NATIONAL VALUE-BASED PAYMENT AND PAY FOR PERFORMANCE SUMMIT

MARCH 2, 2018

The Centers for Medicare and Medicaid Services

Kate Goodrich, M.D., MHS

Director, Clinical Standards & Quality and Chief Medical Officer

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

A Value-Based System Requires Focusing on How We **Pay Providers, Deliver Care,** and **Distribute Information**

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provider better care at lower cost across the health care system.

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

PATIENTS OVER PAPERWORK

OUR TOP PRIORITY AT CMS IS PUTTING PATIENTS FIRST

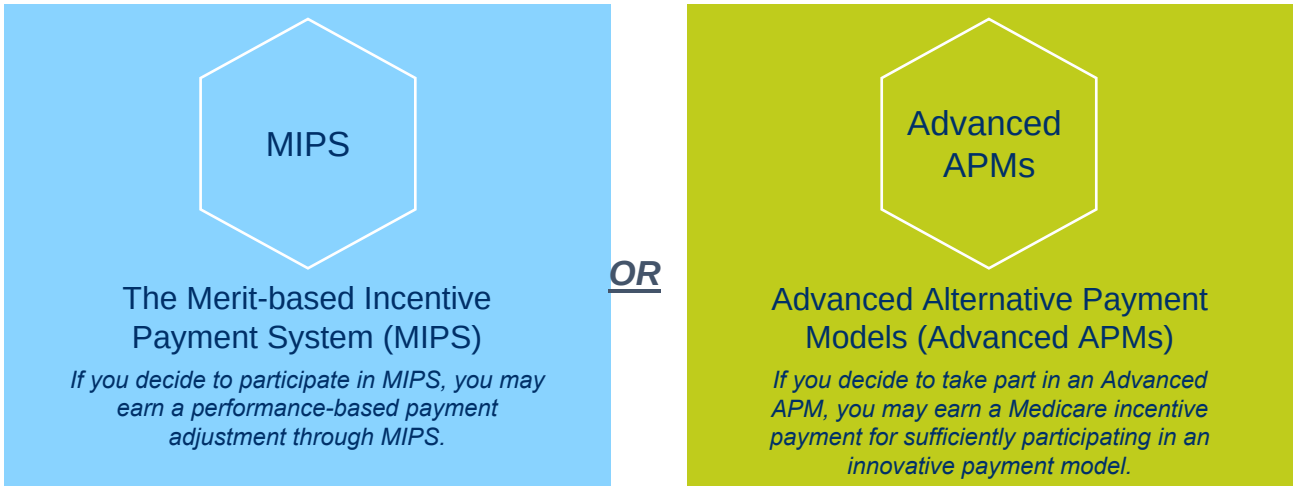
CMS is committed to reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience.

Quality Payment Program

The Quality Payment Program:

•We've heard concerns that too many quality programs, technology requirements, and measures get between the doctor and the patient. That's why we're taking a hard look at reducing burdens. By proposing this rule, we aim to improve Medicare by helping doctors and clinicians concentrate on caring for their patients rather than filling out paperwork. CMS will continue to listen and take actionable steps towards alleviating burdens and improving health outcomes for all Americans that we serve.

Clinicians have two tracks to choose from:



Quality Payment Program

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

MIPS Year 2 (2018)

Who Is Included?

***No change** in the types of clinicians eligible to participate in 2018*

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Eligibility Year 2

***Change** to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

- **Transition Year 1 (2017) Final**

BILLING >$30,000 AND >100

- **Year 2 (2018) Final**

BILLING >$90,000 AND >200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

MIPS Year 2 (2018)

Performance Period

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Advancing Care Information	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

MIPS Performance Categories Year 2

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Cost Category in Year 2

Basics:

- ***Change:*** **10% Counted toward Final Score in 2018**
- **Medicare Spending per Beneficiary (MSPB) and total per capita cost** measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

- *Change*: Cost performance category weight is **finalized at 10% for 2018.**
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.

NEW: Virtual Groups in Year 2

What is a virtual group?

- A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioners** who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

Performance Threshold Year 2

CHANGE: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

•Report all required Improvement Activities.
•Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
•Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
•Submit 6 Quality measures that meet data completeness criteria.

ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

Advanced APMs

Generally Applicable Nominal Amount Standard

Transition Year 1 (2017) Final

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 (2018) Final

**The 8% revenue-based standard is extended for two additional years, through performance year 2020.

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for QP Performance Periods 2017, 2018, 2019, and 2020, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Advanced AMPs

Medical Home Model

A Medical Home Model is an APM that has the following features:

Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.

Empanelment of each patient to a primary clinician; and

At least four of the following additional elements:

- ☐ Planned coordination of chronic and preventive care.
- ☐ Patient access and continuity of care.
- ☐ Risk-stratified care management.
- ☐ Coordination of care across the medical neighborhood.
- ☐ Patient and caregiver engagement.
- ☐ Shared decision-making.
- ☐ Payment arrangements in addition to, or substituting for, fee-for-service payments.

Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Advanced APM.

Advanced APMs

Overview: All-Payer Combination Option

- The All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP for a year.
- QP Determinations under the All-Payer Combination Option will be based on an eligible clinicians' participation in a combination of both Advanced (Medicare) APMs and Other Payer Advanced APMs.
- QP Determinations are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option.
- Only clinicians who do not meet the minimum patient count or payment amount threshold to become QPs under the Medicare Option (but still meet a lower threshold to participate in the All-Payer Combination Option) are able to request a QP determination under the All-Payer Combination Option.
- The All-Payer Combination Option is available beginning in the 2019 QP Performance Period.

Advanced APMs in 2017

For the 2017 performance year, the following models are Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.

Bundled Clinical Episodes: A New Concept

- BPCI Advanced requires new thinking
- Participants must now coordinate the entire episode

FFS

Bundled Clinical Episode

Hospital

Hospital

SNF

Patient's Home

Cardiologist

PCP

BPCI Advanced is Different Than BPCI

Streamlined design

- One model, 90 day episode period
- Single risk track
- Inpatient and Outpatient episodes
- Preliminary target prices provided in advance
- Payment tied to performance on quality measures

Greater focus on **physician engagement and learning**

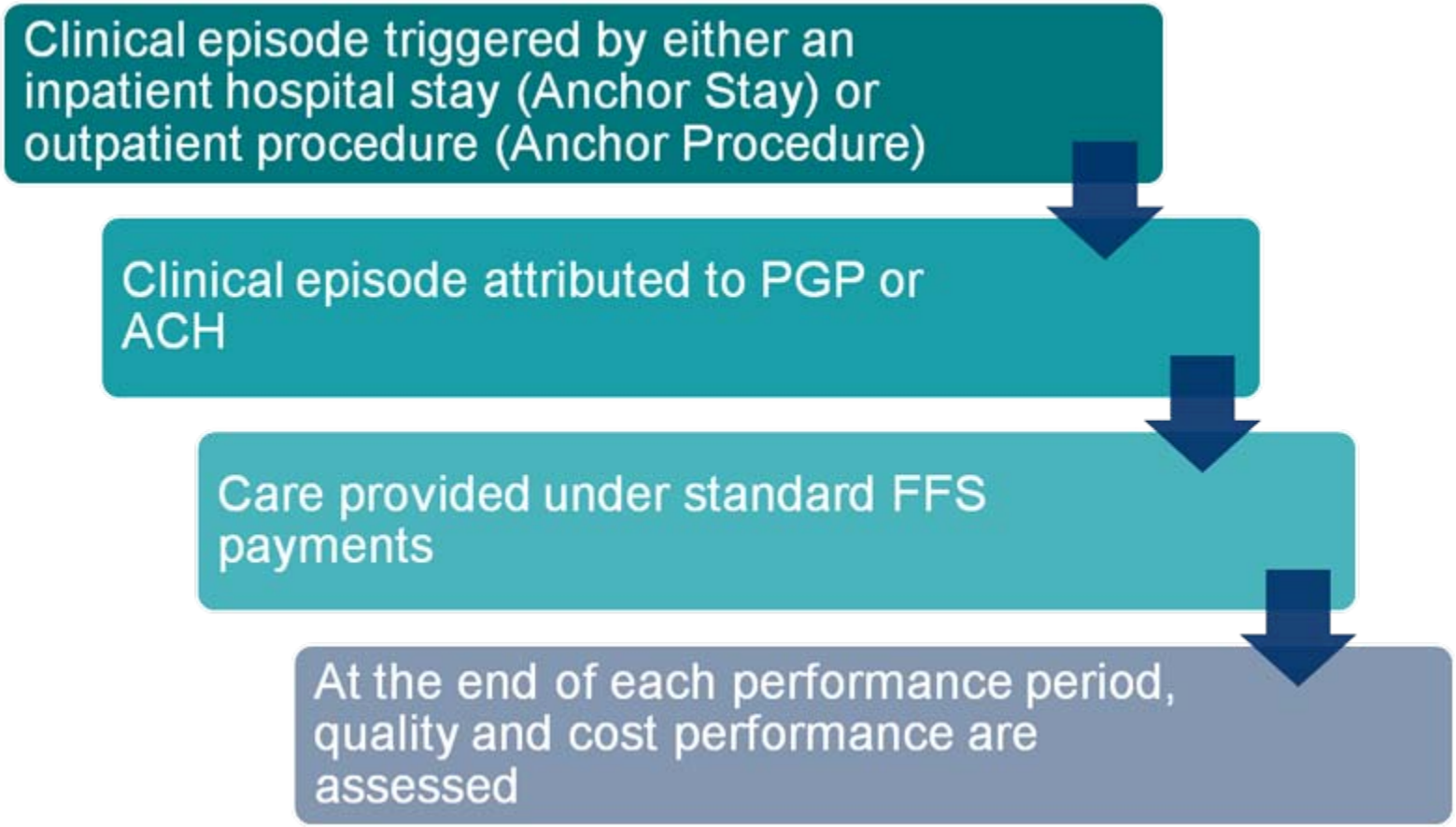
Designed as an **Advanced APM** under the Quality Payment Program

