Hogan Lovells

The Quality Payment Program

2018 Proposed Rule: Moving Forward Slowly But Surely

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Quality Payment Program (QPP): What's the Story So Far?

Quality-Based Payment: The Movement

- U.S. health care system is moving away from fee for service (FFS) payment and toward payment that incentivizes high-quality and cost-efficient care
- Both Medicare/Medicaid and private payers are pushing these initiatives – quality-based adjustments to FFS and alternative payment models (APMs) to replace FFS (e.g., accountable care organizations (ACOs))
- Affordable Care Act created three quality-based payment systems for doctors:
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VBPM)
  - Electronic Health Records (EHR) Incentive

How Does the QPP Fit In?

- Replaces and enhances existing quality-based payment systems for doctors
- Increases the amount of traditional FFS payments at stake (from 5% for performance in 2018 to 9% for performance in 2020 and beyond)
- Incorporates APMs that many clinicians already are using by allowing clinicians who participate in such APMs to get a 5% bonus and avoid penalties under FFS – this includes some Medicare-sponsored ACOs, some Medicare payment models (but not the Oncology Care Model (OCM) one-sided risk arrangement), and starting in 2019 will include ACOs sponsored by non-Medicare payers (Medicaid, Medicare Advantage)

QPP: The Basics

MACRA (Medicare Access and CHIP Reauthorization Act) created the QPP in 2015

Under the QPP, Medicare participating physicians and other clinicians have two options:

- Advanced Alternative Payment Model (APM) – Participate in a qualifying APM – 5% lump-sum bonus to Part B payments, no penalty
- Merit-Based Incentive Payment System (MIPS) – Try to do well compared to other clinicians on measures of quality, cost, EHR use, and care improvement – payment bonus or penalty depending on performance, up to 9% based on performance in 2020 and beyond

QPP Year 1

Centers for Medicare & Medicaid Services (CMS) published final rule for Year 1 on November 4, 2016

- Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf.
- Slower phase-in for payment adjustments – clinicians can "pick their pace"
- 0% weight for the cost score in the first year
- January 1, 2017 – All clinicians pick either MIPS adjustments or participation in a qualifying APM, at the pace they choose
- January 1, 2019 – Bonuses and penalties will hit Medicare payments (based on calendar year (CY) 2017 performance)

QPP Year 1: Pick Your Pace

In Year 1, CMS allowed clinicians to "pick their pace":

Reporting Level	Description
Minimum reporting	Report at least 1 quality measure, 1 clinical improvement activity, or the 5 base advancing care information measures. No payment reduction but not eligible for a payment bonus in CY 2019.
Partial reporting	Report (for at least a 90-day period but less than the full year) more than 1 quality measure, more than 1 improvement activity, or more than the required advancing care information measures. No payment reduction and potential for small payment bonus in CY 2019.
Full reporting	Report (for at least a 90-day period up to the full year) the required measures for full reporting in each category. Up to 4% payment reduction or payment bonus depending on performance, as well as a potential exceptional performer bonus, in CY 2019.

QPP Year 2 Proposed Rule:
Moving Forward Slowly But Surely

QPP Year 2: The Basics

Proposed Rule published June 21, 2017

- Available in the June 30, 2017 Federal Register at: https://www.gpo.gov/fdsys/pkg/FR-2017-06-30/pdf/2017-13010.pdf.
- Applies to performance in CY 2018, with bonuses and penalties paid in CY 2020 based on that performance
- All eligible clinicians fully subject to QPP – end of "pick your pace"
- Potential bonus or penalty under MIPS track increases to a maximum of ±5% on each Medicare Part B payment
- Comments due **August 21, 2017**

QPP Year 2: Key Proposed Changes

- Expanded exclusion for clinicians with low Medicare volume
- Implementation of virtual group option
- Cost category again weighted at 0%
- Starting over on episode-based cost measures, with implementation of new measures for CY 2019
- Bonus for improved performance in quality and cost categories
- New improvement activity: Use of imaging appropriate use criteria
- CY 2017 cancer-related quality measures and specialty sets continue to be available in CY 2018
- No major changes to APMs, but non-Medicare APM option coming in CY 2019

Eligible Clinicians: Review and 2018 Proposals

Eligible Clinicians: Basic Definition

The MIPS payment adjustment applies to “eligible clinicians.”

An “eligible clinician” includes:

- Physicians (MDs, DOs, dentists, optometrists, podiatrists, chiropractors)
- Other health care professionals (e.g., nurse practitioners, physician assistants)
- Groups that include individuals who are eligible clinicians

Other health care professionals will become subject to MIPS in CY 2019 (certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, physical/occupational/speech therapists, audiologists)

Eligible Clinicians: Exclusions

"Eligible clinician" excludes clinicians who:

- Recently enrolled in Medicare
- Qualify for the APM incentive for a given year and do not report MIPS data
- Did not meet the volume thresholds – Proposed Rule would expand this exclusion to cover clinicians who had *either* $90,000 or less in Medicare Part B allowed charges *or* saw 200 or fewer Medicare Part B beneficiaries (currently $30,000 and 100)

Slightly different standards apply to non-patient-facing physicians such as radiologists (no proposed changes for CY 2018)

- Defined as 100 or fewer patient-facing encounters (including groups with 75% of national provider identifiers (NPIs) billing under the group's tax identification number (TIN) are non-patient-facing)
- Need to perform fewer practice improvement activities to get full credit

Eligible Clinicians: Virtual Groups

For CY 2018 and beyond, CMS proposes allowing clinicians to be scored together in "virtual groups"

- Open to solo practitioners and groups of no more than ten eligible clinicians in the same TIN
- Excludes solo practitioners who are exempt from MIPS, TIN groups that are exempt based on the low-volume threshold, or TIN groups whose members all are exempt
- Clinicians may not be in more than one virtual group
- Virtual groups must include at least two separate solo practitioners/TIN groups
- TIN groups may not be split between more than one virtual group
- Location, specialty, and size of virtual group are irrelevant, at least for CY 2018
- Members of a virtual group must opt to be scored as a virtual group by December 1 of the year before the performance year (i.e., Dec. 1, 2017 for CY 2018) and enter into a written agreement to be scored as a virtual group

Eligible Clinicians: Facility-Based Scoring

For CY 2018 and beyond, CMS proposes to allow certain facility-based clinicians to be scored on Quality and Cost based on the facility's score under the Hospital Value-Based Purchasing Program

- Available to clinicians who furnish 75% or more of their covered professional services in an inpatient hospital or emergency department
- Completely optional
- Would not apply to the clinician's Improvement Activities or Advancing Care Information scores
- Quality and Cost scores would be derived from score of facility where the clinician provided services for the most Medicare beneficiaries

Calculation of the MIPS Adjustment: Review and 2018 Proposals

Four Scores and Two Years Ago

A clinician's adjustment is based on a composite score

- Weighted average of scores in four categories

- Composite score calculated based on performance two years earlier (2020 score and adjustment based on 2018 performance)

Quality Score

60% in CY 2018, decreasing to 30% in CY 2019

- Based on performance on quality measures chosen and submitted by the physician
  - Full reporting requires six quality measures
  - Must include an outcomes-based measure or a “high-priority” measure
- Proposed Rule retains almost all of the hundreds of quality measures finalized last year, including pre-selected sets for different specialties
- PQRS/VBPM measures automatically are included unless specifically removed by CMS
- CMS will continue annual call for quality measures

Quality Score: Measures Retained for 2018

Cancer Screening

PQRS #112 (Breast cancer screening)

PQRS #113 (Colorectal cancer screening)

PQRS #309 (Cervical cancer screening)

End of Life Measures

New measures developed by ASCO:

% of cancer patients who received chemo within last 14 days of life;

had >1 ER visit in last 30 days;

admitted to ICU in last 30 days;

not admitted to hospice; or

admitted to hospice for less than 3 days

Precision/Genetic Measures

New measures developed by ASCO tailoring treatment for breast cancer to HER2 status and for colorectal cancer to KRAS gene mutation status

Radiation Oncology

PQRS #143 (Pain intensity quantified for those receiving chemo or radiation)

PQRS # 144 (Document plan of care for those receiving chemo or radiation)

Radiation Dosing

PQRS # 359-364 (Existing PQRS measures related to optimizing radiation doses)

PQRS # 156 (Limiting radiation doses to normal tissues)

ASCO = American Society of Clinical Oncology

Quality Score: Specialty Sets Proposed for CY 2018

- Proposed Rule includes a specialty measure set for Oncology, including a specialty subset for Radiation Oncology
- Clinicians earn full credit for reporting a specialty subset even if there are fewer than the minimum measures in the subset
- Cancer screening measures also are included in the Preventive Medicine specialty set
- CMS also proposes a Diagnostic Radiology specialty subset that includes some measures related to screening mammography

Oncology Specialty Subsets: Measures for CY 2018

General Oncology (* = new for CY 2018)

- PQRS #047 – NCQA – advance care plan for patients 65 or older
- PQRS #102 – PCPI – avoid overuse of bone scan for low risk prostate cancer patients
- PQRS #130 – CMS – documentation of medication in medical record
- PQRS #143 – PCPI – pain intensity quantified for chemo or radiation therapy
- *PQRS #144 – ASCO – plan of care for pain for chemo or radiation therapy
- PQRS #226 – PCPI – screening and intervention for tobacco use
- PQRS #250 – CAP – radical prostatectomy reporting
- PQRS #317 – CMS – screening for high blood pressure
- PQRS #374 – CMS – receipt of specialist report
- PQRS #402 – NCQA – adolescent tobacco use intervention
- PQRS #431 – PCPI – screening and counseling for unhealthy alcohol use

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NCQA = National Committee for Quality Assurance; PCPI = Physician Consortium for Performance Improvement Foundation; CAP = College of American Pathologists, ASCO = American Society of Clinical Oncology

Oncology Specialty Subsets: Measures for CY 2018

General Oncology (*cont'd from previous slide*)

- PQRS #449 – ASCO – HER2 negative patients spared HER2 therapies
- PQRS #450 – ASCO – Trastuzumab received by HER2 positive patients
- PQRS #451 – ASCO – KRAS testing for appropriate colorectal cancer patients
- PQRS #452 – ASCO – KRAS positive patients spared anti-EFGR monoclonal antibodies
- PQRS #453 – ASCO – patients who died of cancer received chemo in last 14 days of life
- PQRS #454 – ASCO – patients who died of cancer with more than one ER visit in last 30 days of life
- PQRS #455 – ASCO – patients who died of cancer admitted to ICU in last 30 days of life
- PQRS #456 – ASCO – patients who died of cancer not admitted to hospice
- PQRS #457 – ASCO – patients who died of cancer admitted to hospice for less than three days
- *New measure – Oregon Urology Institute – bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy

Oncology Specialty Subsets: Measures for CY 2018

Radiation Oncology

- PQRS #102 – PCPI – avoid overuse of bone scan for low risk prostate cancer patients
- PQRS #143 – PCPI – pain intensity quantified for cancer patients receiving chemo or radiation therapy
- PQRS #144 – ASCO – plan of care for pain for cancer patients receiving chemo or radiation therapy
- PQRS #156 – ASCO – radiation dose limited to normal tissue for breast, rectal, pancreatic, lung cancer patients receiving 3D conformal radiation therapy

Quality Score: Topped-Out Measures

- CMS proposes to add a process for eliminating topped-out measures
- Once a measure is identified by CMS as topped out for three consecutive years, CMS would have authority to remove the measure in the fourth year through notice and comment rulemaking
- Before being removed, measures identified as topped-out would be capped at six points toward the overall Quality score (normally each measure is worth up to ten points)

Quality Score: Bonus for Improvement

- CMS also proposes to offer bonus points for improvement in Quality and Cost scores
- Bonus would be calculated based on improvement in the total score for the category, not improvement on individual measures
- Bonus would be based on the rate of improvement, so more improvement would result in more bonus points

Cost Score

0% in the first year, proposed 0% again in 2018, 30% in subsequent years

- Two overall cost measures will apply to all clinicians
  - Total per capita cost for all Medicare fee for service beneficiaries
  - Medicare spending per beneficiary
- Clinicians also may be scored on additional episode-based cost measures if they perform such procedures
  - CMS proposes to discard ten proposed episode-based measures from CY 2017 final rule
  - Currently developing new episode-based measures that would go into effect for CY 2019
- Measures are based on claims data, so physicians don't have to report anything
- Cost scores do not include Part D drug costs

Cost Score: Developing New Episode-Based Measures

CMS proposes a process for developing new episode-based cost measures to be used starting in CY 2019:

- Consider comments submitted on the draft list of care episode and patient condition groups, posted in December 2016
- Consider feedback from a technical expert panel that has met three times so far, including feedback on how to define an episode group, assign costs to the group, and attribute episode groups to individual clinicians
- Solicit names of additional clinicians to participate in the development of episode-based measures
- Provide feedback to clinicians on existing episode-based measures, beginning in fall 2017
- Provide further feedback on newly developed episode-based measures as they become available in a new format, likely in summer 2018

Improvement Activities Score

15% for CY 2018 and future years

- Based on participating in specified "improvement activities" in nine categories, including:
  - Expanded practice access
  - Beneficiary engagement
  - Achieving health equity
  - Care coordination
  - Participation in an APM
- CMS proposes to add several new improvement activities from which to choose, each assigned medium or high weight
- The more activities you participate in, the higher your score can go

Improvement Activities: Examples

- Population management - targeted at specific geographic or disease communities (e.g., rural populations or diabetics)
- Beneficiary engagement –aimed at getting patients more involved in their treatment (e.g., participating in a Qualified Clinical Data Registry that promotes collaborative learning, patient self-action plans, patient adherence tools)
- Care coordination – coordination between primary and specialist, communication of test results, closing the referral loop
- Expanded practice access – 24/7 access, expanded hours in the evenings and weekends, use of telehealth, collection of patient satisfaction data

Improvement Activities: AUCs for Imaging

- CMS proposes a new improvement activity for clinicians who attest that they are consulting appropriate use criteria (AUCs) for advanced diagnostic imaging services through a qualified clinical decision support mechanism
- All ordering professionals will be required to consult AUCs for these services, likely beginning January 1, 2018
- The new improvement activity would give clinicians credit for consulting AUCs whether required or not

Advancing Care Information Score

25% in CY 2018 and future years, based on two sub-scores:

Base Score

- Worth 50 out of 100 available points
- Requires reporting of 5 measures:
  - Security risk analysis performed (yes required)
  - % of prescriptions by e-prescribing (at least 1)
  - % of patients given timely electronic access to health information (at least 1)
  - % of transitions of care and referrals where summary of care record created and sent electronically (at least 1)
  - % of patient encounters where clinician received transition of care or referral and accepted a summary of care record electronically (at least 1)

Performance Score

- Worth up to 80 out of 100 available points
- Cannot earn these points unless you qualify for the base score.
- Based on performance on specific measures within 8 objectives, including:
  - Protection of patient health information
  - Patient electronic access
  - Secure messaging
  - Participation in health information exchanges and public health databases

Advancing Care Information: Exemption

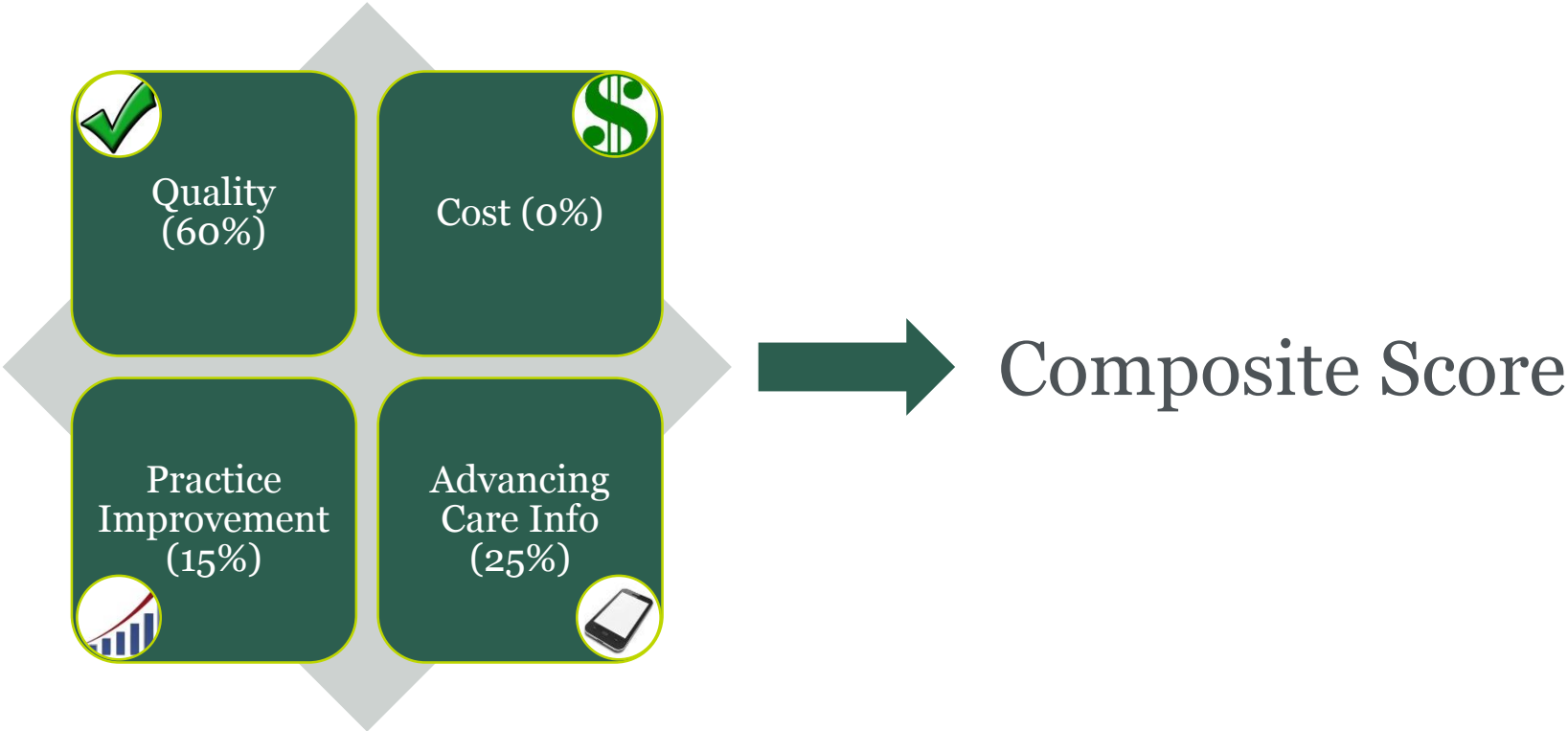
"Hospital-based" clinicians already are exempt from being scored on Advancing Care Information

- Clinicians who furnish 75% or more of their covered professional services in the inpatient hospital, on-campus outpatient hospital, or emergency department setting
- Advancing Care Information reweighted to 0% for these clinicians

21st Century Cures law exempts Ambulatory Surgery Center (ASC)-based clinicians as well

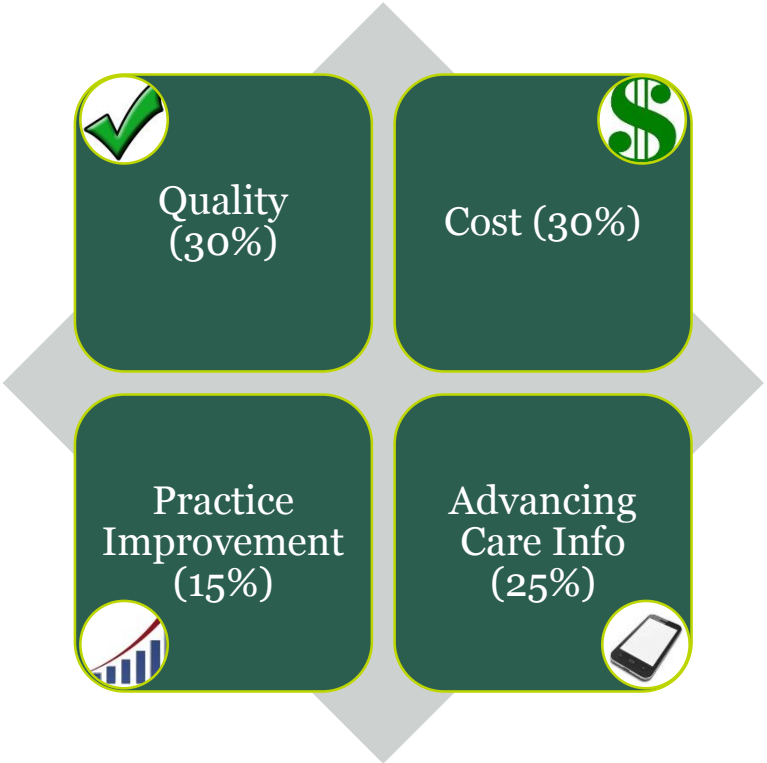
- Clinicians who furnish 75% or more of their covered professional services in the ASC setting
- CMS proposes the ASC-based exemption would be calculated separately from hospital-based exemption, so a clinician who performs 50% of services in hospital and 50% in ASC would not qualify

Putting It Together: CY 2018 (CY 2020 bonus/penalty)



Scores will be reweighted if a clinician does not have sufficient data to earn a score in a particular category.

