Quality Payment Program: A Closer Look at the Proposed Rule for Year 3

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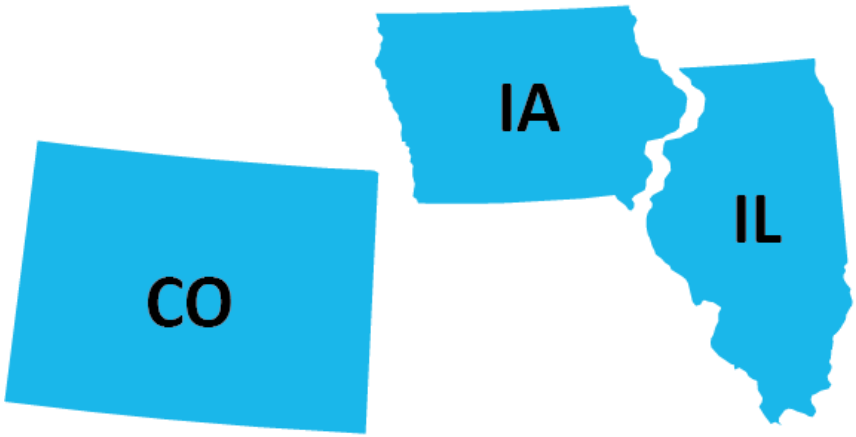
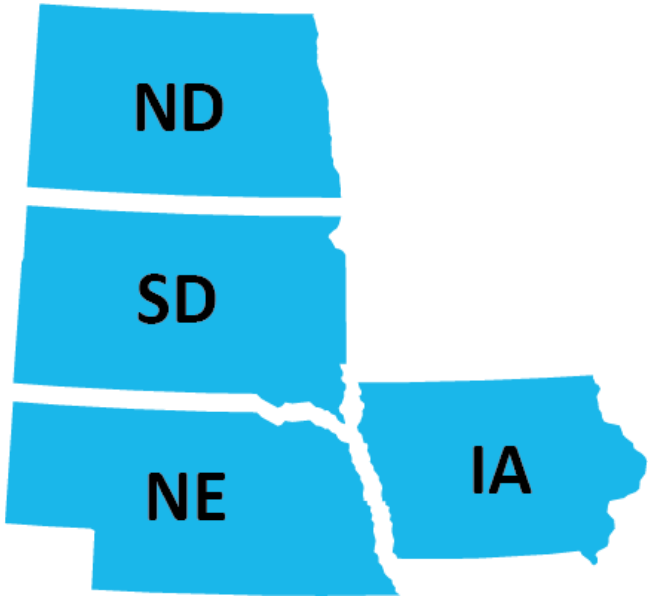
QIO 16 or more



SURS 15 or fewer



2019 Quality Payment Program (QPP)

Overall takeaway from 2019 QPP proposed rule:
MIPS is continuing to ramp up

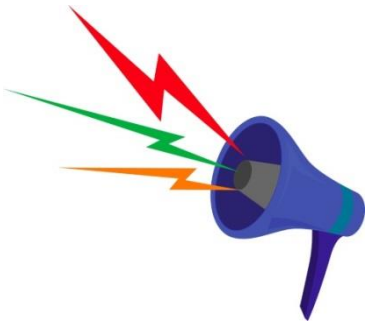
Disclaimer: Today's presentation content is the presenter's interpretation of the content, is subject to our interpretation and is not intended to include all the proposed changes outlined in the NPRM QPP Year 3.

Agenda

- Proposed changes to 2019 quality reporting
  - Identify how MIPS reporting, scoring and performance thresholds in 2019 differ from prior years
  - Share how CMS is changing measures with a special focus on interoperability
  - Explore new ways to participate in Advanced APMs
- Potential impact on your practice
  - Recognize how these changes affect your clinicians and organization
- Your opportunity to comment
  - Alert you to things you may want to comment on

Speaking Out on the Proposed Rule Year 3

- CMS wants to hear from the healthcare community on the implications for clinicians
- How to comment on the proposed rule:
  - Regular mail
  - Express/overnight mail
  - Hand or courier
  - Electronically through http://www.regulations.gov or Direct link for electronic comments
- Submit comments by 5 p.m. on Sept. 10, 2018



What is Staying the Same?

- Timeline
  - Performance period: January – December, 2019
  - Reporting period: January – March, 2020 (*intend to align due dates for all submissions including web interface*)
  - Payment adjustment, begins January 1st, 2021
- Performance periods
  - Quality & Cost: 12 months
  - Improvement Activities & Promoting Interoperability: 90 – 365 days
- Types of exemptions
  - Newly enrolled in Medicare
  - Below low-volume threshold (*though a new threshold is added*)
  - Significantly participating in Advanced APMs

What is Changing?

