

Quality Payment Program (MACRA) Final Rule 2019

December 6, 2018

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Agenda

1. Quality Payment Program (QPP): Background
2. Merit-based Incentive Payment System (MIPS) Overview and Eligibility
3. Performance Categories
4. MIPS Scoring and Performance Thresholds
5. Qualified Participants in Advanced APMs
6. MIPS APMs
7. MSSP ACO Changes
8. Question and Answer

2019 Medicare Physician Fee Schedule and Quality Payment Program Final Rule

- Displayed November 1, published in Federal Register November 23
- Medicare Physician Fee Schedule/Quality Payment Program Final Rule
 - <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>
- CMS Fact Sheet on QPP
 - <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Year-3-Final-Rule-overview-fact-sheet.pdf>

MACRA Crossroads: Quality Payment Programs

Merit-based Incentive Payment System (MIPS)

- +/- 4% in 2019
- +/- 5% in 2020
- +/- 7% in 2021
- +/- 9% in 2022

CMS estimates 798,000 clinicians will be assigned a MIPS score for 2021 payment year

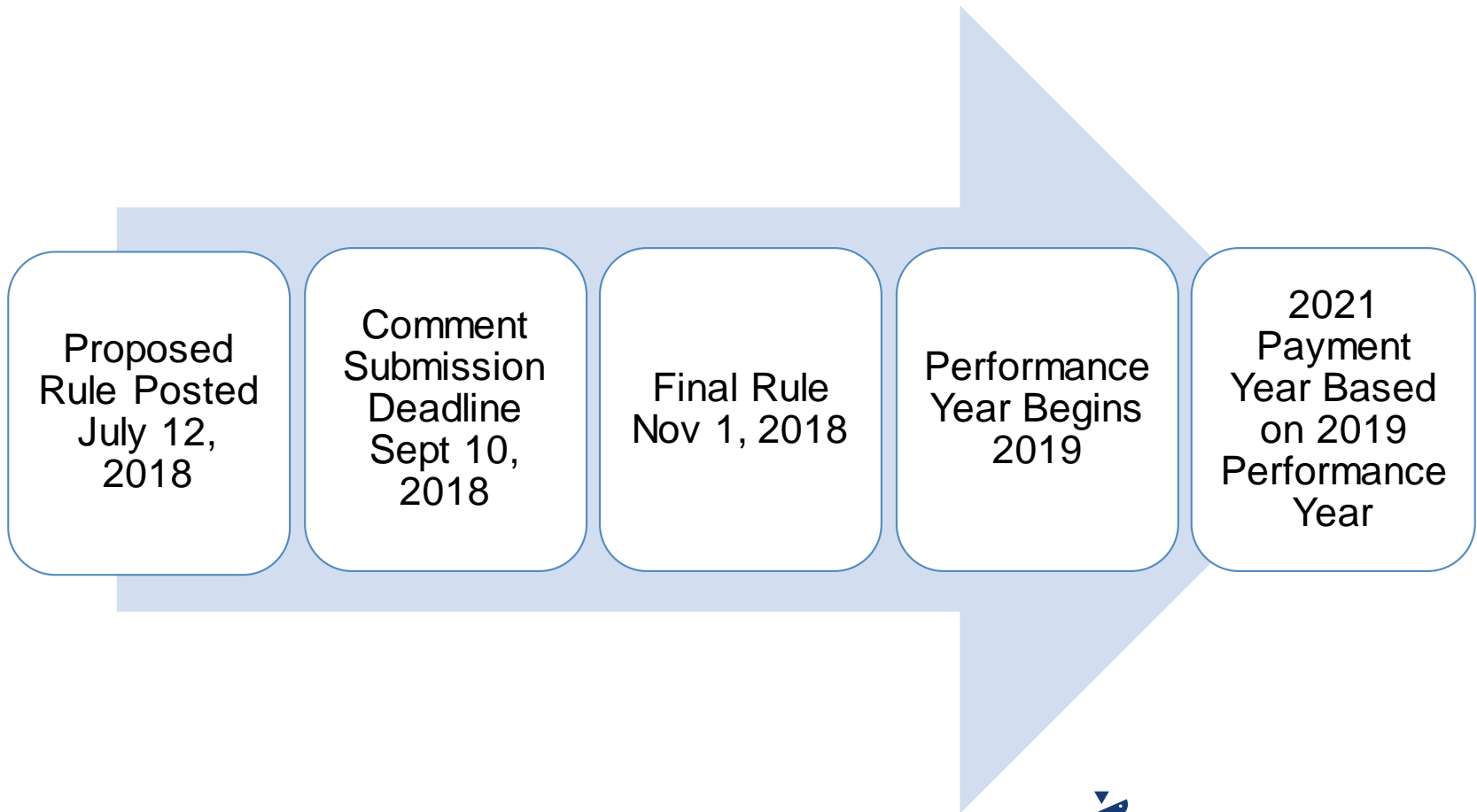
Advanced Alternative Payment Models (AAMPs)

- +5% for 2019-2024
- Estimates 165,000 to 220,000 clinicians will become QPs for 2021 payment year
- Total lump sum payments \$600-800 million

MACRA Timeline

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
Fee Schedule Updates	0.5	0.5	0.5	0.5	0	0	0	0	0	0	.75 for QAPMS .25 for MIPS/partial QAPMS
QAPMS				5% Incentive Payment							
MIPS		1st MIPS performance year		+4%	+5%	+7%	+9%				
<p>*QAPMS: qualifying alternative payment models based on Medicare payment/patient threshold requirements and excluded from MIPS</p> <p>*MIPS: Merit-based Incentive Payment System, a consolidated pay-for-performance program, \$500M annual pool is allocated for exceptional performers for CY 2019-2023</p>											