Who Leads Clinical Episodes?

Physician Group Practices (PGPs)

Acute Care Hospitals (ACHs)

How Does BPCI Advanced Work?



Key Dates


START
Request for Applications Released 1/9/2018
Application Portal Opens 1/11/2018
Application Portal Closes 3/12/2018
CMS screens Applicants
March – June 2018
CMS distributes Target Prices to Applicants
May 2018
CMS offers Participant Agreements to Applicants
June 2018
Signed Participant Agreements due to CMS
August 2018
Clinical Episode selections and program deliverables due to CMS
August 2018
Model Go Live 10/1/18
First date for QP determination
March 31, 2019
Next Application Period 1/1/20
JOURNEY CONTINUES
UNTIL 12/31/23

Data Submission

- Single site to submit all data
- Designed using Human-centered design techniques
  - Frequent proto-typing and testing with practicing clinicians and practice managers
- On-screen notifications and warnings
- Drag and drop File Upload
- No “Submit” button
- Submit data as often as you like
- Real-time performance category scoring
  - New “claims to quality” feature
  - Scoring changes if you upload new data – you can re-submit data any time
- **Data submission ends March 31st, 2018**

Legislative Changes to MACRA
Bipartisan Budget Act of 2018

- Additional 3 years to phase in cost category
- Eliminates requirement to score improvement in the cost category for the first 5 years
- Additional 3 years to set performance threshold at mean or median
- MIPS payments and eligibility based on “covered professional services” rather than Part B items and services
  - Part B drugs no longer included

What's Next?

- 2018 Eligibility look-up for MIPS
- Predictive Qualified Participant status (Advanced APMs)
- Multi-payer Advanced APMs
- Feedback reports
  - New look and feel
  - Easier to access
  - Will include MIPS payment adjustment in addition to quality/cost performance information
- Year 3 rule-making
  - Reviewing flexibilities provided in the CR bill
  - Simplification of some of the complex policies and scoring
  - Facility-based scoring details
  - Exploring ways to further reduce burden on clinicians

Contact Information

Kate Goodrich, MD, MHS

Director, Center for Clinical Standards and Quality
Chief Medical Officer

Centers for Medicare and Medicaid Services

410-786-6841 | kate.goodrich@cms.hhs.gov


DEPARTMENT OF HEALTH & HUMAN SERVICES · USA


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES