

# 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**

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**

Stephanie Glover, Health Policy Analyst, Coalition for Better Care

## **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

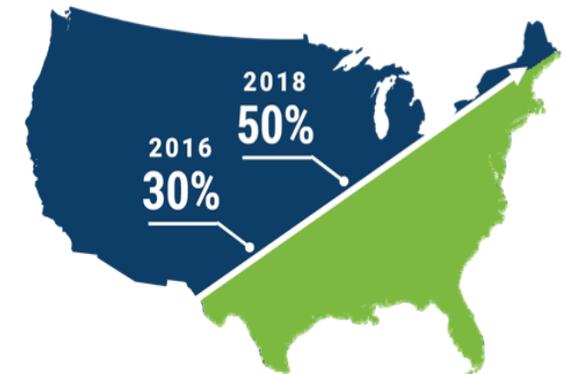
Goals for U.S. Health Care

**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.

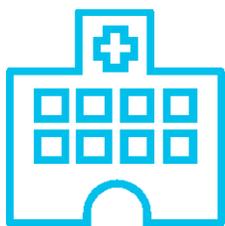
Adoption of Alternative Payment Models (APMs)



*Better Care, Smarter Spending, Healthier People*

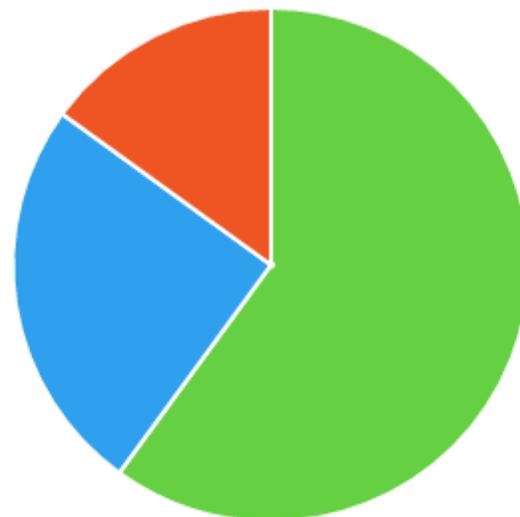
# Transition Year: “Pick Your Pace” for 2017

## 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

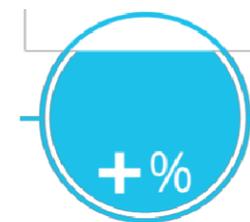


Partial Year

30-day  
or  
2017

or

## Full Year



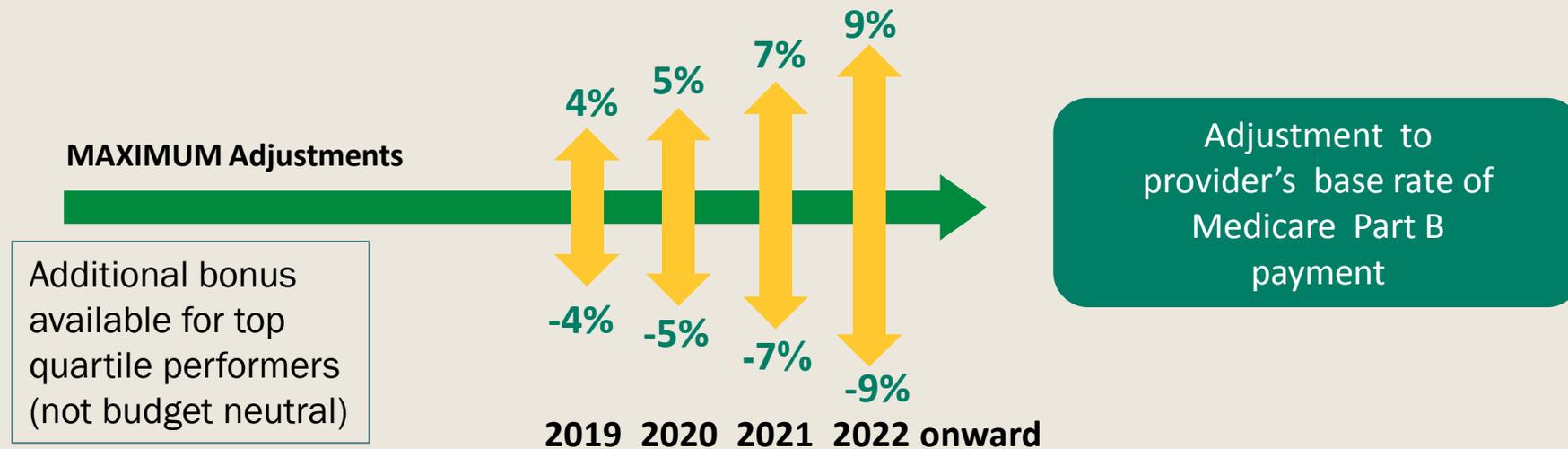
Submit a Full Year

- 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](http://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 3<sup>rd</sup> 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      |
| <b>Bonus up to 15%</b>   |   |   |                               |                       |
| 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)<br>+<br>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