2019 Rule Timeline (Year 3)



Key Themes for QPP Program: 2019

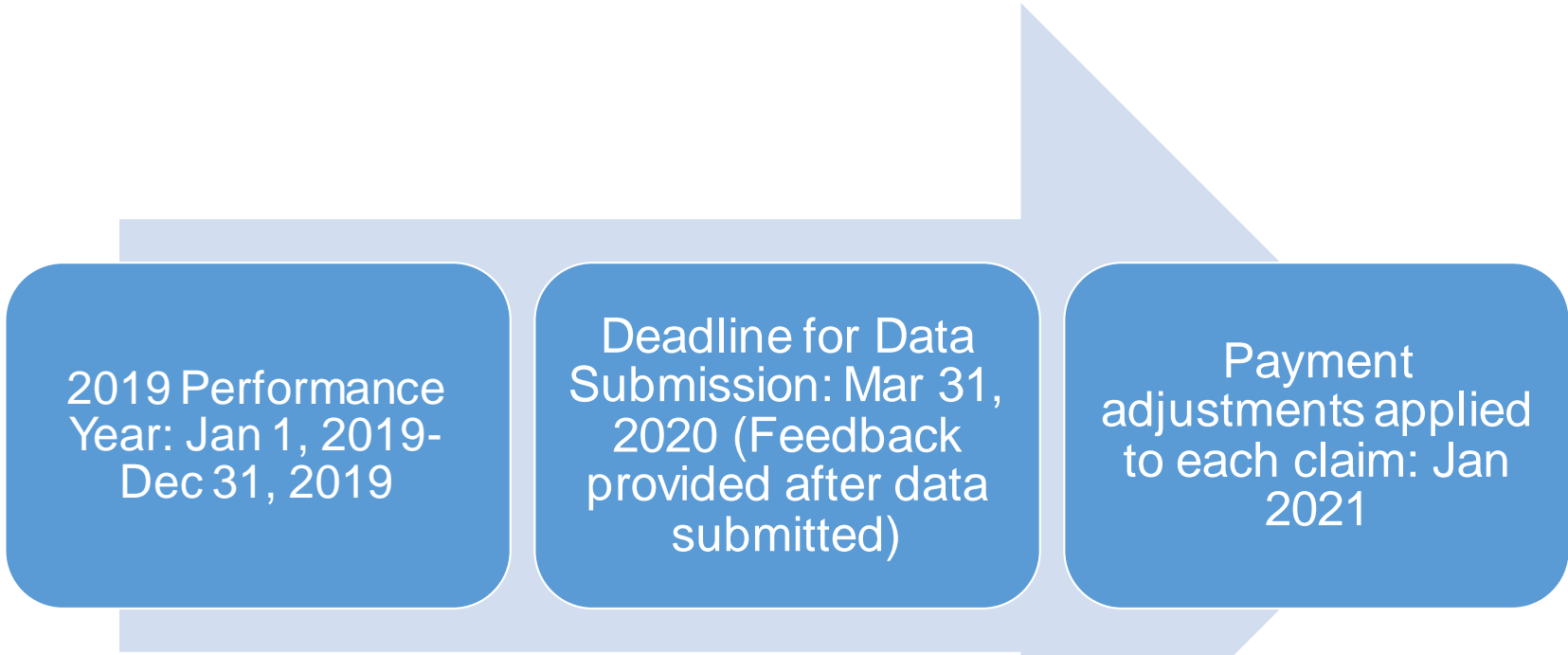
- Ease burden on clinicians in MIPS track
- Revise the MIPS Promoting Interoperability category (formerly known as Advancing Care Information)
- Support small and rural practices
- Focus on more meaningful measures
- Gradual transition

