The Quality Payment Program

Final Rule Continues the Drive Toward Value-Based Payment

Beth Roberts, Partner
beth.roberts@hoganlovells.com
(202) 637-8626

Andrew Furlow, Senior Associate
andrew.furlow@hoganlovells.com
(202) 637-5843

Beth Halpern, Partner
elizabeth.halpern@hoganlovells.com
(202) 637-8609

What is MACRA?

MACRA – the basics

MACRA is the Medicare Access and CHIP Reauthorization Act of 2015

- Repealed the sustainable growth rate (SGR) physician payment methodology and replaced it with 0.5% annual increases to Part B payment for physicians for the next five years
- Also authorizes Medicare to continue its push to link more and more provider payments to quality and cost-efficiency with a two-track program that CMS calls the "Quality Payment Program"

MACRA – the basics

Under the Quality Payment Program, 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, electronic health record (EHR) use, and care improvement – payment bonus or penalty depending on performance, up to 9% after 2021

Final Rule – the basics

Final Rule published October 14, 2016

- 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 must pick one of the two options above, at the pace they choose
- January 1, 2019 – Bonuses and penalties will hit Medicare payments (based on CY 2017 performance)
- Final Rule also makes it easier for clinicians with few Medicare patients to be exempt from adjustments and makes it easier for clinicians who don’t directly treat patients to meet less burdensome requirements
- Final Rule open for comment until December 19, 2016

Quality-based payment:
Putting the Quality Payment Program in context

Quality-based payment – the basics

- 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
- This includes both quality-based adjustments to FFS and alternative payment models that replace FFS (such as accountable care organizations (ACOs))
- Both Medicare/Medicaid and private payers are pushing these initiatives
- In Medicare, the Affordable Care Act (ACA) triggered a big shift to quality-based payment
  - Payments to physicians, hospitals, skilled nursing facilities, dialysis providers all now at least partly quality-based
  - Federal government has public goal of tying 50% of Medicare payments to alternative or bundled payment by end of 2018 and tying 90% of traditional Medicare payments to quality or value

Quality-based payment – Medicare payments to physicians

Physician Quality Reporting System (PQRS)

- % adjustment to Medicare payment for successfully reporting quality measures, regardless of performance

Value-Based Payment Modifier (VBPM)

- Takes physician's performance on PQRS quality measures, balances against cost of care, and calculates the value of the physician's care
- % adjustment to Medicare payment (up or down) based on how well the physician does relative to all other physicians

How does MACRA fit in?

- Replace and enhance existing quality-based payment systems for doctors (PQRS, VBPM, EHR incentive) – seen as too complex and redundant
- Increases the amount of traditional FFS payments at stake (from 4% now to 9% after 2021)
- Also incorporates alternative payment models that many clinicians and other providers are already using by allowing clinicians who participate in these 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 all-payer ACOs (Medicaid, commercial)

When does it take effect?

New Systems: Performance in 2017, consequences in 2019

- The first payment adjustments under MIPS will apply to items and services billed on or after January 1, 2019
- Payment adjustments for 2019 will be based on performance in 2017
- Likewise, first bonuses will be paid in 2019 for participation in advanced APM

Old Systems: Sunset after 2018

- PQRS, VBPM, and EHR incentive all will disappear after 2018
- 2016 will be the last year in which performance matters for the old systems

And…lift-off? – Timing under the Final Rule

The Final Rule slows down implementation of the MIPS payment adjustments by allowing 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.

Who is subject to the new rules?

“Eligible clinicians”

The MIPS payment adjustment will apply 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

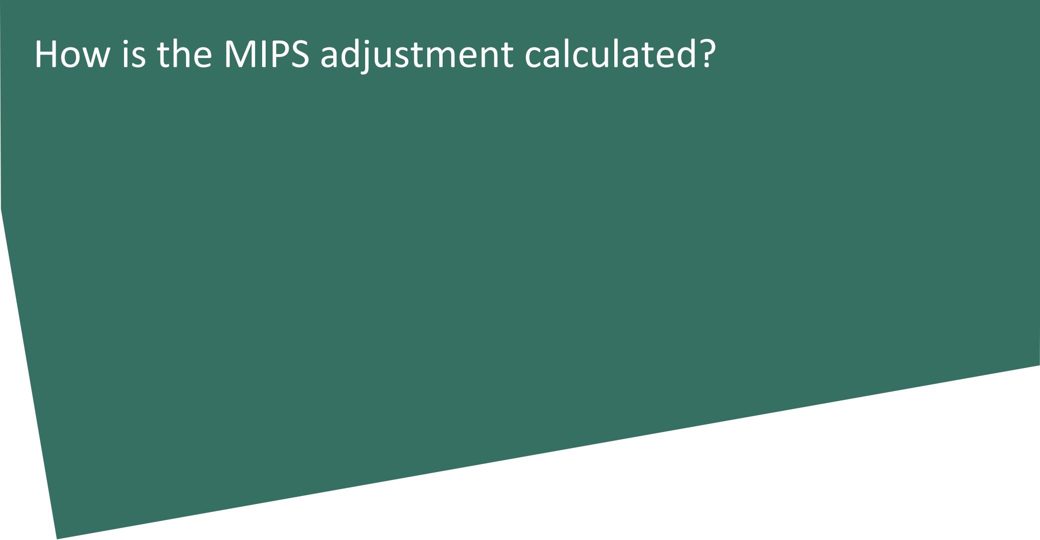
“Eligible clinicians”

