MACRA Roadmap: An Overview of the Quality Payment Program in 2019

ACP℠
American College of Physicians
Leading Internal Medicine, Improving Lives

ACP's Take on Major 2019 MIPS Changes

2019 MIPS Policy Change	ACP Perspective
MIPS performance threshold doubled to 30 points; Exceptional threshold increased by 5 points	Need to address lower performance by small and rural practices. Exceptional performance increase cut in half following ACP advocacy.
New "opt-in" option for Low-Volume Threshold	Support. Based on prior ACP advocacy. Increases MIPS participation without adding burden.
Promoting Interoperability scoring overhauled	An improvement, but we need to move away from a stringent set of required measures.
2015 CEHRT required	Support goal to increase interoperability but need more time to implement responsibly.
"Low value" quality measures were retired	Support moving toward reliable, evidence-based, and outcomes-focused quality measures.
New facility-based scoring option	Support. Reduces burden & benefits ECs' scores.
Cost Category increased to 15%; 8 episode-based measures added	Strongly oppose increasing Cost Category weight until all measures are verified as reliable & valid.

ACP's Take on Major 2019 APM Changes

2019 APM Policy Change	ACP Perspective
8% revenue-based risk threshold maintained through 2024	Prior ACP advocacy ask. Provides predictability and consistency for model developers and participants.
QP determinations made at TIN-level (in addition to the NPI and APM Entity levels)	Support. Increases opportunities to qualify for QP status in Advanced APMs.
CEHRT threshold increased to 75%. Must document threshold is being met.	APM CEHRT threshold should not be increased at the same time that clinicians are transitioning to 2015 CEHRT.
New All-Payer Combination Option	Support, but CMS should count all models (including private payer APMs) in 2019.
Other Payer AAPM determinations stand for up to 5 years (provided no changes)	Prior ACP advocacy ask. Reapplying annually adds unnecessary burden.

What didn't change?

- The minimum data reporting period for the MIPS Quality Category is still a full calendar year.
- Each MIPS performance category continues to have its own complex scoring methodology.
- No wholescale changes to reduce MIPS complexity or burden.
- The Centers for Medicare & Medicaid Innovation (CMMI) introduced only 1 new nation-wide Advanced APM in 2018.
  - More expected to be announced in early 2019…

ACP Top QPP Advocacy Asks:

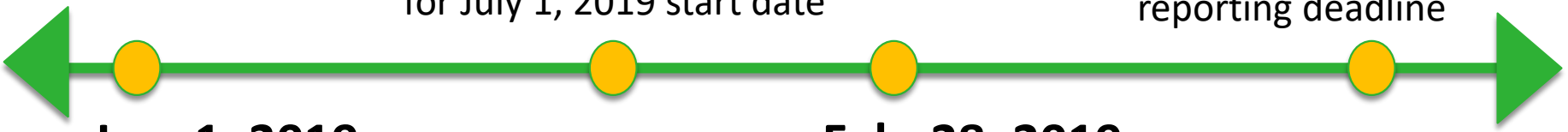
- Streamline MIPS scoring; offer more cross-category credit.
- Reduce MIPS reporting requirements; add more flexibility.
- Finalize consistent 90-day reporting across all MIPS categories.
- Ensure quality and cost metrics are evidence-based, reliable, accurate, and within the clinician's control.
- Improve risk adjustment.
- Level the playing field for small and rural practices .
- Create more opportunities to participate in Advanced APMs.

ACP Advocacy in Action

- Written comments, statements, testimony, and letters
  - Visit our QPP advocacy archive >>
- In-person meetings with senior CMS, Congressional staff 👀
- Coalition building
  - Group of 6
  - MIPS and APM workgroups
- Strategic Advocacy Initiatives
  - Patients Before Paperwork
  - Reducing Administrative Burden

Important QPP Dates & Deadlines to Remember!

Want more? Check out ACP's Physician Practice Timeline >>



Jan. 1, 2019

- 2019 MIPS $ adjustments & QP bonuses applied based on 2017 data
- Check *final* 2018 MIPS eligibility status before reporting 2018 data
- 2019 performance period begins

Feb. 19, 2019

MSSP application deadline for July 1, 2019 start date

Feb. 28, 2019

2018 deadline for reporting optional CAHPS data

March 31, 2019

2018 MIPS data reporting deadline

Quality Payment Program (QPP) Deep Dive:

What you Need to Know in 2019

MIPS

Merit-based Incentive Payment System

Who Participates in MIPS?