Merit-based Incentive Payment System (MIPS) Overview and Eligibility

Overview of MIPS

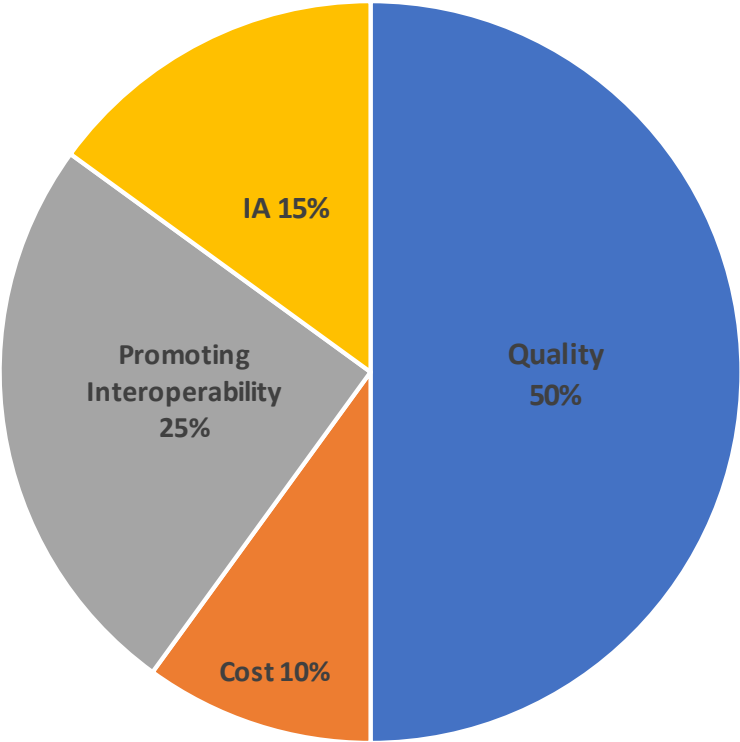


MIPS Timeline

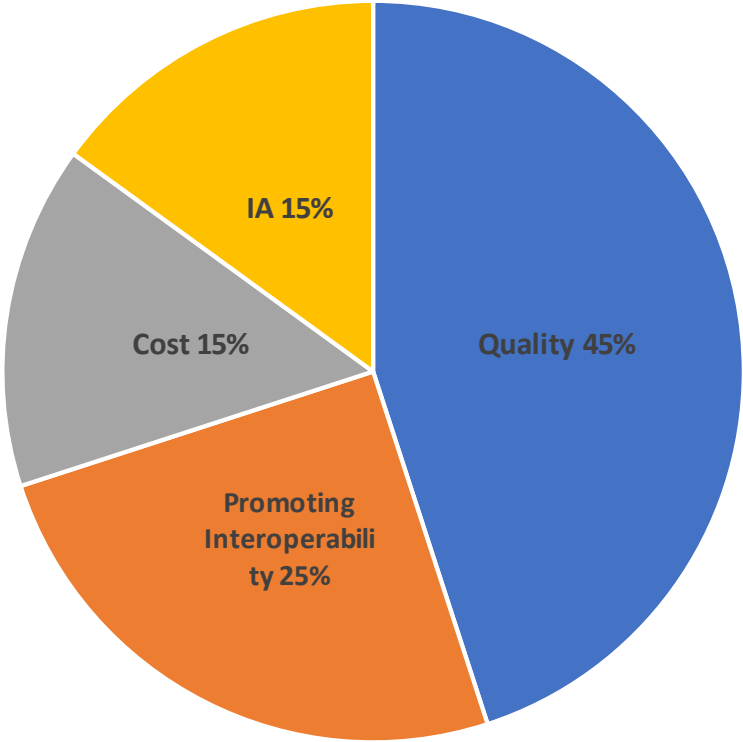


MIPS Composite Performance Score: Four Categories

2018 Performance Year



2019 Performance Year



Who Does MIPS Apply to?

Year 2 (2018)

- Physicians
- Nurse Practitioners
- Clinical Nurse Specialists
- Physician Assistants
- Certified Registered Nurse Anesthetists

Year 3 (2019)

- Same as Year 2 plus:
- Physical Therapists
- Occupational Therapists
- Clinical Psychologists
- Speech-Language pathologists
- Audiologists
- Registered dietitians

Exceptions to MIPS Participation for Certain Clinicians

Participants in Advanced APMs

- Must meet threshold of Medicare payments or patients through Advanced APM to be qualifying APM participant or partial qualifying APM participant.

First year clinician enrolled in Medicare program

- Not treated as MIPS-eligible clinician until subsequent year.

Exceptions to MIPS Participation for Certain Clinicians

Low Patient Volume Year 2

- CMS excludes clinicians or groups who bill \leq \$90,000 OR provide care for \leq 200 Medicare beneficiaries

Low Patient Volume Year 3

- CMS excludes clinicians billing $<$ \$90,000 a year in allowed charges for covered professional services under MPFS, AND
- Providing covered professional services to fewer than 200 Medicare beneficiaries a year **AND**
- **Providing fewer than 200 professional services under the MPFS.**

