Quality Payment Program: What Ob-gyns Need to Know for 2018

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MACRA QPP

Background
What is MACRA?

• The Medicare Access and CHIP [Children’s Health Insurance Program] Reauthorization Act of 2015 (MACRA) replaced the faulty sustainable growth rate (SGR).

• MACRA passed with near-unanimous bipartisan support in both the House and the Senate.

• The intent of the law is to move physicians and other providers to deliver care that is reimbursed through an alternative payment model (APM) and ensure that payments are tied to quality.
Quality Payment Program

• CMS has renamed MACRA the Quality Payment Program (QPP).
• The final rule was released on November 2 and is more than 1,600 pages.
• ACOG submitted comments in response to the proposed rule and provided suggestions of how CMS can improve its proposal.
• Some of ACOG’s recommendations have been incorporated into the final version of the QPP.
Two Different Tracks

Merit-based Incentive Payment System (MIPS)
or
Advanced Alternative Payment Models (APMs)
Key Changes from Last Year

• Different low-volume threshold for individuals and groups: \( \leq \$90,000 \) in Medicare Part B charges or \( \leq 200 \) Medicare patients.

• Cost performance will be measured.

• Data completeness thresholds increased from 50% to 60% for quality performance.

• Quality and cost performance categories require a full year of data (advancing care info and improvement activities still \( \geq 90 \) days).
MIPS

Merit-based Incentive Payment System
Merit-based Incentive Payment System (MIPS) Summary

- Sunsets current Meaningful Use (MU), Value-based Payment Modifier (VM), and Physician Quality Reporting System (PQRS) programs at the end of 2018, rolling requirements into a single program.
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified nurse anesthetists.
Overview of MIPS: Who Is Exempt

• Ob-gyns who are new to billing Medicare.

• Qualifying Participant (QP) under an Advanced APM.

• Individuals and groups that meet the low-volume threshold of ≤$90,000 in Medicare allowed charges or ≤200 Medicare patients.
MIPS Performance Categories

- MIPS is made up of 4 performance categories:
  - Quality
  - Cost
  - Improvement Activities
  - Advancing Care Information
- The category weights will change during the first 3 years of the program to give less weight to quality scores and more weight to cost over time.

Last updated 12/15/17.
Quality Performance Category

• Clinicians choose 6 measures to report.
  o One measure must be an outcome measure or another high-priority quality measure
  o For groups with ≥ 16 clinicians, CMS will automatically calculate all-cause hospital readmission based on claims
  o CMS identified 27 measures for obstetrics and gynecology

• Reporting period is the full year.
• If reporting via claims, you must report on 60% of Medicare Part B patients.
• If reporting via qualified registry, qualified clinical data registry (QCDR), or electronic health record (EHR), you must report on 60% of ALL patients.
Quality Performance Reporting

Individual reporting options:

- Claims
- QCDRs
- Qualified Registries
- EHRs

Group reporting options:

- QCDRs
- Qualified Registries
- EHRs
- CMS Web Interface
- CMS-approved survey vendor for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS

Last updated 12/15/17.
Cost Performance Category

• Will account for 10% of final score.
• Will be based on:
  o Total per capita cost
  o Total spending per Medicare beneficiary
• Calculated through claims, no reporting requirements.
• Full year of data used to calculate measures.
Advancing Care Information

• In 2018, there are 2 measure sets for reporting based on your EHR version.
  o For 2015 EHR standards, the measure set is known as Advancing Care Information Objectives and Measures
  o For 2014 EHR standards, the measure set is known as 2018 Advancing Care Information Transition Objectives and Measures
  o Practices have the option of reporting a combination of the 2 sets
• Bonus available for practices that report entirely using 2015 certified electronic health record technology (CEHRT).
Advancing Care Information Performance Category Components

Base Score + Performance Score = Total Performance Category Score
Advancing Care Information Base Score

• **No changes to the base score requirements.**

• The base score accounts for 50 points of the total Advancing Care Information category score.

• To receive the base score, clinicians must provide the numerator/denominator or yes/no for each objective and measure.

• If you do not report all of the base score measures, you cannot receive any credit for this category.
Advancing Care Information Performance Score

• If you achieve the full base score, you can earn up to 90 points in the performance score.

• You can earn 10% of your score from reporting to any single public health agency or clinical data registry.

