Quality Payment Program: Looking Ahead to Year Two

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Healthcare Intelligence

Learning Objectives

- Quality Payment Program 2017 policy facts
- Changes Proposed for Year Two (2018)
  - Merit-Based Incentive System (MIPS)
  - Alternative Payment Models (APMs)
- How to Submit Comments

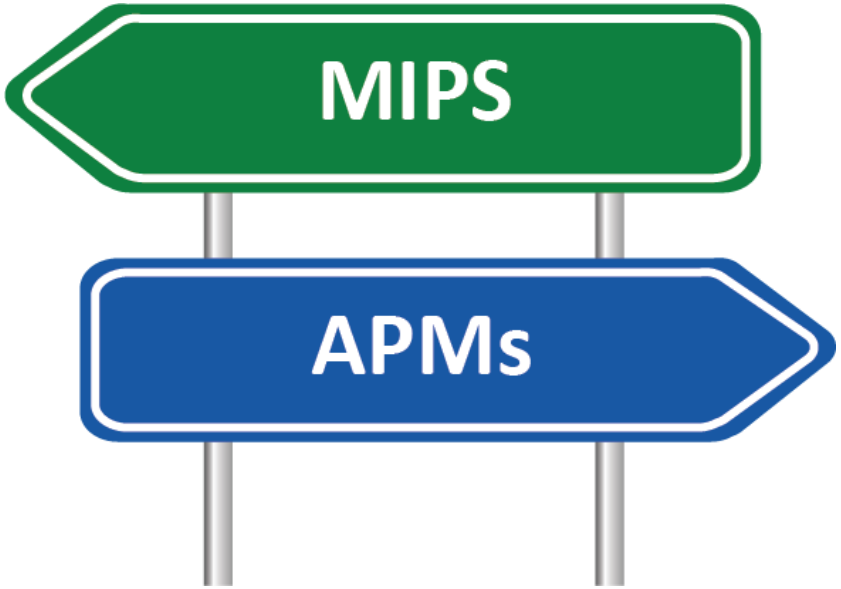
Quality Payment Program Overview

- Established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Transition year began in 2017
- Program's main goals:
  - Improve health outcomes
  - Spend wisely
  - Minimize burden of participation
  - Be fair and transparent

Quality Payment Program Overview

QPP Has 2 Tracks

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)



2017 Transition Year Policies

- "Pick your pace" data submission options
  - Minimal amount
  - 90-days
  - Full year
- Exclusions
  - Low-volume threshold
  - Newly enrolled
  - Significantly participating in APM
- Flexibilities for clinicians
  - Small, underserved, rural
  - Hospital-based
  - Limited face-to-face encounters with patients

Proposed Rule for Year 2

Proposed Rule for Year 2

General Policy Proposals

- Virtual Groups participation option
  - Solo practitioners and groups of ≤ 10 eligible clinicians come together to participate as a group regardless of location or specialties
  - Don't have to be on same EHR
  - Qualified non-patient facing clinicians eligible
  - Elect to participate before the start of 2018
- Multiple data submission methods within a performance category (Quality, ACI and IA)
- Minimum 90-day performance period for ACI and IA

Proposed Rule for Year 2

Eligibility Proposals

- Increase the low-volume threshold
  - $90,000 and/or 200 Medicare beneficiaries
  - Include more small, rural and HPSA clinicians
- Add a third component to the opt-in option for LVT
  - Medicare revenue and number of beneficiaries
  - Add Number of Part B items and services

Proposed Rule for Year 2

Quality Category Proposals

- 12-month calendar year data
- Reward improvement in performance with bonus points
  - Based on rate of improvement at the performance category level, rather than the measure level
  - Up to 10% points available
- Keep 60% scoring weight for 2018
  - Decrease to 30% in 2019
- Keep data completeness threshold at 50% for 2018
  - Give 1 point for measures that don't meet completeness threshold
  - Continue 3 points for small practices that don't meet data completeness

Proposed Rule for Year 2

Quality Category Proposals

- Keep 3-point floor
  - Measures scored against benchmark
  - Measures that don't have a benchmark
  - Measures that don't meet case minimum
- Changes to CAHPS for MIPS survey collection and scoring
- Timeline for removing topped out measures in future years
  - 6 point cap starting in 2018 for 6 measures
  - Median score for any measure – between bottom 5 deciles and start of the top 5 deciles
  - In 2nd consecutive year or beyond
  - After 3 years consider removing topped out measures through notice and comment rulemaking for the 4th year.
  - Wouldn't apply to CMS Web Interface measures

Proposed Rule for Year 2

Quality Category Proposals

- Implement a voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program
  - Available only for facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital setting or emergency department
  - The facility-based measurement option converts a hospital Total Performance Score into a MIPS Quality and Cost category score
  - Include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality and cost measures
  - Scores derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries
  - Participation through opt-in or opt-out

Proposed Rule for Year 2

ACI Category Proposals

- Allow use of 2014 CEHRT or combination of 2014 & 2015
- Encourage 2015 CEHRT with scoring bonus
- Minimum 90-day performance period
- Add new hardship exception for clinicians in small practice
  - Reweight category to 0% and reallocate to Quality category
- Reweight ACI to 0% for ambulatory surgical centers (ASC)

Proposed Rule for Year 2

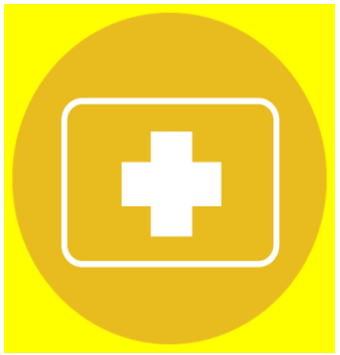
ACI Category Proposals

- Add <100 exclusions for E-prescribing and HIE measure
- Add potential to earn 5% bonus for up to 2 public health or clinical data registries
- Add a decertification exception if EHR was decertified

Note: the delay of Stage 3 and 2015 CEHRT for QPP does not extend to the EHR Incentive Program. These are separate programs.

