

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



COALITION FOR
Better Care



Consumer
Partnership
for **eHealth**

Consumer-Purchaser
ALLIANCE

Better information. Better decisions. Better health care.

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

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Agenda

WELCOME AND INTRODUCTIONS

BACKGROUND & CONTEXT

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MERIT-BASED INCENTIVE PAYMENT SYSTEM

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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

OUR GOAL

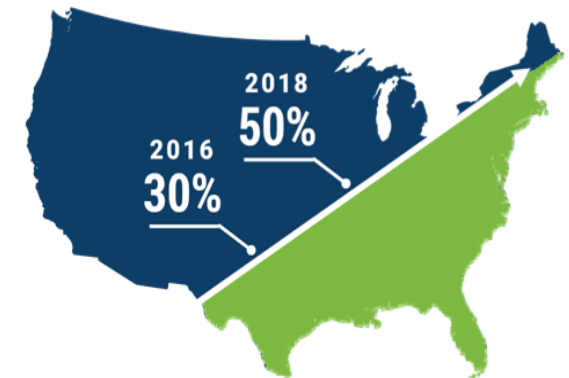
Goals for U.S. Health Care

2016
30% In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

2018
50% In 2018, at least 50% of U.S. health care payments are so linked.

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

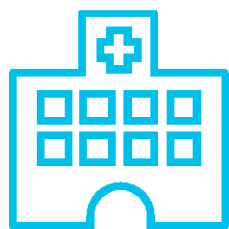
Adoption of Alternative Payment Models (APMs)



Better Care, Smarter Spending, Healthier People

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

2017 MIPS Performance



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

payment adjustment

payment adjustment

MIPS

Year

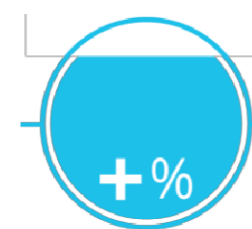


Partial Year

30-day
roll-over
2017

negative

Full Year



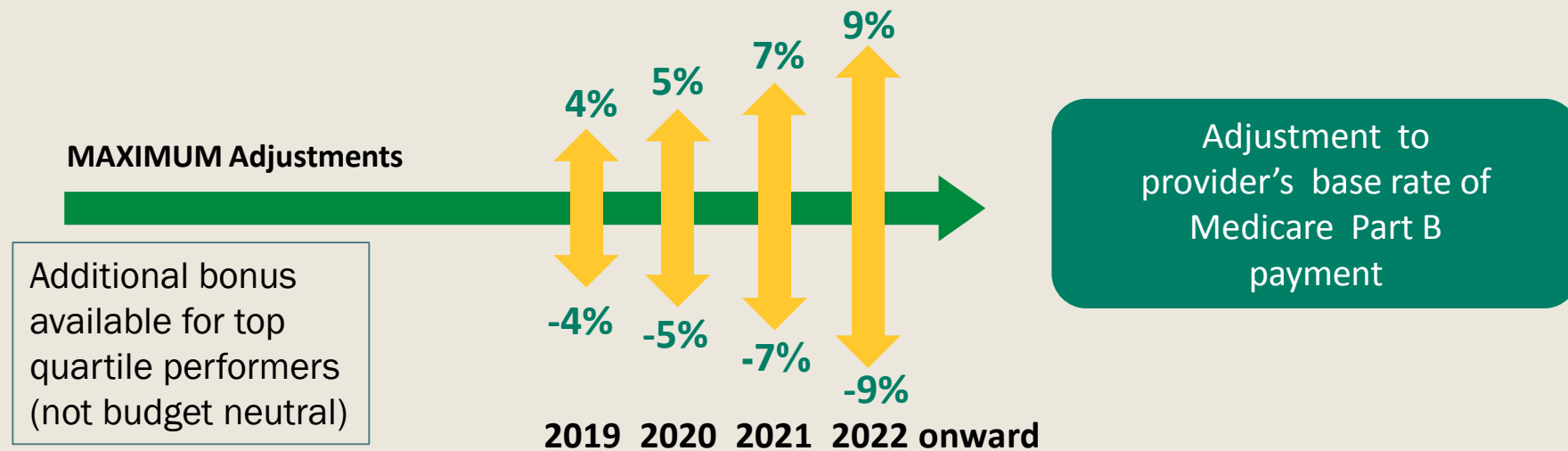
Submit a Full Year

- 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

**BASE
SCORE**



**PERFORMANCE
SCORE**



**BONUS
POINTS**



**COMPOSITE
SCORE**

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

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

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