• You can also receive a 5% bonus for reporting to an additional agency or registry.

• All other scoring and reporting requirements are the same from last performance period.
Improvement Activities Performance Category

• No major changes to requirements from last year.
• There are more than 110 activities from which to choose.
• Must achieve 40 points to get the full score in this category.
• CMS has provided 2 different weights to activities.
  o Highly-weighted activities are worth 20 points
  o Medium-weighted activities are worth 10 points
MIPS Data Reporting: Quality

Individual reporting options:
- Claims
- QCDRs
- Qualified Registries
- EHRs

Group reporting options:
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- CMS Web Interface
- CMS-approved survey vendor for CAHPS for MIPS

Last updated 12/15/17.
**MIPS Data Reporting: Advancing Care Information and Improvement Activities**

<table>
<thead>
<tr>
<th>Individual reporting options:</th>
<th>Group reporting options:</th>
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<tr>
<td>• Attestation</td>
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<tr>
<td>• QCDRs</td>
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<td>• Qualified Registries</td>
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<tr>
<td>• EHRs</td>
<td>• EHRs</td>
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<tr>
<td></td>
<td>• CMS Web Interface for groups of 25 or more</td>
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Last updated 12/15/17.
Scoring Improvement in Quality and Cost

• Quality improvement
  o Assessed at the category level
  o Up to 10 percentage points available
  o Only positive gains will be included

• Cost improvement
  o Assessed at the measure level
  o Must have a statistically significant change in measure performance
  o Up to 1 percentage point available
MIPS Bonus Points

• Complex patients bonus
  o Earn up to 5 bonus points

• Small practice bonus
  o Earn up to 5 bonus points as long as you or your group submits on at least 1 performance category during the performance period
MIPS Final Score and Payment Adjustments

• Based on whether your final score is above or below the performance threshold [15 points (up from 3 points in 2017)], you will see a positive or negative payment adjustment.

• For 2018, the payment adjustment will be 5% of Medicare Part B services, including Part B drugs.
Extreme and Uncontrollable Circumstances

Hardship Exceptions for Individual Clinicians Affected by Natural Disasters in 2017
Significant Hardship Exceptions

• Under current regulations, starting in 2018, CMS will allow clinicians and groups to request that any/all MIPS performance categories be reweighted.

• If the clinician does not report any data for a performance category, CMS will weight that category as zero.

• CMS will score any data you do submit.

• If you have requested an exception and it is approved, you will not receive a negative payment adjustment.
2017 Transition Year Policies

• For this performance period, CMS released an interim final rule that allows individual clinicians affected by Hurricanes Harvey, Irma, and Maria as well as the California wildfires to receive special accommodations.

• Individual clinicians in FEMA-designated major disaster areas will automatically receive this hardship exception for 2017 without having to apply.

• Eligibility is based on practice location listed in PECOS.
Advanced APMs

Advanced Alternative Payment Models
Advanced APM Bonus Rewards Participation in New Models

• Requires significant share of provider revenue in APM with 2-sided risk and quality measurement or a federal medical home model demonstration.

• Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements.

• Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS.
What Counts As an Advanced APM?

• Model approved by the Physician-Focused Payment Models Technical Advisory Committee (PTAC).
• Model developed by the Centers for Medicare and Medicaid Innovation (CMMI).
• Medicare Shared Savings Accountable Care Organization (ACO).
• Demonstration under the Medicare Health Care Quality Demonstration Program.
• Any demonstration required by Federal law.
What APMs Currently Qualify As Advanced?

• Comprehensive End-stage Renal Disease Care Model for Large Dialysis Organizations with 2-sided Risk
• Comprehensive Primary Care Plus (CPC+)
• Medicare Shared Savings Program – Track 2 and Track 3
• Next Generation ACO Model
• Oncology Care Model with 2-sided Risk
• Comprehensive Care for Joint Replacement Payment Model
• Medicare ACO Track 1+ Model
What Are the Standards for Advanced APMs?

• Bear a certain amount of financial risk.
  o An Advanced APM will meet the financial risk requirement if CMS withholds payment, reduces rates, or requires the entity to make payments to CMS if its actual expenditures exceed expected expenditures.

• Base payments on quality measures comparable to those used in the MIPS quality performance category.

• Require participants to use CEHRT.
Medical Home Model Standards

• Medical home models that have been expanded under CMMI authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria.