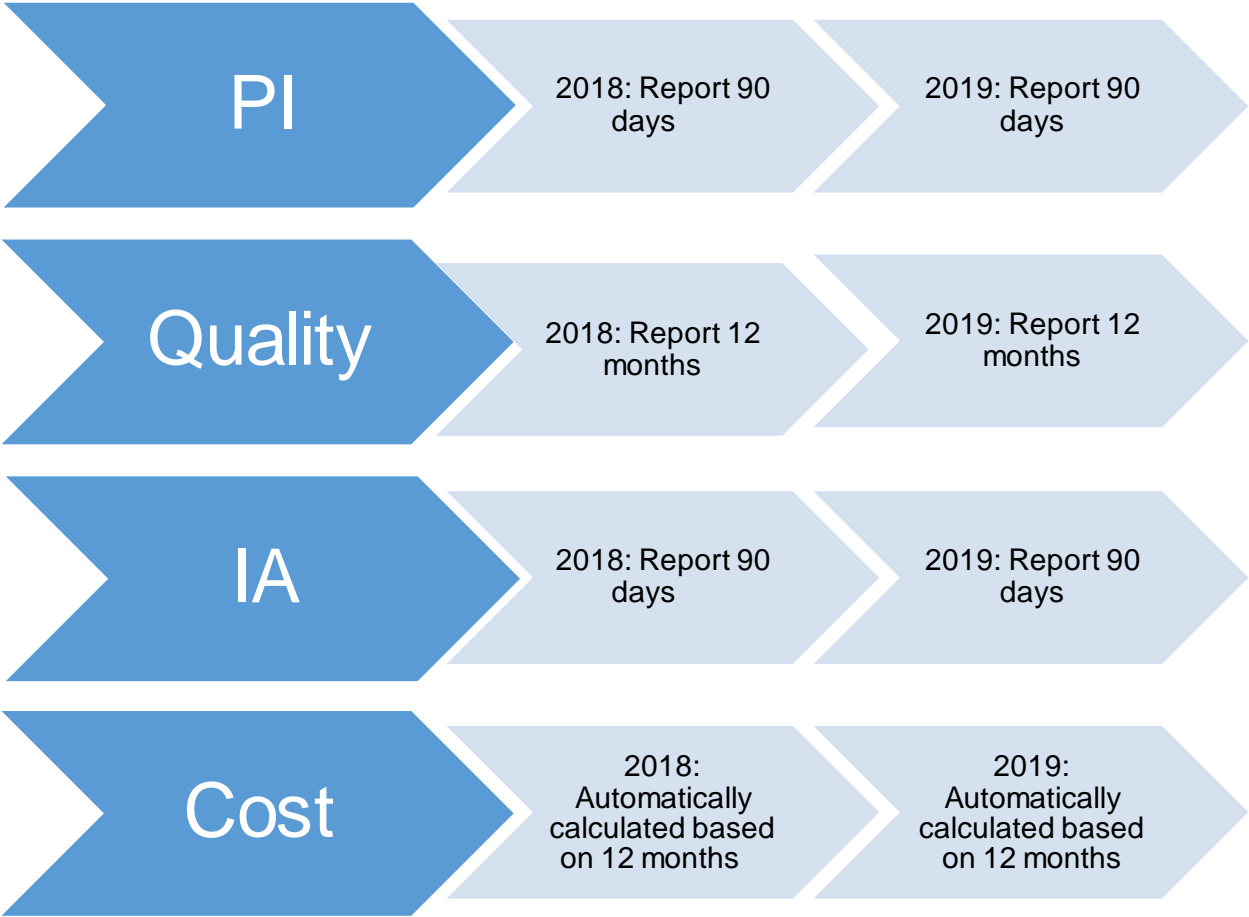
Opt-in Policy for Low-Volume Threshold

- CMS finalizes an opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold
- If MIPS eligible clinicians meet or exceed at least one of low-volume threshold criteria, they may choose to participate and report under MIPS.

Eligible Clinician Identifiers in MIPS: Options for Participation in 2019

Individuals	Group Practices	In an APM (Groups)	Virtual Groups
<ul style="list-style-type: none">• Defined by unique TIN/NPI• Similar reporting mechanisms as current programs	<ul style="list-style-type: none">• Defined by TIN• Similar reporting mechanisms as current programs	<ul style="list-style-type: none">• APMs recognized by CMS• Examples are ACOs (all tracks), Oncology Care Model, CPC+	<ul style="list-style-type: none">• Two or more TINs composed of solo practitioner or group with 10 or fewer eligible clinicians under TIN• Providers can elect to form a virtual group with at least one other solo practitioner or group

MIPS Performance Period



Data Submission: Group Reporting 2019

Performance Category	Group Reporting
Quality (eCQMs, MIPS CQMs, QCDR measures, CMS-approved survey measures, administrative claims measures, claims)	<ul style="list-style-type: none">• Direct• Log-in and upload• CMS Web Interface (groups 25 or more eligible clinicians)• Medicare Part B claims (small practices only)
Cost	<ul style="list-style-type: none">• Administrative claims (no submission required)
Promoting Interoperability	<ul style="list-style-type: none">• Direct• Log-in and upload• Log-in and attest
Improvement Activities	<ul style="list-style-type: none">• Direct• Log-in and upload• Log-in and attest

2019 Performance Year: Facility-based Clinicians

- May select Hospital Value-based Purchasing (VBP) score in place of MIPS reporting
- Limited to quality and cost performance categories
- Hospital VBP score converted to MIPS score
- Applies to clinicians that furnish 75% or more of their services in inpatient hospital or emergency room or outpatient hospital.
 - For a group, 75% of ECs must meet eligibility criteria as individuals

MIPS Performance Categories: Quality, Cost, Improvement Activities, Promoting Interoperability

Quality (45% Weight): 2019

Select from individual measures or a specialty measure set

- Requires reporting of 6 measures
- 1 of 6 measures must be an outcome measure (if there is no outcome measure, must report high priority measure)
- Data completeness criteria set at 60%

GPRO web interface users required to report all quality measures for a full year

One additional population measure (All-Cause Hospital Readmission--only for groups of 10+, minimum case of 200)

Quality Performance: Key Changes in 2019

26 quality measures are removed (refer to Appendix 1 Table C).

New facility-based scoring option.

Topped out measures: CMS would remove an extremely topped out measure could be removed in the next rulemaking cycle.

Web Interface Measures in 2018

NOTE: Only those measures with a MSSP Benchmark will count towards your final score (11 of the 15 measures).

Measure	Savings Program Benchmark
2-Component Diabetes Composite Measure	Yes
Preventative Care and Screening: Influenza Immunization	Yes
Pneumonia Vaccination Status for Older Adults	Yes
Breast Cancer Screening	Yes
Colorectal Cancer Screening	Yes
BMI Screening and Follow-up	Yes
Depression Screening and Follow-up	Yes
IVD: Use of Aspirin or other Antiplatelet	Yes
Tobacco Use Screening and Cessation Intervention	Yes
Screening for Falls Risk	Yes
Controlling High Blood Pressure	Yes
Statin Therapy for the Prevention and Treatment of CVD	No
Medication Reconciliation Post-Discharge	No
Depression Remission at 12 Months	No

Web Interface Measures Removed for 2019

- Medication Reconciliation Post-Discharge
- Pneumococcal Vaccination Status for Older Adults
- Diabetes Eye Exam
- Preventive Care and Screening: BMI Screening and Follow-up plan
- Ischemic Vascular Disease (IVD) Use of Aspirin or Another Antiplatelet

Changes to Web Interface Measures

Depression Remission at 12 months

Previous description: The percentage of patients 18 years of age and older with major depression or dysthymia who reached remission 12 months after an index visit

Change: The percentage of adolescent patients 12-17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months after an index event date.