Carried over from 2018:

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

New additions in 2019:

- Physical Therapists
- Occupational Therapists
- Qualified speech-language pathologists
- Qualified audiologists
- Clinical psychologists
- Registered dietitians or nutrition professionals

Who does NOT participate in MIPS?

Automatic Exclusions:

- QP or Partial QP in Advanced APM
- 1st year enrolled in Medicare
- Below Low-Volume Threshold
- Excluded practitioner types
- Neutral adjustment for MIPS Eligible Clinicians (ECs) who join a new TIN in Oct-Dec if: *

  1) TIN is newly formed **or**
  2) Practice does NOT report as a group

Check your MIPS eligibility status

Application-Based Exclusions:

- Extreme & uncontrollable circumstances hardship
  - Due Dec. 31st every year
  - Can be submitted at TIN-level *
- MA Qualifying Payment Arrangement Incentive (MAQI) Demo excludes ECs with significant combined participation in qualifying MA and Medicare APMs *

  2018: 25% of $ **or** 20% of patients

  2019-2020: 50% of $ **or** 35% of patients

Low-Volume Threshold

Excluded individuals or groups must meet one of the following criterion:

- ≤ $90,000 Part B allowed charges **OR**
- ≤ 200 Part B patients **OR**
- New in 2019! ≤ 200 covered professional services under the PFS

New in 2019! Clinicians, groups or APM Entities may "opt-in" to MIPS if they meet 1-2 criteria (but not all 3)

ACP Win!

2019 Data Submission Changes

- **Oversight:** Greater oversight, penalties for vendors who submit inaccurate data
- **Part B claims:** Only available to small groups (can be reported at NPI or TIN-level)
- **Web Interface:** Can only be used to report quality data; no more bonus points
- **QCDRs:** Developers must have clinical expertise in medicine and quality measure development and must allow any QCDR to use their measure

  ACP, others warned the latter could disincentivize future development of QCDR measures. ACP urged CMS to instead post measures under development so vendors can collaborate.

- **CAHPS survey:** Incomplete measures won't be scored (in these cases the Quality Category would be scored out of 50 points to not penalize clinicians)
- **Measure validation criteria:** Only applied to MIPS CQMs & claims (not eCQMs)
- **Data completeness criteria:** Remains at 60% for most submission types

2019 MIPS Terminology Changes

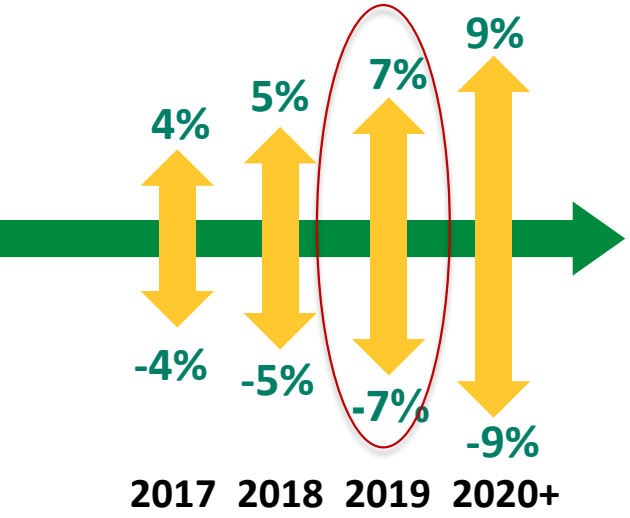
- **MIPS Clinical Quality Measures (CQMs):** Formerly registry measures
- **Collection type:** Set of quality measures with specifications and data completeness criteria (e.g. eCQMS, MIPS CQMs, QCDR measures, Part B claims measures, Web Interface measures, CAHPS survey measures, and administrative claims measures)
- **Submitter type:** EC, group, or 3rd party intermediary that submits data
- **Submission type:** Mechanism by which data is submitted (e.g. direct, log in and upload, log in and attest, Part B claims, and Web Interface)
- **3rd party intermediaries:** Entities that have been approved to submit data on behalf of a clinician, group or virtual group (e.g. QCDRs, qualified registries, health IT vendors, or CMS-approved survey vendors)

