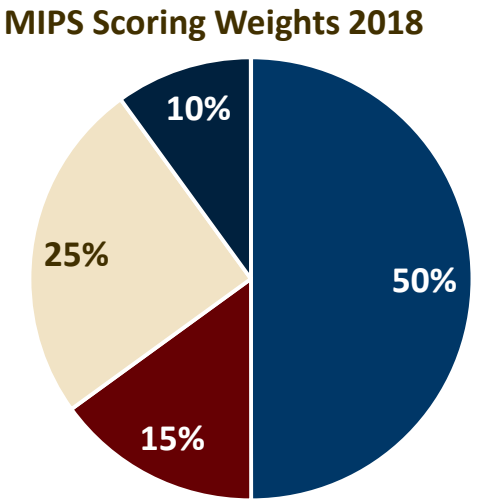
MIPS Anticipated Participation



MIPS Scoring







MIPS 2018: Quality

MIPS Quality Category Changes

2017

- 60% of total composite score
- Six measures
- 50% data completeness
- Threshold of three
- Scoring methodology – no changes
- Bonuses – no change

2018

- 50% of total composite score
- Six measures
- 60% data completeness except for web interface and CAHPS
- Threshold of 15
- Topped out measures for two consecutive reporting periods will earn four points

2018 Topped Out Measures

1. Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
2. Melanoma: Overutilization of Imaging Studies in Melanoma.(Quality Measure ID: 224)
3. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)

2018 Topped Out Measures – Cont.

4. Image Confirmation of Successful Excision of Image Localized Breast Lesion. (Quality Measure ID: 262)
5. Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)
6. Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52)

Biggest Quality Changes

A ***minimum*** of 12 months of reported measures

Strategy for success:

- Consider applicability of 2017 selected measures
- Focus on outcome measures aligned to initiatives, disease state or wellness

*Complex patient bonus of 5 points

  - Based on ratio of dual-eligible or HCC average
  - Applies to practices of <16 eligible clinicians

*

Quality Measures with Substantial Change

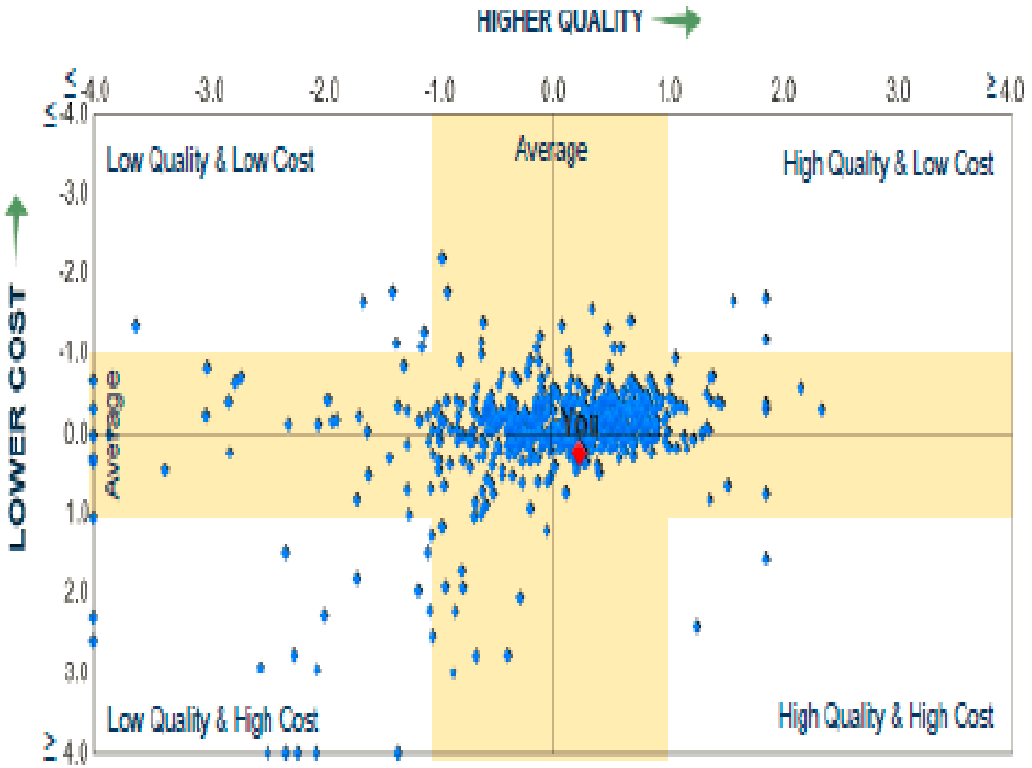
- Influenza immunization
- Tobacco use screening and intervention
- Use of high risk medications in the elderly
- Closing the referral loop
- Body mass index: screening and plan
- Statin therapy
- Colorectal cancer screening
- CAHPS: MIPS for clinicians

MIPS 2018: Cost

MIPS Cost Performance

- **CHANGE:** Weighting the MIPS cost performance category to 10% of your total MIPS final score.
- CMS will include the **Medicare Spending per Beneficiary** (MSPB) and **Total per Capita Cost** measures to calculate your cost performance category score for the 2018 MIPS performance period.
  - These two measures carried over from the value modifier program and are being used in 2017
  - Chronic care management codes included in attribution for 2018
  - The 10 episode-based measures utilized for the 2017 MIPS performance period have been eliminated in 2018. Episode based cost measures are being tested for 2019
  - No reporting is required from clinicians, claims data is utilized
  - More regular feedback with goal of July, 2018

Quality and Resource Use Reports (QRUR)



QRUR Data

1. Attribution
2. Cost of Chronic Conditions
3. Cost of Acute Conditions
4. Cost of Specialist Care
5. Cost of Post Acute Care
6. Patient Leakage
7. Patient Risk Profile

Improvement Scoring

- Quality
  - Measured at performance category level from previous to current
    - ◊ Up to 10 percentage points available
    - ◊ Can't be a negative number
- Cost
  - Statistically significant changes at the measure level
  - If no attributed cost measures, no improvement score
- Applies to both quality and cost
  - Will be measured only when sufficient data.
  - CMS will calculate when EC uses same measures in two consecutive years

MIPS 2018: Improvement Activities

Improvement Activity Changes

2017

92 Activities

2018

112 Activities

- Total of 21 activities added, 27 changes, and 1 deletion.
- Only 1 eligible clinician in a group must complete an IA in order to attest for the group.
- No change in scoring
  - <16 eligible clinicians need 20 points, all others require 40 points

MIPS 2018: Advancing Care Information

Advancing Care Information

- No changes to base scoring for 2018
  - If using entirely 2015 CEHRT, 10% bonus available
- Performance score:
  - 10% bonus for reporting to a public health agency or clinical data registry
  - 5% bonus for reporting to an additional clinical data registry (not reporting under the quality improvement score)
- Hardship exemptions are no longer limited to 5 years, multiple applications

Advancing Care Information

- Syndromic surveillance reporting
  - Objective updated to specify from an urgent care setting

CMS Physician Compare

The CMS Physician Compare provides a significant amount of performance data publically and creates a reputational risk for poor performers as well as the financial risk.

Clinical Quality of Care

Preventive Care:

- Getting a flu shot during flu season.
- Making sure older adults have gotten a pneumonia vaccine.
- Screening for depression and developing a follow-up plan.
- Screening for tobacco use and providing help quitting when needed.

Patient Experience (CAHPS):

- Getting timely care, appointments, and information.
- How well health care professionals communicate.
- Courteous and helpful office staff.
- Attention to patient medication cost.

More stars is better.

Data from CMS Physician Compare Website: https://www.cms.gov › Medicare › Physician Compare Initiative.

And along comes MEDPAC…

- Act of Congress required to repeal MIPS
- June 2017 MEDPAC report…"Sunset MIPS"
- October 2017 annual meeting
  - Replace with voluntary value program
    - ◊ Eliminate ACI and IA
    - ◊ Replace quality measures with six population-based "outcome" measures captured through claims data
    - ◊ Withhold 2% of all Medicare payments to be earned back voluntarily by
      1. Joining an APM
      2. Being measured together against population-based measures
      3. Doing nothing and surrendering the 2%

Alternative Payment Models: 2018

Alternative Payment Models (APMs)

Quality

Tie clinician payments to certain quality measures comparable to those under MIPS

AND

CEHRT

Uses certified EHR technology

AND

RISK

Bears more than nominal financial risk for monetary losses OR Is a medical home model expanded under CMMI authority

All elements above must be met to meet the requirement for Advance APM's

Current Advanced APMs

- AMI Model Track 1*
- CJR Track 1
- ESRD Care Model (LDO)
- ESRD Care Model (Non-LDO, two-sided risk)
- CPC +
- CABG Model Track 1*
- Medicare ACO Track 1*
- Medicare DPP*
- Medicare/Medicaid Shared Savings Model Track 2and 3
- MSSP Track 2 and 3
- Next Gen ACO
- Oncology Care Model (two-sided risk)
- SHFFT Model Track 1*
- Vermont All-Payer ACO*

**** 2018 implementation***

QPP Year 2 – APM Highlights

- CMS is taking action to increase APM participation
  - Increases the “low volume threshold”
  - Extending the 8% of revenue as nominal risk for two additional years
  - Exempting round 1 CPC+ participants from the >50 clinicians limit
- Reducing complexity
  - Providing greater detail for MIPS APMs scoring.
  - Establishes other payer APMs starting in 2019.
    - ◊ Maintains 8% revenue as nominal risk across all payer models
    - ◊ Other payers are in addition to, not in place of Medicare
  - “Recognized” = “Certified” for Patient Centered Medical Homes

QPP Year 2 – APM Highlights

- QP performance period stays the same, with some exceptions for advanced APMs that begin or end during the performance period
  - 60 day minimum of participation

What about the Physician Payment Model Technical Advisory Committee?

Sample APMs Under Current Consideration by PTAC (Physician Model Technical Advisory Committee)

- Hospital at Home Plus (HAH+)
- Annual Wellness Visits at Rural Health Clinics
- Intensive Care Management in SNFs
- Advanced Primary Care: A Foundational APM
- Project Sonar (GI)
- The ACS-Brandeis
- The COPD and Asthma Monitoring Project
- Oncology Bundled Payment using CNA guided care

CMS "New Direction" RFI

- Purpose of RFI… "new direction to promote patient-centered care and test market-driven reforms that ***empower beneficiaries as consumers***, ***provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes***."

  September 20, 2017

Special Attention to

1. Increased participation in Advanced APMs;
2. Models focused on consumer-directed care and market-based innovation;
3. Physician specialty care (PTAC);
4. Prescription drugs;
5. Medicare Advantage innovation;
6. State-based and local innovation, including Medicaid-focused models;
7. Mental and behavioral health;
8. Improving program integrity

Guiding Principles of New Models

- Choice and *marketplace competition*
- Provider choice and incentives
- *Patient-centered care*
- Benefit design and *price transparency*
- Transparent model design and evaluation
- Small scale testing (1332 waivers)

Upcoming Webinars (1st of a Series of 4)

- MIPS Quality: So Much More Than eCQMs
- MIPS Cost: The Most Important MIPS Category?
- Beyond MIPS Reporting – Planning for Long-Term Value-based Success Under MACRA

Questions?

Thank you!

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