Cost (Weight 15%): 2019

- Based on current two Value Modifier Program Measures
 - Medicare Spending Per Beneficiary (MSPB)
 - Total Per Capita Cost (includes Medicare Part A and B payments)
- CMS finalizes 8 episode-based cost measures developed in collaboration with expert clinicians and stakeholders for 2019
- No additional reporting required; calculated from claims data
- Will provide feedback to providers

CMS Announces 8 Episode Groups

1. Elective Outpatient Percutaneous Coronary Intervention (PCI)
2. Knee Arthroplasty
3. Revascularization for Lower Extremity Chronic Critical Limb Ischemia
4. Routine Cataract Removal with Intraocular Lens (IOL) Implantation
5. Screening/Surveillance Colonoscopy
6. Intracranial Hemorrhage or Cerebral Infarction
7. Simple Pneumonia with Hospitalization
8. ST-Elevation Myocardial Infarction (STEMI) with (PCI)

Attributing Episode Groups to Clinicians

- Assignment of responsibility for an episode of care to a clinician.
- Procedural episode groups are attributed to clinician responsible for triggering procedure (e.g. surgical procedure).
- For acute inpatient medical condition groups, episodes are attributed to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization.

Improvement Activities (Weight 15%): 2019

Report for 90 days. Subcategories of activities:

<p>Expanded Practice Access</p> <ul style="list-style-type: none"> • Same day appointments • After hours clinician advice 	<p>Population Management</p> <ul style="list-style-type: none"> • Monitoring health conditions & providing timely intervention • Participation in a QCDR 	<p>Care Coordination</p> <ul style="list-style-type: none"> • Timely communication of test results • Timely exchange of clinical information with patients AND providers • Use of remote monitoring and telehealth 	<p>Beneficiary Engagement</p> <ul style="list-style-type: none"> • Establishing care for complex patients • Patient self-management & training • Employing shared decision making 	<p>Patient Safety & Practice Assessment</p> <ul style="list-style-type: none"> • Use of clinical or surgical checklists • Practice assessments related to maintain certification 	<p>Participation in an APM</p> <ul style="list-style-type: none"> • As defined on prior slide • At a minimum receive ½ CPIA score for APM participation
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CMS adds six measures.

Improvement Activities and Group Reporting

- For MIPS group reporting, all clinicians in the group will receive credit if at least one clinician in the group (TIN) has performed the Improvement Activity for 90 days.

Promoting Interoperability (Weighted 25%): Key Changes 2019

- Advancing Care Information renamed Promoting Interoperability.
- Clinicians must use 2015 Edition CEHRT in 2019.
- 10 point bonus for use of 2015 Edition CEHRT eliminated.
- New Performance-based Scoring
 - Eliminates base, performance and bonus scores
- 100 total points in category

Promoting Interoperability Scoring: Key Changes 2019

2018

- Base score (worth 50%)- submit at least a 1 in the numerator of certain measures AND submit “yes” for Security Risk Analysis measure
- Performance score (worth 90%) determined by a performance rate for each measure
- Bonus score of 10%
- Maximum score is 165% (capped at 100%)

2019

- Performance scoring at individual measure level
- Each measure scored based on numerator and denominator or yes/no
- Add scores from each measure together to calculate total score

Promoting Interoperability: 2019

Objectives	Measures	Maximum Points
E-prescribing	E-prescribing	10 point
	Query of PDMP	5 bonus points
	Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to their Health Information	40 points
Public Health and Clinical Data Exchange	Choose 2: -Immunization Registry Reporting -Public Health Registry Reporting -Clinical Data Registry -Syndromic Surveillance	10 points

Promoting Interoperability

- Two new measures were added to the e-prescribing objective:
 - Query of Prescription Drug Monitoring Program (PDMP)
 - Verify Opioid Treatment Agreement

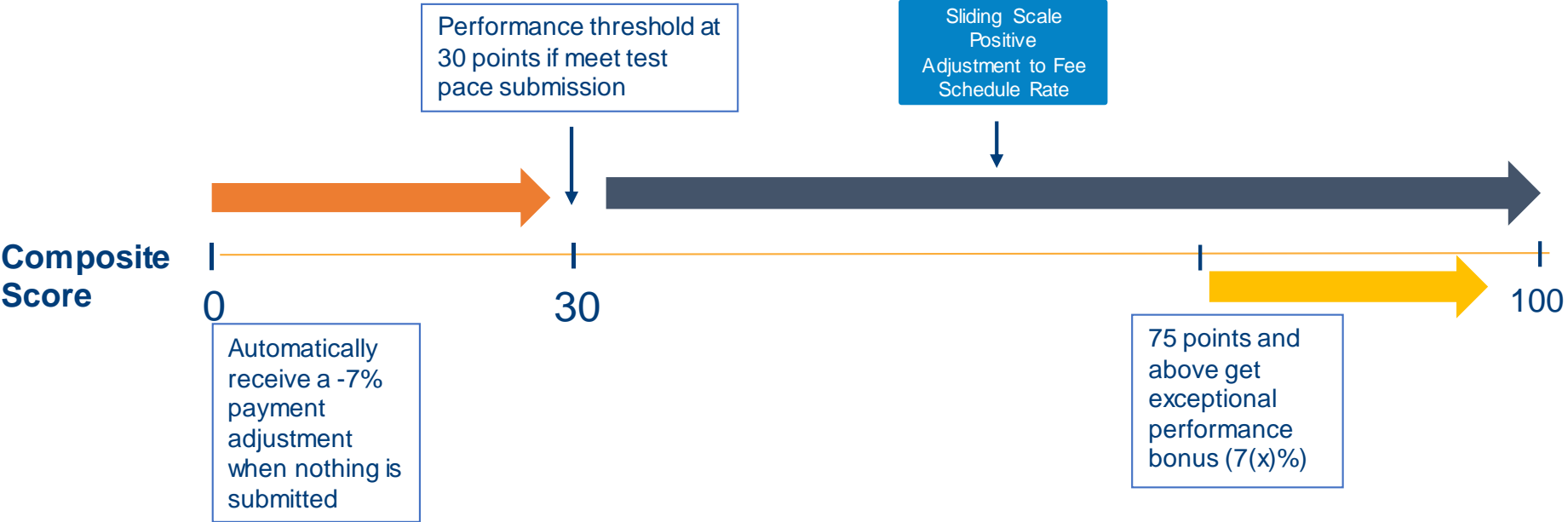
CMS will allow 5 bonus points for these two measures in 2019.