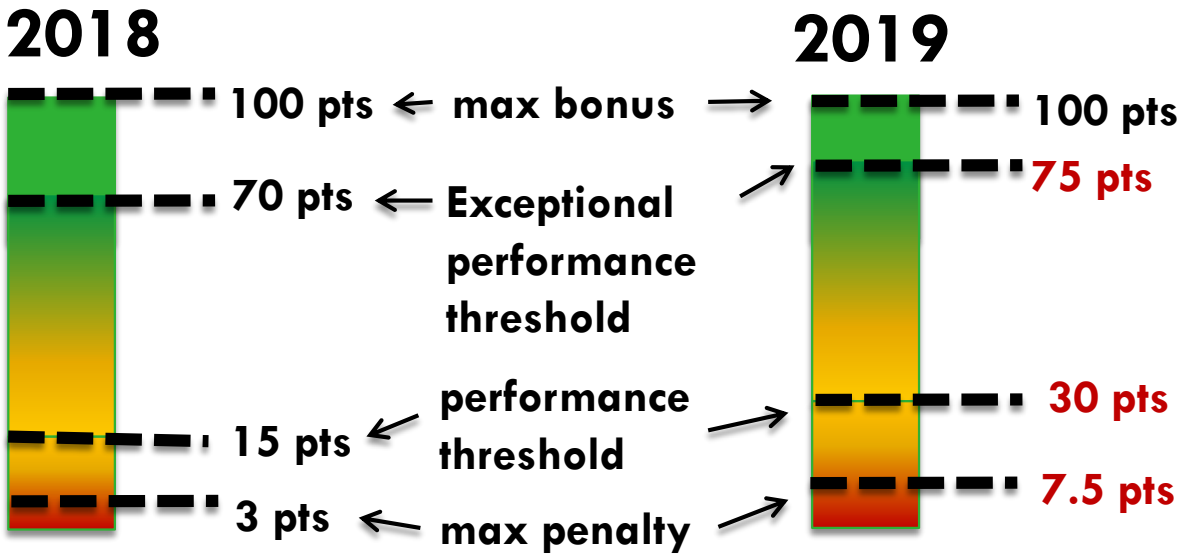
MIPS Payment Adjustments

Standard MIPS adjustments are budget neutral

Based on allowed charges for Part B covered professional services

The BBA excluded Part B drugs from MIPS payment adjustments & extended MIPS performance threshold flexibility through 2021





Performance Category Weighting

Performance Category	2018	2019
Quality	50%	45%
Cost	10%	15%
Improvement Activities	15%	15%
Promoting Interoperability	25%	25%

* BBA extended flexibility for setting weight of Cost Category through 2021 (though it cannot be <10%)

MIPS APM Scoring Standard

What is a MIPS APM? Either:

- Does not meet qualifications to be considered an Advanced APM
- Qualifies as an Advanced APM but individual APM Entity did not meet Qualified APM Participant (QP) thresholds and therefore has the option to participate in MIPS under the MIPS APM scoring standard

What are the advantages?

- Streamlines certain MIPS reporting & scoring
- MIPS scores aggregated at the APM Entity level
- Generally automatic full credit toward IA Category
- MIPS performance categories are weighted differently

  Quality: 50% Cost: 0% IA: 20% PI: 30%

List of 2019 MIPS APMs

New in 2019! Facility-Based Scoring Option

- Uses data from Hospital VBP Program for MIPS Quality, Cost scores
- Score is based on corresponding percentile score
- Automatically applied only if it benefits a clinician's/group's score
- Must report IA or PI data as a group to be evaluated as a group
- ACP supports because it minimizes burden, only benefits MIPS scores

	Eligibility	Attribution
ECs	Bill at least 1 service with POS codes 21, 23 AND furnish 75%+ of services in POS codes 21, 22, or 23	Attributed to hospital where he/she provides services to majority of patients
Groups	At least 75% of the clinicians billing under the TIN qualify for facility-based scoring as individuals	Attributed to hospital where majority of group's clinicians are attributed

New Streamlined MIPS Determination Period

Aligns with fiscal year & features two segments:

- 1st: Oct. 2017 - Sept. 2018 (30-day claims run-out)
- 2nd: Oct. 2018 - Sept. 2019 (no claims run-out)

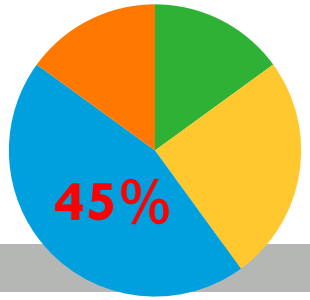
***Clinicians/groups only have to qualify during one**

Applies to the following determinations:

- Low-volume threshold
- Non-patient facing
- Small practice
- Hospital-based
- ASC-based
- Virtual groups*
- Facility-based*

* Use only 1st segment

Quality



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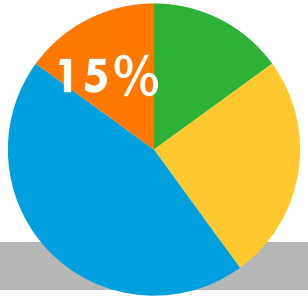
50-70 pts

- Full-year reporting
- 26 “low-value” measures removed
- “Extremely” topped out measure may be removed sooner than 4 years
- Measures significantly impacted by clinical guideline changes/patient safety concerns won’t be scored; Quality would be scored out of 50 points
- 2019 Benchmarks based on collection type (not submission mechanism)
- Opioid-related measures added to list of high-priority measures
- **Starting in 2020**, most will earn 0 points for incomplete measures (small practices will continue to earn 3 points)
- Complete measures will continue to earn at least 1 point

Cost



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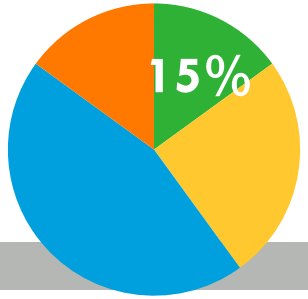
20-100 pts

- Weight increased to 15%
- No credit for improvement until 2022 under BBA
- MSPB and TPCC measures will continue to count
  - CMS is considering substantial changes to these measures in the future
- 8 brand-new episode-based measures
  - Risk-adjusted and payment-standardized
  - Based on allowed amount from Medicare Parts A & B claims
  - Case min. = 10 for procedural; 20 for acute inpatient condition episodes
  - ACP expressed concern over low reliability for these measures

Improvement Activities



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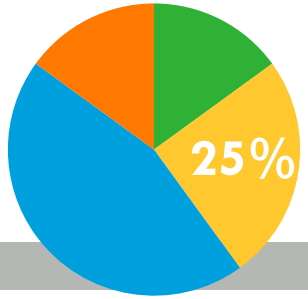
40 pts

- 2019 Improvement Activities inventory
- Reminder: Only 1 clinician in group has to perform activity
- Small practices, non-patient facing clinicians & clinicians located in rural practices/HPSAs continue to get points double counted
- MIPS APMs, PCMHs & PCSPs get full credit (must attest)
- Process to submit, approve new activities now earlier, longer
- Web Interface can no longer be used to submit activities

Promoting Interoperability



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100 pts

- 2015 CEHRT now required
- No more separate performance, base, and bonus scores
- Every measure scored independently based on performance
- Now 6 required measures (i.e. must report or claim an exclusion or you will earn a zero for the entire performance category)
- No more bonus points for end-to-end reporting
- Web Interface can no longer be used to submit data
- Bonus points for 2 new optional opioid-related measures

2019 PI Objectives & Measures

Objectives	Measures	Maximum Points
e-Prescribing	! e-Prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	! Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	! Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	! Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	! Choose two: • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

! denotes required measures

Note: Security risk analysis continues to be required but is not worth points

PI Category Level Exceptions

Automatic Exceptions:

- Non-patient facing
- Hospital-based or ASC-based ECs
- Non-physician ECs
- Extreme circumstances determined by CMS

Application-Based Exceptions:

- Small practices
- Lack of control over CEHRT availability

25% redistributed to Quality Category

Note: The PI Category will be scored if data is submitted!

Advanced Alternative Payment Models (APMs)

Step 1: What Makes an *Advanced* APM?