Proposed Key Changes

New Eligible Clinician Types by Credentials

2018 eligible clinician types	2019 proposed additions
• Physician • Physician Assistant • Nurse Practitioner • Clinical Nurse Specialist • Certified Registered Nurse Anesthetist • A group that includes such professionals	• Physical Therapist • Occupational Therapist • Clinical Social Worker • Clinical Psychologist

Low-Volume Thresholds

Excluded	Included
• ≤ $90,000 in Medicare Part B OR • ≤ 200 Medicare Part B patients OR • ≤ 200 Medicare Part B services	• > $90,000 in Medicare Part B AND • >200 Medicare Part B patients AND • >200 Medicare Part B services

MIPS-APM participants threshold is determined at APM entity level

Eligibility Opt-in Proposal

- Any clinician or group may opt in if:
  - MIPS Eligible
  - Qualifies for Low Volume Threshold by < 3 criteria
  - Make irrevocable election
    - Sign in to qpp.cms.gov
    - Select option to opt-in (or voluntarily report)
    - If opt-in subject to the MIPS payment adjustment
  - APM entities interested in opt-in
    - APM Scoring Standard
    - Must do at APM Entity level
  - When must the election be made?

CMS Estimates

- ***3rd criterion @ 200 services will not exclude more ECs***
- ***19,621 eligible to opt-in without 3rd criteria***
- ***42,025 eligible to opt in at 200 services criteria***

Single “MIPS” Determination Period

- For all determination of eligibility and special status:
  - Low-volume
  - Non-patient facing
  - Hospital based
  - Small practice
  - ASC-based
- First 12-month segment:
  - Oct. 1, 2017 to Sept. 30, 2018
  - including a 30-day claims run out
- Second 12-month segment:
  - Oct. 1, 2018 to Sept. 30, 2019
  - does not include a 30-day claims run out

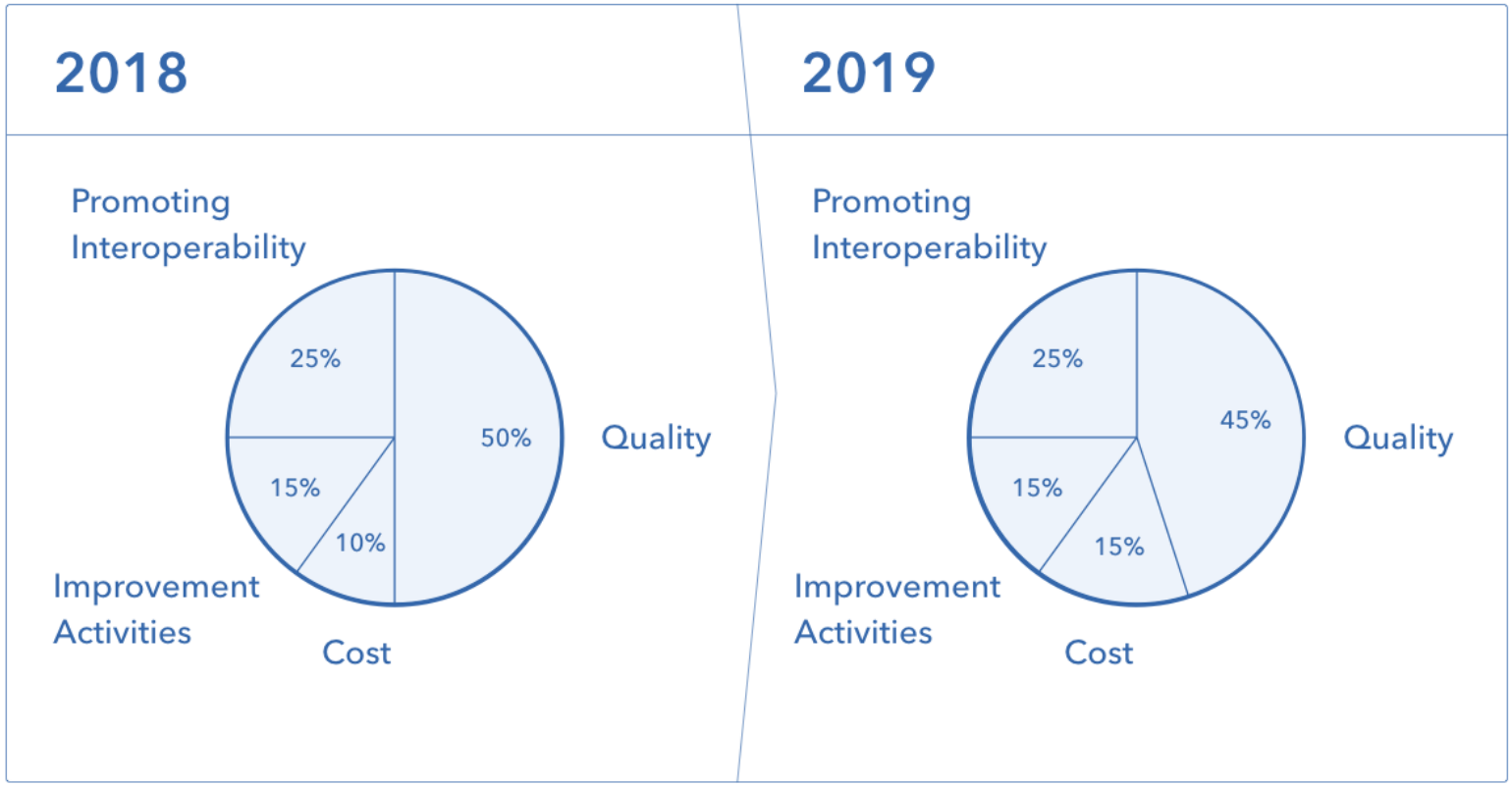
Flexibilities for Small Practice

- Retain hardship exception under PI
  - Expand to include new clinician type
- Incorporate small practice bonus
  - Into the Quality category
- Quality measures don't meet data completeness
  - Award 3 points
- Consolidate the LVT determination periods
  - With the determination period for identifying a small practice and other types of MIPS ECs

2019 Proposed "New" Terminology

Collection Type	Submitter Type	Submission Method
• A **set of quality measures** with comparable specifications an data completeness criteria including, as applicable, e.g. electronic clinical quality measures (eCQMs), MIPS clinical quality measures (CQMs)	• The **MIPS eligible clinician, group, or third party** intermediary acting on behalf of a MIPS EC or group, as applicable, that submits data on measures and activities	• **The mechanism by which the submitter type submits** data to CMS, e.g. direct (EHR, Registry, QCDR) Medicare Part B claims, and the CMS Web Interface

Performance Category Weights



Performance Category

Quality

Quality: What Remains Stable?

- Still 6 measures, 1 outcome or high-priority

  Or
- CMS Web Interface
- Still 1-10 points per measure depending on classification
- Still a 12-month performance period
- Still 60% data completeness requirement
- Case minimum remains at 20
- Same submission mechanism options
- Same bonus points
  - End to End Electronic capped at 10% denominator
  - Extra High Priority Measures capped at 10% denominator
  - Improvement bonus stays the same (some conversation about it)

Quality: Key Changes

- Performance weight shifts to 45%
- Reweighting extends to a clinician that during the final 3 months of performance period (Oct. – Dec.)
- Ten new quality measures
  - 4 patient reported outcome measures
  - 7 high-priority
  - 1 measure that replaces an existing measure
- Retire 34 quality measures
  - Many popular measures
- Opioid-related measures are now high-priority

Quality: Meaningful Measures & Web Interface

#	Measures Proposed for Removal
46	Medication Reconciliation Post-Discharge
111	Pneumococcal Vaccination Status for Older Adults
117	Diabetes: Eye Exam
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
318	Falls: Screening for Future Fall Risk

- 6 Measures proposed for removal
- Consider extending Web Interface use to groups $\geq$ 16

Quality: Other Key Changes

- Claims submissions limited to clinicians in “small” practice
- Small practice bonus now added to Quality instead of Final Score
- Register for CAHPS and don’t meet the CAHPS case minimum
  - Only 5 measures required (reduce denominator from 60 to 50)
- Increase flexibility for submission
  - Submit measures from multiple mechanisms
  - CMS will score across mechanisms

Quality: Key Changes to Bonus Points

- **Same:**
  - 2 points for outcome and patient experience measures,
  - 1 point for other high priority measures, capped at 10%
  - 1 point for each measure submitted electronically end-to-end, capped at 10%
- **Change:**
  - Small practice bonus will be applied at the Quality category level, rather than being applied to the overall Final Score

Quality: Implement Facility Based Scoring

- Facility-Based for Individual or Group level
  - Where ≥75% of MIPS ECs individually qualify facility-based group attributed to hospital with plurality of their individual clinicians
  - The measure set for the fiscal year Hospital Value-Based Purchasing (HVBP) program that begins during the applicable MIPS performance period will be used
  - Automatically applied to individuals if Cost/Quality scoring beneficial - no other submission requirements
  - Must make an effort to participate in MIPS submit and CMS will automatically look at HVBP if you qualify and score best
  - If attributed hospital does not have a facility score for the year, NPI or TIN must participate in MIPS another method.