• Medical home models must focus on primary care and accountability for empaneled patients across the continuum of care.

• Advanced APMs that are medical homes have financial risk standards that are somewhat less stringent.
Additional Requirements

- To qualify for incentive payments, clinicians will have to receive enough of their payments or see enough of their patients through Advanced APMs.
- In performance years 2019 and 2020, the participation requirements for Advanced APMs are only for Medicare payments or patients.
- Starting in 2021, the participation requirements for Advanced APMs may include non-Medicare payers and patients, including those with Medicare Advantage plans.
All-Payer Combination Option

Beginning in 2019
All-Payer Combination Option

• Beginning in performance year 2019, APM Entities and individual eligible clinicians can gain QP status through participation in a combination of Medicare Advanced APMs and other-payer Advanced APMs.
• Other-payer arrangements must require at least 50% of participants to use CEHRT, include quality measures comparable to those in MIPS, and exceed specified thresholds of risk.
• The All-Payer QP performance period will align with the Medicare Option.
All-Payer Combination Option

• Determination of QP status will be made at the individual eligible clinician (NPI) level.

• Two pathways to gain status:
  o Payer-initiated Determination Process
  o APM Entity or Eligible Clinician-initiated Determination Process

• Eligible clinicians who are partial QPs for the year under the All-Payer Combination Option can elect whether to report in MIPS.

Last updated 12/15/17.
## All-Payer Combination Option

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Determining Next Steps
Assessing Your Level of Participation in 2018
Establish Whether You Meet the New Low-volume Threshold

• Because the low-volume threshold is higher in 2018, you should check whether you are exempt even if you weren’t this year.

• Determine whether the aggregation of the Medicare patients or allowed charges across your group is over or under the low-volume threshold if you decide to report as a group.

• If your group exceeds the threshold, decide whether to report as individuals.
Determine Whether You Have a Certified EHR

• You should check whether your electronic health record (EHR) is certified or has been decertified by the Office of the National Coordinator for Health Information Technology (ONC). Go to: https://chpl.healthit.gov/#/search

• If it is certified, you should then determine what standard it is certified to – 2014 or 2015 – so you know what Advancing Care Information objectives and measures you are able to report.
Evaluate the Business Case for Reporting MIPS

• If you are **not** exempt from MIPS, you should carefully examine how the infrastructure and staff costs required for reporting compare to your greatest potential negative payment adjustment in each payment year.

• Check your previous year’s Medicare revenue/relative value units (RVUs) to see how you would fare if you didn’t report and received the lowest possible payment adjustment.
Evaluate the Business Case for Reporting MIPS

• You should also consider your payer mix and how well Medicare reimburses relative to other payers.
  o Is Medicare one of your main payers?
  o Does Medicare pay as well or better than your private payers?

• If you have participated in the existing Medicare reporting programs, either PQRS, VM, or EHR Incentive Program, you may have already made investments that will put you in a better position to report in MIPS and be successful.
Evaluate the Business Case for Reporting MIPS

• How do you avoid a negative adjustment?
  o Report all 6 required quality measures 
      or
  o Satisfy the improvement activities performance category 
      or
  o Achieve an advancing care information score of 60%
Choose Your Measures and Reporting Mechanisms

• If you are a urogynecologist, you have the option to report through the AUGS registry, AQUIRE, for free. AUGS is opening up participation to non-members for the 2018 performance period. Go to https://www.augs.org/aquire/ for more info.

• Contact your EHR vendor to see if your system can support MIPS reporting and what the associated costs and timeframe are for being able to submit MIPS measures.
Choose Your Measures and Reporting Mechanisms

• For individual ob-gyns who would like to report quality measures via claims, you will have to append the claims associated with the measure that you want to be evaluated on with a billing code.

• CMS will allow attestation for Advancing Care Information and Improvement Activities performance categories.
Resources

Tools to Help Ob-gyns Participate in the QPP
CMS/CMMI Resources

• CMS’s website: https://qpp.cms.gov
• Quality Payment Program Year 2 Executive Summary: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf.
ACOG Resources

• We are continuing to partner with other medical associations to improve and simplify these regulations.

• We are working to define quality measures that matter - including meaningful patient-reported outcomes so that participation in the QPP will enhance and improve our practices.

• All QPP resources are available on our webpage: www.acog.org/macra.

• Send questions to practicemanagement@acog.org.