1. Use CEHRT

   75%+ of clinicians must use CEHRT (up from 50%)*

   Must now provide documentation that threshold is being met*

2. Base payment on quality measures comparable to MIPS

3. Either:
   - Are a Medical Home Model under CMMI **or**
   - Bear more than "nominal" financial risk…
     - 3% of estimated expenditures (e.g. benchmark); OR
     - 8% of average est. Parts A & B revenue (through 2024*)

* New in 2019

2019 Medicare Advanced APMs

- Medicare Shared Savings Program (MSSP) Tracks 1+, 2, 3
- Next Generation ACOs
- Comprehensive Primary Care Plus (CPC+)
- Comprehensive ESRD Care (CEC) Model
- Oncology Care Model (OCM) (2-sided risk)
- Comp. Care for Joint Replacement (CJR) Model (CEHRT track)
- Bundled Payments for Care Improvement (BPCI) Advanced
- Vermont Medicare ACO Initiative
- Maryland All-Payer and Total Cost of Care Models (Primary Care and Care Redesign Programs)

Step 2: Do I qualify as a *Qualified Participant?*

Can qualify through…

* New in 2019

- Medicare Option **or**
- All-Payer Combination Option*
  - Medicaid, MA & CMMI multi-payer models count starting in 2019
  - Private payer APMs will count starting in 2020

^ Payers, clinicians & groups can submit models for approval as Other Payer APMs starting next year

Check your QP status >>

Step 2: Do I qualify as a *Qualified Participant?*

2019-2020 Medicare Threshold Option

	Payments	Patients
QP	50%	35%
Partial QP	40%	25%

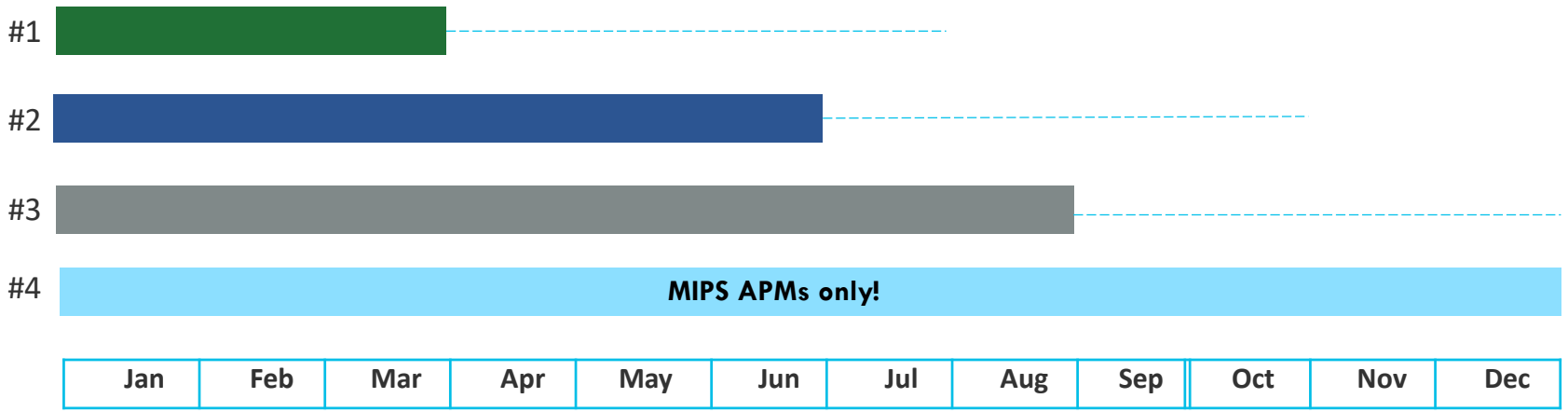
2019-2020 All-Payer Combination Threshold Option

	Payments	Patients
QP	50% (25%)	35% (20%)
Partial QP	40% (20%)	25% (10%)

( ) denotes Medicare Minimum

QP Status "Snapshot" Dates

- 3 "snapshots" all start Jan 1 & end Mar 31, June 30, or Aug 31
- Must surpass threshold during **at least** 1 snapshot
- 4th snapshot added on Dec. 31st for MIPS APMs **only**
- QP determinations now available at TIN level*
- Check your QP status: https://data.cms.gov/qplookup



Step 3: What's the *incentive*?