Putting It Together: CY 2019 (CY 2021 bonus/penalty)



Composite Score

Scores will be reweighted if a clinician does not have sufficient data to earn a score in a particular category.

What's That In Dollars?

- Each physician's score is compared to a benchmark based on the performance of all other physicians
- Based on performance relative to the benchmark, physician gets positive, negative, or no adjustment
- Based on performance in CY 2018, a physician can gain or lose up to 5% of Medicare Part B payments for all of CY 2020
- This increases to 7% for CY 2021, and 9% for every year thereafter
- Additional payment bump for "exceptional performance" (top 25% of scores)

APMs: Still a Narrow Track

Another Route to Quality

- Participation in a qualifying alternative payment model (APM) is an alternative to the MIPS adjustment, but still geared toward quality-based payment
- APM has to qualify as an "advanced APM"
  - Requires use of certified EHR by its participants
    - At least 50% of eligible clinicians must use certified EHR technology (CEHRT)
  - APM participants are paid based on quality measures similar to MIPS quality measures
  - Either APM is a CMS "medical home" (under Center for Medicare & Medicaid Innovation (CMMI) authority) or APM participants bear more than a nominal risk for losses
- Extra incentives for APM participation, but does not change the underlying rules of qualifying APMs

Advanced APMs: Timing and Examples

- CMS issued a list of Advanced APMs for CY 2017 and will update this list at least annually
- A number of prominent APMs were excluded from the list:
  - Oncology Care Model's "one-sided" risk arrangement, i.e. participants not at risk for Medicare expenditures over target (does not meet financial risk criteria)
  - Bundled Payment for Care Improvement (BPCI) model (no use of CEHRT, MIPS-equivalent quality measures)
- Other APMs were included on the list and expected to be included again for CY 2018:
  - Oncology Care Model "two-sided" risk arrangement
  - Medicare Shared Savings Program (Track 2 & Track 3)
  - Next Generation ACO Model
  - Comprehensive Primary Care Plus model

Advanced APMs: Risk and Reward

- For CY 2018, clinicians must receive at least 25% of Part B payments or see at least 20% of Medicare patients through the APM to successfully participate
- If they do, they will:
  - Receive incentive payment equal to 5% of Part B payments in the payment year
  - Also be exempt from any MIPS adjustment
- Partial qualifying participants:
  - Lower thresholds (20% of payments or 10% of patients)
  - No 5% incentive, but also no MIPS adjustment

APM Incentive: If You Build It…

- CMS estimates that 180,000 to 240,000 eligible clinicians will successfully participate in an Advanced APM in CY 2018 (vs. 70,000 to 120,000 expected in CY 2017)
- About 572,000 clinicians expected to be subject to MIPS
- APM incentive may not spur new interest in ACOs or other models, but at least protects those who already are participating from MIPS adjustments
- MIPS APMs – clinicians who are participating in an APM that does not qualify for the incentive still can simplify reporting by using the MIPS APM option, allowing the APM entity to report together

APM Incentive: Widening the Track?

- CMS also proposes new details for the All-Payer Combination Option that would take effect for CY 2019
- Would allow eligible clinicians to become qualifying participants in Advanced APMs (and earn the incentive) through participation in a Medicare Advanced APM and one or more APMs sponsored by another payer (e.g., Medicaid, Medicare Advantage organization)
- Participating only in another payer's Advanced APM not sufficient
- Other Payer Advanced APMs must meet similar requirements as Medicare Advanced APMs

For More Information

- Visit the CMS website for the QPP: https://qpp.cms.gov/
- Review fact sheets and other resources at the QPP resource library page: https://qpp.cms.gov/about/resource-library
- Sign up for the CMS e-mail list for QPP updates: Scroll to the end of the resource library page and click on “Subscribe”
- Submit comments to CMS on the QPP Proposed Rule
- Continue to work with ACCC and share your thoughts with us to incorporate into ACCC’s comment letter

Questions?

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