MIPS Scoring and Performance Thresholds

Performance Threshold and Payment Adjustment

Year 1 (2017)	Year 2 (2018)	Year 3 (2019)
3 points (to avoid penalty and get neutral score)	15 points (to avoid penalty and get neutral score)	30 points (to avoid penalty and get neutral score)
70 points (qualifies for exceptional performance bonus)	70 points (qualifies for exceptional performance bonus)	75 points (qualifies for exceptional performance bonus)
Payment adjustment for 2019 MIPS payment year ranges from -4% to + (4% x scaling factor)	Payment adjustment for 2020 MIPS payment year ranges from -5% to + (5% x scaling factor)	Payment adjustment for 2021 MIPS payment year ranges from -7% to + (7% x scaling factor)

MIPS Payment Adjustment: 2021



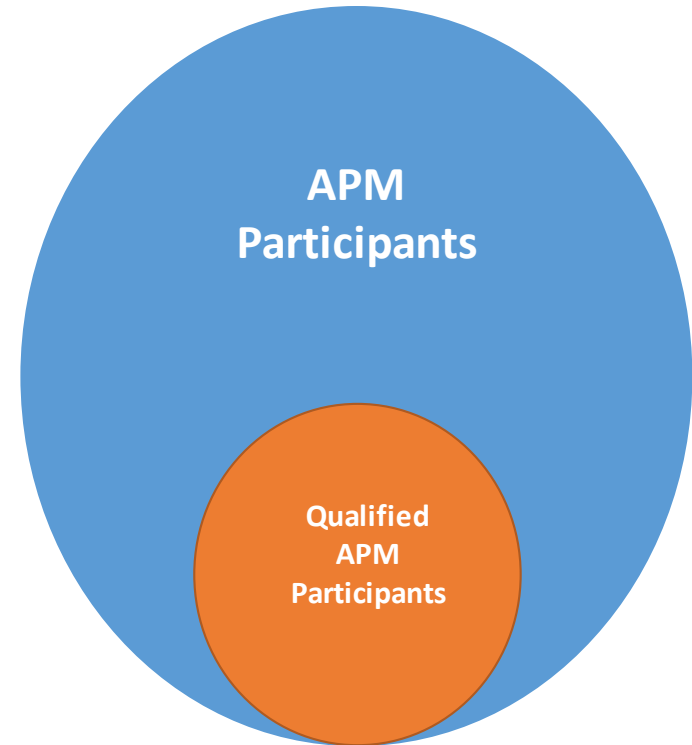
MIPS Scoring: Bonus for Complex Patients

- Complex patient bonus is continued in the 2019 performance year.
- Awards small bonus for caring for complex patients.
- Determined by Hierarchical Condition Category (HCC) risk score and score based on the percentage of dual eligible beneficiaries.
- Bonus of 1-5 points.

Qualified Participants in Advanced APMs

Advanced APMs and Bonus Payments

- Clinicians who participate in **the most advanced** APMs may be determined to be **qualifying APM participants (“QPs”)**.
- **QPs:**
 - Have to meet a threshold requirement
 - Are **not subject** to MIPS
 - Receive 5% lump sum **bonus payments** for years 2019-2024
 - Receive a **higher fee schedule update** for 2026 and onward



What does it take to be an Advanced APM and receive the 5% bonus?

- Use of certified EHR technology (CEHRT)
- Payment based on quality measures comparable to MIPS quality measures
- Bear financial risk for monetary losses in excess of a nominal amount, or APM is a Medical Home Model expanded under §1115A(c)

Advanced APM 2019: Change to CEHRT Use

Year 1 and 2

To qualify as advanced APM, at least **50%** of eligible clinicians in each APM entity must use CEHRT

Year 3 Final

To qualify as advanced APM, at least **75%** of eligible clinicians in each APM entity must use CEHRT

Nominal Risk Amount: In General

- Revenue-based nominal amount standard is:
 - 8% of average estimate total Medicare Parts A & B revenue of **providers and suppliers participating in APM entities**
- CMS finalizes retaining 8% revenue based nominal amount standard through performance period 2024.