Qualified Participants ("QPs"):

1. NOT subject to MIPS
2. Receive 0.5% higher PFS update for 2026 onward
3. Share in rewards of APM
4. Receive 5% lump sum bonus in 2019-2024

Partial QPs:

1. Have the option to participate in MIPS
2. Receive favorable scoring if they do
3. Share in rewards of APM

MSSP

Medicare Shared Savings Program

Timing

- July 1, 2019 start date under newly finalized rules
  - Non-binding but required letters of intent are due **Jan. 18**
  - Applications due **Feb. 19**
- ACOs may complete current contracts **or** terminate early and begin a new 5-year agreement period under updated rules on July 1
- Voluntary 6-month extension for ACOs whose contracts would end Dec. 31, 2018 to avert participation disruptions
- Next start date will be Jan. 1, 2020 with applications in Spring 2019

New Tracks

BASIC: Starts as a one-sided model then incrementally phases-in more risk until the final level qualifies as an Advanced APM

ENHANCED: Based on existing Track 3; highest levels of risk, reward

	BASIC					ENHANCED
	Level A	**Level B**	**Level C**	**Level D**	**Level E**	
Min. Savings Rate	**2-3.9%** based on beneficiary population		Choice of symmetrical MSR/MLR of **0%, 0.5%, 1%, 1.5%, 2%, or 2-3.9%** based on beneficiary population			
Max. Savings Rate	**40%** (up to **10%** of benchmark)		**50%** (up to **10%** of benchmark)			**75%** (up to **20%** of benchmark)
Min. Loss Rate	N/A		**30%** (up to **2%** of revenue; **1%** of benchmark)	**30%** (up to **4%** of revenue; **2%** of benchmark)	**30%** (up to **8%** of revenue; **4%** of benchmark)	**40-75%** (up to **15%** of benchmark)

Qualifies as an Advanced APM

*Final sharing rate for Levels A, B was increased from 25% following ACP advocacy

Time in 1-Sided Risk

- ACOs can progress to higher levels of risk at the start of any year.
- Most ACOs can spend max 2 years in 1-sided risk (BASIC Levels A & B).
  - ACOs with prior experience in ACO models will be allowed less time in one-sided risk or required to enter at higher levels of risk.
  - New, low revenue ACOs can spend up to 3 years in one-sided risk (but must advance straight to Level E in year 4).
- Low-revenue ACOs can enter a 2nd agreement period in the BASIC track under Level E. High revenue ACOs must move on to the ENHANCED track.

An ACO is considered "low-revenue" if its total Medicare Parts A & B FFS revenue is less than 35% of its total Medicare Parts A & B FFS expenditures for assigned beneficiaries.

An ACO is considered "experienced" if at least half its clinicians have prior experience in a Medicare ACO program. The terms depend on if they previously faced downside risk and if they are renewing or re-entering. See Tables 6-7.

Note: ACOs that start July 1, 2019 would have an additional 6 months in 1-sided risk

Financial Benchmarks

- Institutes 5-year agreement periods
- Begins phasing-in regional expenditures in 1st agreement period
- Reduces weight of regional adjustment to 50% (from 75%) and caps at 5% of national per capita expenditures
- Increases weight of national update factor as ACO's penetration in region increases
- Slows phasing-in of regional adjustment for ACOs with above-average spending relative to their region
- Allows for increases in risk scores (capped at 3% over 5 years)
  - No cap on risk score decreases

Non-Financial Incentives

- Expanded coverage of telehealth services for risk-bearing ACOs with prospective assignment to include services furnished:
  - Outside approved geographic service areas
  - Inside beneficiaries' homes
- Expanded SNF 3-day rule waivers
  - Available to all risk-bearing ACOs regardless of beneficiary assignment
  - CAHs and swing bed hospitals now eligible SNF affiliates
- 2-sided ACOs can implement Beneficiary Incentive Programs (BIPs)
  - In-kind items or services related to medical care
  - Incentive payments up to $20 for qualifying primary care services

Beneficiary Attribution, Notification

- Annual selection between prospective assignment or preliminary prospective assignment with retrospective reconciliation
- New qualifying PC services, including advanced care planning
- Certain voluntary beneficiary assignment requirements lifted:
  - Beneficiaries may designate specialists as their PCP
  - Beneficiaries are no longer required to receive at least 1 PC service
  - Beneficiaries remain assigned for subsequent years unless status changes
- CMS considering changes to beneficiary opt-in based assignment
- ACOs must notify beneficiaries annually about participating clinicians, data sharing, voluntary assignment, and BIPs

Data Reporting & Feedback

- PI data can be reported at NPI-level (in addition to TIN-level)
- Performance feedback can be accessed at TIN-level
- 10 quality measures removed; 2 added (See Table 27)
- **ALL** ACOs must certify that at least 50% of ECs use 2015 CEHRT
- For two 6-month agreement periods in 2019, financial and quality data will be calculated based on the entire year, then prorated

Repayment Mechanisms

- Required min. duration of repayment mechanism reduced 1 year
  - Renewing ACOs only have to extend 2 additional years up front
- Repayment $ recalculated annually due to participant list changes
  - Must secure more funding if amount increases by 50% or $1 million
- More stringent requirements for financial issuing institutions
- New qualifying repayment mechanisms:
  - Placing funds in escrow
  - Establishing a line of credit with an insured institution (incl. credit unions)
  - Obtaining a surety bond

Program Integrity

- ACOs with prior experience must advance to risk faster
- ACOs can be terminated for multiple years of poor $ performance
- Financial, quality performance will be considered for renewals
- ACOs terminating early will owe pro-rated shared losses

Educational QPP Resources:

- ACP's Analysis of 2019 Physician Fee Schedule/ QPP final rule
- ACP comments on final rule; proposed rule
- CMS' executive summary; fact sheet on final rule
- CMS' fact sheet on 2019 MIPS payment adjustments
- 2019 PFS/QPP final rule
- CMS QPP Resource Center
- CMS QPP Participation Status Lookup Tool
- ACP Physician Practice Timeline
- ACP QPP Resource Page

ACP Practice Support Tools

ACP Advance

Physician-led coaching for quality improvement

Quality Connect

Collaborative networks of learning centered on clinical conditions

The Genesis Registry®

CMS approved QCDR

Practice Advisor

Online practice management tool with tips to improve your practice

Appendix

Glossary of MIPS Special Scoring Status

- **Non-patient facing:** ECs that bill 100 or fewer patient-facing encounters and groups in which 75%+ of clinicians meet this definition
- **Small practice:** 15 or fewer clinicians
- **Rural practice:** in health professional shortage area (HPSA) zip code
- **Hospital-based:** furnish 75%+ of services in POS codes 19, 21, 22, 23
- **ASC-based:** furnish 75%+ of services in POS code 24
- **Virtual groups:** 2+ TINs of ≤10 clinicians with at least 1 MIPS EC
- **Facility-based:** ECs that bill at least 1 service at POS codes 21, 23 AND furnish 75%+ of covered professional services in POS codes 21, 22, 23 and groups in which 75%+ of clinicians meet this definition

ACP's QPP Acronyms Glossary

ACO: Accountable Care Organization
APM: Alternative Payment Model
ASC: Ambulatory Surgical Center
BBA: Bipartisan Budget Act of 2018
BPCI: Bundled Payments for Care Improvement
CAH: Critical Access Hospital
CAHPS: Consumer Assessment of Healthcare Providers & Systems
CEC: Comprehensive ESRD Care
CEHRT: Certified Electronic Health Record Technology
CJR: Comprehensive Joint Replacement
CMS: Centers for Medicare & Medicaid Services
CMMI: Centers for Medicare & Medicaid Innovation
CPC+: Comprehensive Primary Care Plus
CQM: Clinical Quality Measure
EC: (MIPS) Eligible Clinician
eRx: e-prescribing
ESRD: End-State Renal Disease
FFS: Fee For Service
HIE: Health Information Exchange
HPSA: Healthcare Professional Shortage Area
IA: Improvement Activities
LVT: MIPS Low Volume Threshold
MA: Medicare Advantage
MAQI: MA Qualifying Payment Arrangement Incentive
MHM: Medical Home Model
MIPS: Merit-based Incentive Payment System
MLR: Minimum Loss Rate
MSPB: Medicare Spending Per Beneficiary
MSR: Minimum Savings Rate
MSSP: Medicare Shared Savings Program
NPI: National Provider Identifier
OCM: Oncology Care Model
PCMH: Patient-Centered Medical Home
PCSP: Patient-Centered Specialty Practice
PI: Promoting Interoperability
QCDR: Qualified Clinical Data Registry
QP: Qualified APM Participant
QPP: Quality Payment Program
SNF: Skilled Nursing Facility
TIN: Tax Identification Number
TPCC: Total Per Capita Cost
VBP: Value-Based Purchasing