Performance Category

Improvement Activity (IA)

IA: What Remains Stable?

- No changes to category scoring methodology
  - 10 points for each medium-weighted measure
  - 20 points for each high-weighted measure
  - Double points for small and rural practices
- Reporting period remains at 90-days up to full CY
- Weighted at 15% points toward the final score

IA: Minimal Changes

- Additions or Edits to Activities
  - **Add 6 new activities**
  - **Modify 5 existing activities**
    - **"CMS Study on Burdens" changed to "CMS Factors Associated with Reporting Quality**
  - **Remove 1 existing activity**
    - **Participation in Population Health Research**
  - **Add 1 new criteria**
    - **"Include a public health emergency as determined by the Secretary"**
  - **Removal of PI bonus points**

New Activities

- **Comprehensive eye exams**
- **Financial Navigation Program**
- **Completion of Collaborative Care Management Training Program**
- **Relationship-Centered Communication**
- **Patient Medication Risk Education***
- **Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support**

Appendix 2: IA Table B in NPRM

Performance Category

Promoting Interoperability (PI)

PI: What Remains the Stable?

- Weight of 25% continues
- Security Risk Analysis required
- Still 90-365 days
- Automatic reweighted available for
  - NPs, PAs, CNS, and CRNAs
  - Extended to additional clinician types

PI: Restructure Changes

2018 Final

- Score based on a combination of
  - Base
  - Performance
  - Bonus

2019 Proposed

- Score based on a single, smaller set of measures, no longer divided into Base, Performance and Bonus

Greater Flexibility

- All measures in the new measure set will be scored based on the MIPS EC's performance for that measure based on the submission of a numerator and denominator, or a "yes or no" submission

PI: Scoring Changes

- Must use 2015 CEHRT
- Security Risk Assessment is a minimum requirement to receive any points
  - Sole remaining Base Measure
  - No score attached
- Scores for measure are added for up to 100 points
- All measures are mandatory unless exclusions
  - Exclusions are no longer a “free pass”
  - If exclusions are claimed, the points are reallocated to other measures
- Aligned with Hospital/CAH requirements to reduce reporting burden

Proposed PI Measure Set

TABLE 36: Proposed Scoring Methodology for the MIPS Performance Period in 2019

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	Bonus: Verify Opioid Treatment Agreement	5 points bonus
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 two of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

PI: Proposed Measure Set Table

TABLE 39: Summary of Proposals for the Promoting Interoperability Performance Category Objectives and Measures for the MIPS Performance Period in 2019

Measure Status	Measure
Measures retained – no modifications*	• e-Prescribing
Measures retained with modifications	• Send a Summary of Care (name proposal -Support Electronic Referral Loops by Sending Health Information) • Provide Patient Access (name proposal – Provide Patients Electronic Access to Their Health Information) • Immunization Registry Reporting • Syndromic Surveillance Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting
Removed measures	• Request/Accept Summary of Care • Clinical Information Reconciliation • Patient-Specific Education • Secure Messaging • View, Download or Transmit • Patient-Generated Health Data
New measures	• Query of Prescription Drug Monitoring Program (PDMP) • Verify Opioid Treatment Agreement • Support Electronic Referral Loops – Receiving and Incorporating Health Information

*Security Risk Analysis is retained, but not included as a measure under the proposed scoring methodology.

Performance Category

Cost

Cost: What Remains the Stable?

- Derived from Medicare claims
- Two measures
  - Total Per Capita Cost (TPCC)
    - Plurality of primary care services rendered by the clinician determine attribution
  - Medicare Spending Per Beneficiary (MSPB)
    - Plurality of Part B services billed during the index admission to determine attribution
- Calculating the score
  - Cost Achievement Points/Available = Cost Percent Score

Cost: Key Changes

- 15% category weight
- Addition of 8 new episode-based measures
  - 5 procedural measures
    - 10 case minimum
    - Attribution to each clinicians who renders trigger services
  - 3 inpatient medical condition measures
    - 20 case minimum
    - Attribution to each clinician who bills in the episode
    - Where the billing TIN renders $\geq$ 30% of E&M claim lines
  - Calculated using Medicare Parts A and B fee-for service claims data and are based on episode groups.

Proposed Episode-based Cost Measures

Measures	Types
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural
Routine Cataract Removal with Intraocular Lens (IOL)	Procedural
Screening/Surveillance Colonoscopy	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition
Simple Pneumonia with Hospitalization	Acute inpatient medical condition
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition

Cost: Scoring

- For each cost measure attributed to a MIPS eligible clinician, the clinician receives **one to ten points** based on the clinician's performance on the measure compared to the measure's benchmark
- Cost measure benchmarks are determined based on cost measure performance **during the performance period**
- For cost measures to be scored, **a case minimum of 10 for procedural episodes** and **20 for acute inpatient medical condition episodes** must be met
- CMS will **not calculate a Cost performance category score** if the eligible clinician is not attributed any Cost measures, because of case minimum requirements or the lack of a benchmark
- CMS is proposing to **remove the Cost improvement score** (previously up to 1 percentage point available in the Cost category for improvement)

Scoring and Performance Thresholds

Increasing Performance Thresholds, Incentives and Penalties

2018 Final

- Threshold: **15 points** to avoid the negative payment adjustment
- Incentive: **70 points** to be an exceptional performer
- Penalty: **+/-5%** payment adjustment

2019 Proposed

- Threshold: **30 points** to avoid the negative payment adjustment
- Incentive: **80 points** to be an exceptional performer
- Penalty: **+/-7%** payment adjustment
- Estimate +5.6% for exceptional performer

Changes in Performance Thresholds

MIPS Year 3 (2019) Proposed

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Proposed

Final Score 2018	Payment Adjustment 2020
≥80 points	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
30.01-79.99 points	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

How it All Comes Together

$$\left(\left[\frac{\text{\# Quality points}}{60} \times 45\% \right] + \left[\frac{\text{\# PI points}}{100} \times 25\% \right] + \left[\frac{\text{\# IA points}}{40} \times 15\% \right] + \left[\frac{\text{\# Cost points}}{\text{available}} \times 15\% \right] \right) \times 100 = \text{Final Score}$$

Key Changes to APMs

Advanced APMs: What remains stable?

- Maintain the revenue-based nominal amount standard at 8% through performance year 2024
- Implement All-payer option as planned
  - All Payer Combination allows QP status based on a combination of Medicare APM and offered by other payer APMs
  - Multi-year (duration of agreement) eligibility for Other-Payer aAPM
- Partial QP to declare and commit to MIPS

Advanced APMs: Key Changes

- aAPM participant CEHRT usage threshold at 75% (50%)
  - Other Payer aAPM must have 75% in 2020 (starts at 50%)
  - Either Other Payer or Clinician may provide evidence of utilization
- Expand QP determination to include TIN level option

Key Take-Aways

Scoring
- Threshold increasing from 15 to 30 points to avoid negative payment adjustment
- Increase from 70 to 80 points to be an exceptional performance

Quality
- Mostly the same, with new flexibility in submissions

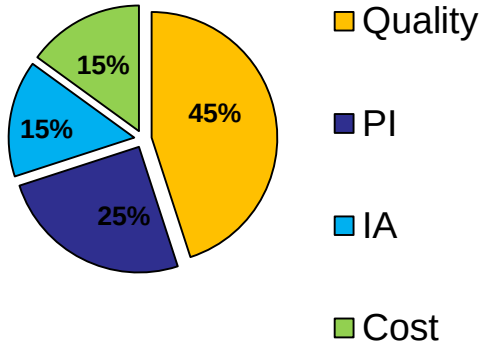
Improvement Activities
- No change except some additions and editing activities

Cost
- Eight new episode-based measures
- No more improvement bonus

Promoting Interoperability
- New measures set with fewer measures, all performance or Yes/No measures
- 2015 CEHRT required

CMS Seeking Comments

- Quality Performance Category
  - Expanding WI core set of measures to include other specialty specific measures (ie. Surgery)
  - What should be measured for opioid related high priority measure
- Improvement Activity Category
  - Applying high weighting for any IA employing CEHRT
- Promoting Interoperability
  - Alternative scoring methodology
  - Measure selection and weights
- Cost
  - Aggressive increase of 5% until reach 30%
  - Expand performance period from 1 to 2 or more years



Thank you for joining us!

Q & A Session

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Resources

- Year 3 Overview Fact Sheet
- Proposed policies for Year 3 of the Quality Payment Program (Federal Register)
- Cost Performance Category in the NPRM
  - Measure methodology documents
  - Measure codes list files
- Quality Payment Program
- CMS Proposed "Pathways to Success" Rule – overhauls ACOs encouraging risk-sharing

CMS Help Desks

CMS Help Desks

- **EHR Information Center Help Desk**
  - (888) 734-6433 / TTY: (888) 734-6563
  - Hours of operation: Monday-Friday 8:30 a.m. – 4:30 p.m. in all time zones (except on federal holidays)
- **NPPES Help Desk**
  - Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do
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