2019 Advanced APMs

Comprehensive End Stage Renal Disease Care Model (2-sided risk)

Oncology Care Model (2-sided risk)

Shared Savings Program Track 1+, 2, and 3

Vermont All Payer ACO Model

Next Generation ACO Model

Maryland Total Cost of Care Model

Comprehensive Primary Care Plus (CPC+)

BPCI Advanced

Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)

New Potential Models

Medicare Threshold Requirements for Qualifying and Partial Qualifying APMs



- To be classified as “qualifying APM participant” or “partial qualifying APM participant,” have to meet or exceed certain thresholds related to APM entities
- Threshold can be set using patients or services

Years	Min Thresholds for APM Participant (Payment)		Min Thresholds for APM Participant (Patient)	
	Qualifying	Partial Qualifying	Qualifying	Partial Qualifying
2019-2020	25%	20%	20%	10%
2021-2022	50%	40%	35%	25%
2023 and beyond	75%	50%	50%	35%

The thresholds are based on Medicare FFS revenue and patients ONLY. FFS & All-Payer combination begins in 2021 and have separate requirements.



All Payer Option: Overview

- Starting in performance year 2019, there are two pathways to become QPs:
 - **Medicare option:** achieve status exclusively based on participation in Advanced APMs within Medicare FFS **or**
 - **All payer option:** achieve status based on combination of participation in Advanced APMs within Medicare FFS AND Other Payer Advanced APMs offered by other payers.

All Payer Combination Option

	2021		2022		2023		2024 and later	
	Payment Amount Method							
	Medicare Min	Total	Medicare Min	Total	Medicare Min	Total	Medicare Min	Total
QP Payment Amt Threshold	25%	50%	25%	50%	25%	75%	25%	75%
Partial QP Payment Amt Threshold	20%	40%	20%	40%	20%	50%	20%	50%
	Patient Count Thresholds							
QP Pt Threshold	20%	35%	20%	35%	20%	50%	20%	50%
Partial QP Pt Threshold	10%	25%	10%	25%	10%	35%	10%	35%

All Payer Combination Option

QP determinations are conducted sequentially so that Medicare option is applied before the All-Payer Combination option.

Only clinicians who do not meet the thresholds to become QPs under Medicare option are able to request QP determination under the All-Payer Combination.

Eligible clinicians can be assessed at the individual level or at the APM Entity level to determine if they meet the QP threshold at 3 snapshot dates.

Other Payer Advanced APMs: Criteria

2019

Any payer other than traditional FFS Medicare (Medicaid, Medicare Advantage, other commercial and private payers, CMS multi-payer models)

75% or more of ECs in each APM entity to use CEHRT (must submit evidence of CEHRT usage)

Payment based on quality measures comparable to MIPS

Must bear more than nominal financial risk or is Medicaid Medical Home Model

Other Payer Advanced APMs Nominal Risk Standards

- For 2019 - 2024 nominal amount of risk must be:
 - Marginal risk of at least 30%
 - Minimum Loss Rate of no more than 4%
 - Total Risk: at least 3% of expected expenditures for which APM entity is responsible **OR** 8% revenue-based nominal amount standard for total risk.

Determination of Other Payer Advanced APMs

- Prior to QP Performance period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers or eligible clinicians.
- Payer initiated process available for performance year 2019 for Medicaid, Medicare Advantage and payers aligning with CMS Multi-Payer Models. (remaining payer types in future years).
- Determination effective for 5 years if no changes made (change from 1 year proposed in last year's rule).

MIPS APM Scoring

MIPS APM Scoring Standard

- Less burdensome way of participating in MIPS for eligible clinicians in APMs that do not meet the definition of “Advanced APM” or
- Applies to eligible clinicians who are in an Advanced APM but do not meet the thresholds for Medicare payments through the APM or Medicare patients treated through the APM.

Background: MIPS APMs and Scoring

Eligible Clinicians considered part of APM Entity

- Must be on APM participation list on March 31, June 30, or August 31 of performance year (in year 2 for full TINs, December 31 is added)

Criteria for MIPS APM

- APM Entities participate in APM under agreement with CMS
- APM Entities include eligible clinicians on participation list
- APM bases payment incentives on performance on cost/utilization and quality measures

Examples

- Shared Savings Program (all tracks)
- Next Generation ACO
- CPC Plus
- Oncology Care