“Eligible clinician” excludes clinicians who:

- Recently enrolled in Medicare
- Qualify for the APM incentive for a given year and don’t report MIPS data
- Did not meet the volume thresholds – clinicians are excluded if they *either* had $30,000 or less in Medicare Part B allowed charges *or* saw 100 or fewer Medicare Part B beneficiaries)

Slightly different standards apply to non-patient-facing physicians such as radiologists

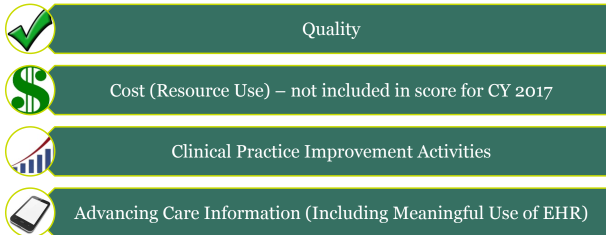
- Defined as 100 or fewer patient-facing encounters (including groups with 75% of national provider identifiers (NPIs) billing under the group’s tax identification number (TIN) are non-patient-facing)
- Need to perform fewer practice improvement activities to get full credit



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 (2019 score and adjustment based on 2017 performance)

Quality score

60% in the first year (2017), going down to 30% by 2019

- Based on performance on quality measures chosen and submitted by the physician
  - Full reporting requires six quality measures (down from nine under current systems)
  - Must include an outcomes-based measure or "high-priority" measure
  - Final Rule eliminates requirement of a "cross-cutting" measure
- Final Rule includes hundreds of quality measures for clinicians to choose from, including pre-selected sets for different specialties
- PQRS/VBPM measures are automatically included unless specifically removed by CMS
- CMS will continue annual call for quality measures

Quality score – Selected final measures for 2017

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 – Final specialty sets for 2017

Final Rule adds a specialty measure set for Oncology

- Divided into two specialty subsets
  - General oncology
  - 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 are also included in the Preventive Medicine specialty set
- CMS also finalizes a Diagnostic Radiology specialty subset that includes some measures related to screening mammography

Oncology specialty subsets

General Oncology

- 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 #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

(cont'd next slide)

NCQA = National Committee for Quality Assurance; PCPI = Physician Consortium for Performance Improvement Foundation; CAP = College of American Pathologists

Oncology specialty subsets

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 1 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 3 days

Oncology specialty subsets

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

Cost score

0% in the first year, 10% in 2018, 30% in subsequent years

- Two overall cost measures apply to all clinicians
  - Total per capita cost for all Medicare fee for service beneficiaries
  - Medicare spending per beneficiary
- Clinicians may also be scored on additional episode-based cost measures if they perform such procedures (only 10 of 41 finalized)
  - Final measures include episode-based measure for mastectomy
  - CMS may add other episode-based measures in later years
- Measures are based on claims data, so physicians don't have to report anything
- CMS finalizes that cost scores will <u>not</u> include Part D drug costs

Clinical practice improvement activities score

15% in the first year and later years

- Based on participating in specified "clinical practice improvement activities" (CPIAs) in nine categories, including:
  - Expanded practice access
  - Beneficiary engagement
  - Achieving health equity
  - Care coordination
  - Participation in an APM
- CMS finalizes more than 90 CPIAs from which to choose, each assigned medium or high weight
- Minimum requirement for the first year is 2 high-weight activities, 4 medium-weight activities, or 1 high-weight and 2 medium-weight activities (continuous over 90 days)
- The more activities you participate in, the higher your score can go

Clinical practice improvement activities – 2017 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

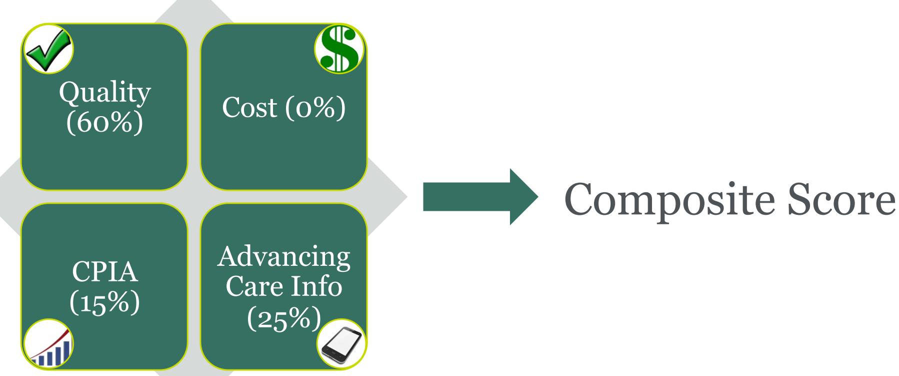
Advancing care information score

25% in the first year and later years, based on two parts:

Base Score	Performance Score

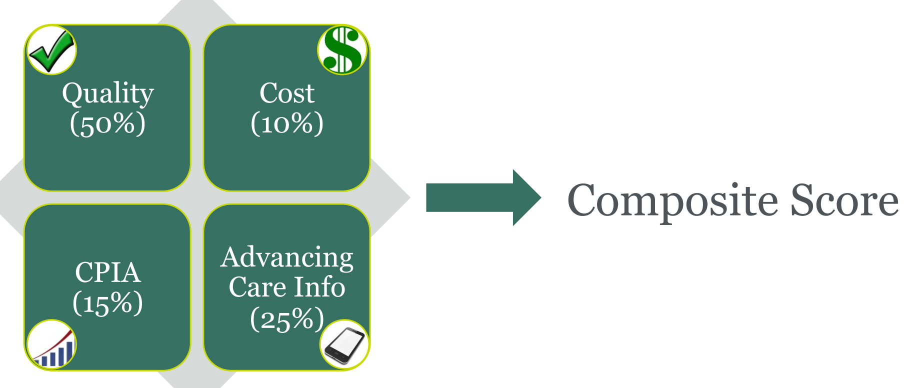
• Worth 50 out of 100 available points
• Requires reporting of 5 measures:
  • Security risk analysis performed (yes required)
  • % of prescriptions by e-prescribing (at least 1)
  • % of patients given timely electronic access to health information (at least 1)
  • % of transitions of care and referrals 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)
	• 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

Putting it all together – CY 2017 (CY 2019 bonus/penalty)



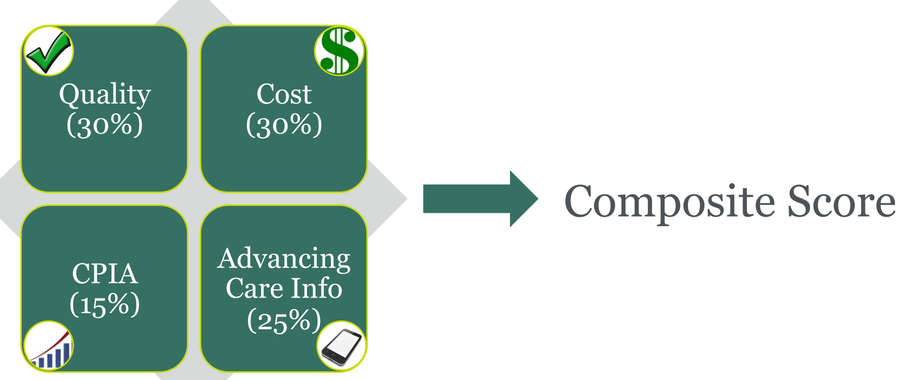
Scores will be reweighted if a clinician does not have sufficient data to earn a score in a particular category.

Putting it all 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 all together – CY 2019 (CY 2021 bonus/penalty)



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

So 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
- For 2019, a physician who opts for the full reporting option can gain or lose up to 4% of Medicare Part B payments for the whole year
- This increases to 5% in 2020, 7% in 2021, and 9% for every year after
- Additional payment bump for "exceptional performance" (top 25% of scores)

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), up to 75% after first year
  - 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 doesn't change the underlying rules of qualifying APMs

Medical Home Models

- Primary care focus
- Patients assigned to a primary clinician
- Meets at least four of the following:
  - Shared decision-making
  - Patient/caregiver engagement
  - Risk-stratified care management
  - Coordination of care across medical neighborhood
  - Coordination of chronic and preventive care
  - Patient access and continuity of care
  - Payment arrangements other than (or in addition to) fee-for-service payment

What types of entities might qualify?

- Final determinations by January 1, 2017
- Final Rule states that a number of prominent APMs will fail the test:
  - 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 will qualify:
  - Oncology Care Model "two-sided" risk arrangement
  - Medicare Shared Savings Program (Track 2 & Track 3)
  - Comprehensive Primary Care Plus model
  - CMMI Models (under Social Security Act section 1115A, other than a Health Care Innovation Award)
  - Demonstrations under the Health Care Quality Demonstration Program

Reward for participation

- 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

Will the APM incentive make a difference?

- CMS estimates that 70,000 to 120,000 physicians will successfully participate in 2017 vs. 592,000-642,000 expected to be subject to MIPS
- APM incentive unlikely to spur new interest in ACOs or other models, but at least protects those who are already participating from MIPS adjustments
- MIPS APMs – clinicians who are participating in an APM that does not qualify for the incentive can still simplify reporting by using the MIPS APM option, which allows the APM entity to report together

The Quality Payment Program

Final Rule Continues the Drive Toward Value-Based Payment

Beth Roberts, Partner
beth.roberts@hoganlovells.com
(202) 637-8626

Andrew Furlow, Senior Associate
andrew.furlow@hoganlovells.com
(202) 637-5843

Beth Halpern, Partner
elizabeth.halpern@hoganlovells.com
(202) 637-8609