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Looking Ahead to Year 2 of the Quality Payment Program

September 27, 2017

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Background: Payment Reform

- The Quality Payment Program is part of a larger payment reform or value-based payment effort

- Move toward payment for quality over quantity
  - Outcomes v. encounters
  - Incentivizing health, preventive care
  - Cost containment

Payment Reform and Indian Health

- Tribes are already seeking out ways to improve quality

- IHS is chronically underfunded
  - $3,688 per capita for the IHS
  - $9,523 per capita for the US overall

- For the Indian health system, payment reform is not necessarily a quality improvement issue so much as a third-party revenue issue

Background: MACRA

- The **Medicare Access and CHIP Reauthorization Act of 2015** (MACRA) was enacted April 16, 2015 as part of a larger payment reform effort to incentivize value and quality.

- MACRA creates two tracks for value-based payments:
  (1) The Merit-based Incentive Payment System (MIPS), and
  (2) Alternative Payment Models (APMs)

Application of MACRA

- Only applies to Medicare Part B payments paid under the Physician Fee Schedule (PFS).
- Although Tribes generally are paid an encounter rate, some providers in Tribal facilities receive Medicare Part B payments under the PFS.
- Only applies to "eligible clinicians"
  - Currently defined to include physicians, physician's assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists. 42 C.F.R. 414.1305

Quality Payment Program

- CMS established the 2017 reporting year as a transition year.
- On June 20, 2017, CMS issued a proposed rule on Year 2 of the QPP
  - Press release: “CMS’s goal is to simplify the program, especially for small, independent, and rural practices, while ensuring fiscal sustainability and high-quality care within Medicare.”
  - Administrator Verma: “We’ve heard the concerns that too many quality programs, technology requirements, and measures get between the doctor and the patient.”
- The comment period closed on August 21, 2017.

Proposed Rule: MIPS Exclusions

- Low-volume Threshold
  - 2017: $30,000 in Part B charges and over 100 Part B patients
  - Proposed 2018: $90,000 in Part B charges and over 200 part B patients
  - CMS estimates this will exclude an additional 585,560 clinicians
  - CMS exploring allowing opt-in beginning 2019

- Advancing Care Information
  - Proposed exemption for small practices (15 or fewer)
  - Proposed exemption for decertified EHR
  - Continues exemptions for:
    - Hospital-based clinicians, clinicians in ambulatory surgical centers, nurse practitioners, physicians assistants, clinical nurse specialists, and certified registered nurse anesthetists
    - Hardship (have to apply)
  - Note:
    - Can use either 2014 or 2015 Edition CEHRT, bonus for 2015 edition
    - Unlike previous Medicare EHR Incentive Program, no 5-year cap on hardship exemptions
    - Exemptions reweight ACI to 0 and increase Quality

Proposed Rule: MIPS Scoring

- Performance Weights
  - Proposed weighting at 2017 levels:
    - 60% Quality
    - 25% Advancing Care Information
    - 15% Improvement Activities
    - 0% Cost
  - Under MACRA, cost must increase to 30% in 2019

- Performance Threshold
  - 2017: 3 points
  - Proposed 2018: 15 points, can no longer report just one measure

- Proposed Bonuses
  - Small practice bonus would add 5 points to final score if data submitted in one performance category
  - Complex patient bonus adds up to 3 points
  - Requested comment on adjusting for social risk factors

- Improvement scoring
  - Proposed to add for Quality category in 2018
  - Proposed to add for Cost category in 2019

Proposed Rule: Reporting

- Facility-based scoring
  - Would allow facility-based clinicians to choose use their facility's performance rates in Hospital Value Base Purchasing Program as substitute for Quality and Cost categories
- Virtual groups
  - Would allow virtual groups composed of solo practitioners or groups of 10 or fewer eligible clinicians.
  - MIPS eligibility assessed at group level
- Flexible submission mechanisms
  - Would allow use of multiple submission mechanisms for measures and activities within same performance category

Proposed Rule: Tribal Requests

- Tribal consultation
- Work with IHS and tribes to align MIPS and GPRA measures
- Add tribal bonus to those for small practices and complex patients
- Support adjusting for patients with social risk factors
- Ensure measures and activities are appropriate for tribal clinicians
- Exclude tribal providers from cap on topped out measures
- Support low-performers

Looking Ahead

- Maximum negative or positive payment adjustments:
  - 4% in 2019 (2017 performance year)
  - 5% in 2020 (2018 performance year)
  - 7% in 2021 (2019 performance year)
  - 9% in 2022 and beyond (2020 performance year and beyond)

- Additionally, scoring will become more difficult.
  - Cost will be 30% in 2019 reporting year (Quality will drop to 30%)
  - The threshold score will continue to rise

- Important to stay engaged, assess tribal impact, and advocate for exempting or tailoring to tribes.
  - Consider joining Medicare Medicaid Policy Committee (MMPC) calls, e-mail Sooner Davenport at sdavenport@nihb.org.

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