MIPS APM Scoring for Eligible Clinicians: Weights



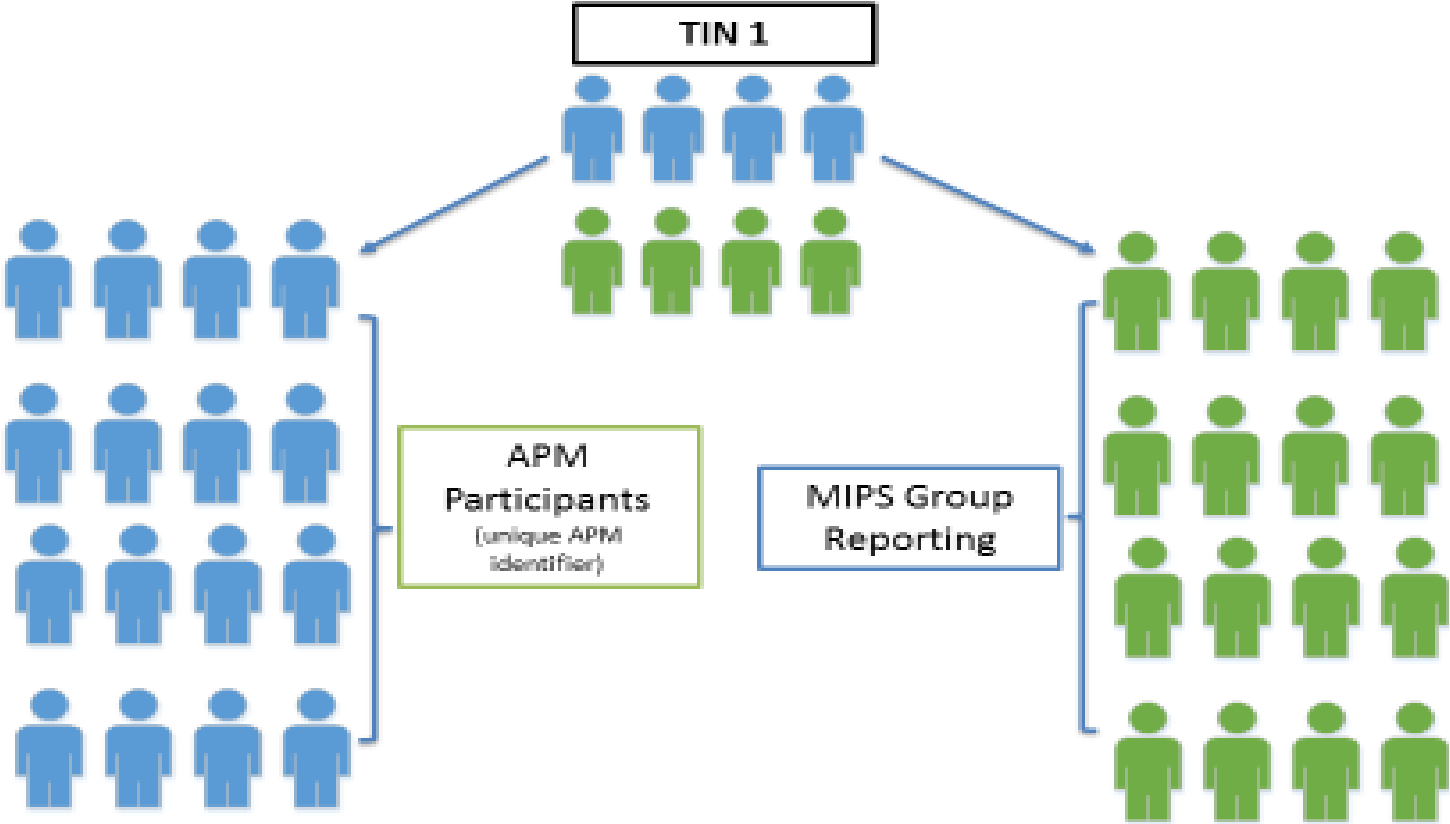
MIPS Performance Category	Transition Year 2017		2018/2019
	SSP & Next Generation ACOs	Other MIPS APMs	All MIPS APMs
Quality	50%	0%	50%
Cost	0%	0%	0%
IA	20%	25%	20%
ACI/Promoting Interoperability	30%	75%	30%



2019 List of MIPS APMs

BPCI Advanced	Comprehensive Care for Joint Replacement Model	Comprehensive ESRD Care Model (LDO Arrangement)	Comprehensive ESRD Care model (non-LDO one-sided risk arrangement)
Comprehensive ESRD Care Model (non-LDO two-sided risk arrangement)	Shared Savings Program Track 1	Shared Savings Program Track 2	Shared Savings Program Track 3
Shared Savings Program Track 1+	Next Generation ACO Model	Oncology Care Model-One-sided Risk	Oncology Care Model-Two-sided Risk
Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)			

Remember: It is possible that parts of your TIN may be in different programs!



Hierarchy for Final Score

Example	Final score used to determine payment adjustments
TIN/NPI has more than one APM Entity Final Score	The highest of the APM Entity final scores
TIN/NPI has an APM final score and also has a group final score	APM entity final score
TIN/NPI has a group final score and an individual final score, but no APM Entity final score	The highest of the group or individual final score

Changes to Medicare Shared Savings Program (MSSP) Measures

MSSP: Changes to CAHPS Measure Set

- Finalized proposal to begin scoring two summary survey measures:
 - ACO-45 CAHPS: Courteous and Helpful Office Staff
 - ACO-46: CAHPS: Care Coordination

MSSP: Changes to Claims-based Quality Measure Sets

- Finalized retirement of measures:
 - ACO-35 Skilled Nursing Facility 30 Day All-Cause Readmission Measure
 - ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
 - ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
 - ACO-44 Use of Imaging Studies for Low-back Pain

MSSP: Changes to QPP Web Interface Measures

Finalized removal

- ACO-12 Medication Reconciliation Post-Discharge
- ACO-15 Pneumonia Vaccination Status for Older Adults
- ACO-16 Preventative Care and Screening: BMI Screening and Follow up
- ACO-41 Diabetes: Eye Exam
- ACO-30 Ischemic Vascular Disease: Use of Aspirin or another Antithrombotic

Did not finalize addition

- ACO-47 Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

MSSP Accountable Care Organizations

6 Month Extension for Participation Agreements

- CMS finalized a voluntary six month extension for existing ACOs whose participation agreements expire on Dec. 31, 2018
- CMS also finalizes the methodology for determining financial and quality performance for this six month performance period (Jan. 1, 2019-June 30, 2019)

Use of Certified EHR Technology

- Finalized removal of ACO-11
 - Replaced with requirement that ACOs certify and attest that the eligible clinicians in the ACO meet the threshold percentage for CEHRT use.
 - ACOs in an advanced APM track will need to meet the 75% requirement.
 - ACOs in a non-advanced APM track will need to meet 50%.

Use of Certified EHR Technology

- MIPS-eligible clinicians not participating in advanced APMs/not qualified participants would continue to report the Promoting Interoperability measures under MIPS

Resource Links

- Medicare Physician Fee Schedule/Quality Payment Program Final Rule
 - <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>
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Questions and Feedback

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