Proposed Rule for Year 2

Improvement Activity Category Proposals



- Minimum 90-day performance period
- Add new activity for using Appropriate Use Criteria (AUC)
  - Through a CDS mechanism
  - For advanced diagnostic imaging services ordered
- Add 20 more activities and change in some existing activities
- For group reporting, only one MIPS EC in a TIN must perform the activity for the TIN to receive credit
  - Seek comment on threshold for future

Proposed Rule for Year 2

Improvement Activity Category Proposals

- Expand definition of certified patient-centered medical home
  - Include CPC+ APM model
  - Clarify term “certified” and “recognized” are the same
  - Propose the threshold of 50% for the number of practices in the TIN must be recognized as PCMH to receive full credit

Proposed Rule for Year 2

Cost Category Proposals

- Proposing 0% weight for 2018
  - Move to 30% in 2019 performance year and beyond
- Proposes an improved scoring methodology
  - Include only 2 Cost measures
    - the Medicare Spending per Beneficiary (MSPB)
    - Total per Capita Cost measures in calculating performance
  - Replace episode-based cost measures with newly developed
- Reward improvement in performance with bonus points
  - Based on statistically significant changes at the measure level in Quality and Cost

Proposed Rule for Year 2

Scoring Proposals

- Add bonus points for scoring
  - Caring for complex patients up to 3 points
  - Using 2015 CEHRT exclusively
  - Small practice bonus to final score up to 5 points
- Incorporate performance improvement in scoring for quality performance
- Implement an optional voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program for Quality & Cost
- Increase the performance threshold to 15 points
  - Exceptional performance continues at 70 points

QPP Year 2 Proposals

APM Proposed changes & updates include

- Extend the revenue-based nominal amount stand for two additional years through performance year 2020
    - Required to bear total risk of at least 8% of their Medicare Parts A and B revenue.
- Changing the nominal amount standard for Medical Home Models so the minimum required amount of total risk increases more slowly
- Exempt Round 1 CPC+ from the requirement the medical home standard only applies those with <50 clinicians

QPP Year 2 Proposals

APM Proposal changes & updates include

- Gives more detail about how the All-Payer Combination Option will be implemented.
  - Allows clinicians to use a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs beginning in performance year 2019.
- Identify a new MIPS-APM participant snapshot date
  - Added 4th performance period Dec. 31st
  - Not used to make QP determination or extend the QP performance period

Continuing the Dialogue

- CMS wants to hear from the healthcare community on the proposed policy in Year 2 and its implications for clinicians
- How to comment on the proposed rule:
  - Electronically through Regulations.gov
  - Regular mail
  - Express/overnight mail
  - Hand or courier
- Submit comments by August 21, 2017
- For more information, visit: qpp.cms.gov

Proposed Rule and Comments

Calendar Year 2018 Updates to the QPP

- If submitting comments electronically:
  - Comments for the CY 2018 Updates to the QPP
- For more information, visit: qpp.cms.gov
- Resources:
  - Fact Sheet: CY 2018 Updates to QPP PROPOSED RULE
  - CY 2018 Updates to QPP PROPOSED RULE (CMS-5522-P)

QPP Proposed Rule Year 2

Take-aways

- **The program is generally following the expected trajectory**
- **MIPS performance thresholds rise, but more opportunities exist for clinicians to improve their score**
  - 15 points minimum to avoid a negative payment adjustment
  - Bonus points available for caring for patients with complex conditions, the exclusive use of 2015 edition EHR systems, and small practice bonus
- **More clinicians will be exempted from MIPS, but most likely not mid-sized and large groups**
  - With new exclusions, 65% of Medicare Part B payments will be captured in the MIPS program, down from 72.2% in the 2017 performance year
- **Guidance for the all-payer combination APM option and virtual groups is coming**

QPP Proposed Rule Year 2

What this means for you!

- **Quality:** tracking and reporting will be critical to scoring well for a 12 month period the Quality category retains 60% (50% APMs)
- **Large and mid-size practices competing for dollars:** with the additional exclusions of small practices – which would likely be lower scorers – mid-size and large will be "competing" against each other in the MIPS track, further enhancing the need to ensure performance and reporting in the 3 relevant categories
- **Advanced APM Contracting:** ensure your contracts with payers reflect the guidance for the All-Payer Combination Advanced APM
- **Virtual Groups:** Begin evaluating whether it will be beneficial to join one, since groups must be established before the start of 2018 performance period (1/1/2018)
- **Prepare for Cost:** As in 2017, CMS proposed to weight Cost performance category at 0%. Without a legislative change, the category will jump to a 30% weighting in 2020

Thank you for joining us!

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This material was prepared by Telligen, the Quality Payment Program Small, Underserved and Rural Support contractor for Iowa, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. HHSM-500-2017-00012C

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