McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

Sound Health Policy Objectives Achieved

2019 QPP Final Rule:

Understanding CMS's Quality Payment Program

With Highlights from the PFS and OPPS

November 13, 2018

Who We Are

McDermott+Consulting serves health industry clients with one-stop lobbying services, data analytics and modeling, and policy advice.

McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

Sound Health Policy Objectives Achieved

- ✓ Work with clients to understand, evaluate and respond to the MACRA/Quality Payment Program
- ✓ Assess coding, coverage and reimbursement landscapes for public and private payers at the national and state level
- ✓ Develop coding, coverage and reimbursement strategies for clients prior to, and after launch of, new products
- ✓ Analyze and model Medicare payment systems (*e.g.,* Medicare Physician Fee Schedule)
- ✓ Create models to demonstrate product and service value (*e.g.*, budget impact models)
- ✓ Develop materials for payer communications
- ✓ Establish and represent issue coalitions

Introducing the McDermott Team

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As the former health director at the White House Office of Management and Budget, Adaeze's responsibilities included a leading role in developing the first set of regulations governing MACRA/QPP implementation.

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Sheila's work with physician specialty societies has given her significant experience in a wide range of Medicare physician payment policy and quality areas including MACRA/QPP implementation.

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As an attorney with over 10 years of Medicare reimbursement experience, Mara assists providers and other stakeholders on MACRA/QPP implementation, analysis and strategy.

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Paul brings his experience as a clinician and clinical researcher to his work with professional society and life sciences company stakeholders on MACRA/QPP strategy and implementation issues.

Agenda

- Quality Payment Program (QPP)
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment System (APMs)
- Highlights from the Medicare Physician Fee Schedule (MPFS) 2019 Final Rule
- Highlights from the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Final Rules
- Moderated discussion

2019 MPFS Final Rule

- **Payments for professional services**
- **Quality Payment Program (MACRA)**
- Medicare Shared Savings Program (ACOs)
- Part B Drugs
- Laboratory Fee Schedule
- Physician self-referral
- Rural Health Clinics and Federally-Qualified Health Centers
- Appropriate Use Criteria
- Summaries of comments on RFIs

2019 OPPS and ASC Final Rules

- **Site-neutral payment policy for off-campus provider-based department**--phased in over two-year period
- **Extension of the 340B payment cuts** to non-excepted off-campus provider-based departments
- Limit expansion of clinical families in excepted off-campus provider-based departments
- Significant changes to ASCs – Broadening the definition of surgical procedures
- Reduce the number of ASC quality measures
- Finalizing policy to separately pay for non-opioid pain management

Quality Payment Program - MIPS

Quality Payment Program Overview

Eligible Clinicians Will Choose a Pathway

Quality Payment Program

Track 1
Merit-based Incentive Payment System (MIPS)

Track 2
Advanced Alternative Payment Models (APMs)

Medicare Access and CHIP Reauthorization Act (MACRA) revised the payment system for physicians and other health care professionals by stabilizing annual updates and establishing incentives for value-based care through quality reporting or participation in payment models that require clinicians to take on risk.

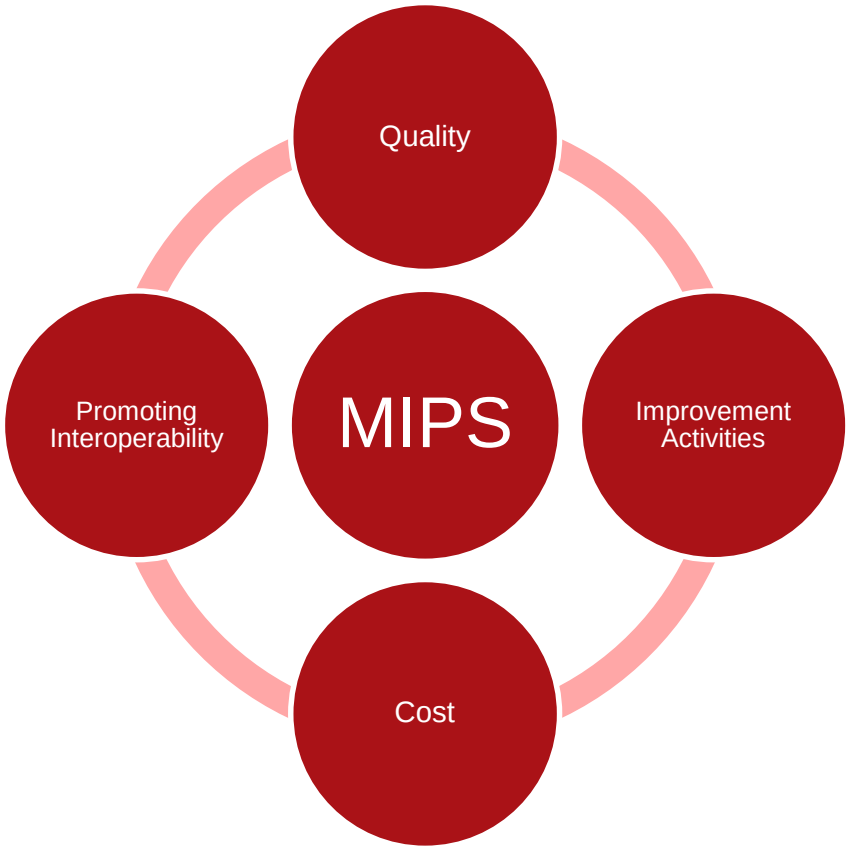
Payment Adjustment Timeline

Payment Year	2015-2018	2019	2020	2021	2022	2023	2024	2025	2026
Physician Conversion Factor									
Annual Update	0.5%	0.25%	0%	0%	0%	0%	0%	0%	QPs = 0.75% All other physicians: 0.25%
MIPS									
*Payment Adjustment**		+/-4%	+/-5%	+/-7%	+/- 9% (2022 & beyond)				
Exceptional Performance Adjustment Applies (Top 25%)		Applies to Top 25% of Performers (2019-2024)						N/A	N/A
Advanced Alternative Payment Models (APMs)									
Incentive Payment		5% Incentive Payment (2019-2024)						N/A	N/A

- ✓ 2019 CF update was reduced to 0.25 percent from the 0.50 authorized by MACRA as a result of a provision in the BBA of 2018
- ✓ Beginning in 2020 a period of zero percent updates begins, which could potentially result in negative updates due to the application of other scalers, such as the RVU budget neutrality adjustment

*Note that the MACRA statute included additional bonus potential due to application of a scaling factor, not reflected here.

MIPS Overview and Timeline



MIPS was designed to tie payments to quality and cost efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information and reduce the cost of care.

https://qpp.cms.gov/mips/overview

Timeline

MIPS Timeline 2017-2021

CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Year 1 Performance Year	**Year 2** Performance Year	**Year 3** Performance Year	**Year 4** Performance Year	**Year 5** Performance Year
		Year 1 Payment Year	**Year 2** Payment Year	**Year 3** Payment Year

- ✓ MIPS is a Medicare pay-for-performance program for eligible clinicians paid under Medicare fee-for-service
- ✓ It was implemented through the MACRA statute beginning in CY 2017
- ✓ CY 2019 is the first year payments will be impacted based on a clinician's performance in CY 2017

Agency's Implementation

Approach

- Incremental approach to full implementation
- Burden reduction for clinicians
- Focus on improved patient outcomes
- Flexible program that supports the needs and diversity of physician practices and patients

* * * * *

Despite these goals, MIPS continues to be a complicated program with a complex scoring system. It is not clear if the objectives will be met.

2019 Payment Adjustments

CY 2017 performance impacts CY 2019 payments. CY 2019 is the first year we will see the impact of MIPS on clinician payment.

Positive payment adjustment + Exceptional performance adjustment	Positive payment adjustment	Neutral payment adjustment	Negative payment adjustment
71%	22%	2%	5%

Maximum Negative Adjustment	Maximum Positive Adjustment
-4%	1.88%

- ✓ Low bar to avoid payment adjustment in 2019 (submit 1 measure)
- ✓ As a result, maximum positive adjustment less than maximum allowed by statute (4%)
- ✓ Initial positive adjustment was estimated at 2.02% but lowered after adjustments made as a result of findings from targeted reviews

MIPS Adjustment Applied to Physician CF

The 2019 Physician CF is $36.0391 (2019 Anesthesia CF is $22.2730)

MACRA mandated 0.5 percent updates from July 1, 2015, through 2019, followed by zero percent updates from 2020 to 2025. As this table illustrates, the 0.5 updates rarely materialized. This was largely due to budget neutrality adjustments that reduced the annual physician updates or provisions from other legislation that affected the update.

Medicare Physician CF (2015-2019)

Year	CF	Update Mandated by MACRA (%)	Actual Update
Jan 1, 2015	35.7547	* * *	* * *
July 1, 2015	35.9335	0.5	0.5
Jan 1, 2016	35.8043	0.5	-0.36
Jan 1, 2017	35.8887	0.5	0.24
Jan 1, 2018	35.9996	0.5	0.31
Jan 1, 2019	36.0391	0.5*	0.11

*The 0.50 percent update specified by MACRA was reduced to 0.25 percent as a result of a provision in the Bipartisan Budget Act of 2018.

MIPS Participation (2017-2019)

CMS estimates 798,000 clinicians will participate in MIPS in 2019

2019	798,000 clinicians	Estimate from the 2019 Medicare Physician Fee Schedule Final Rule
2018	622,000 clinicians	Estimate from the 2018 Medicare Physician Fee Schedule Final Rule
2017	1,057,824 clinicians	Received a positive, negative or neutral adjustment for the 2019 Payment Year (2017 Performance Year)

- ✓ Between 2017 and 2018 there was a change in the MIPS Low Volume Threshold (LVT) that impacted the number of MIPS eligible clinicians
- ✓ Currently, MIPS impacts a greater number of clinicians than the Advanced APM track; in 2017 99,076 eligible clinicians earned Qualified Participant status

MIPS Eligible Clinicians in 2019

CMS estimates an increase the pool of eligible clinicians in 2019

Policy changes*	Estimated Number of MIPS Eligible Clinicians Impacted by Policy Change	Estimated Effect of Policy Change on Number of MIPS Eligible Clinicians
Baseline: Applying previously finalized policy	N/A	751,498
Policy Change 1: Low-volume threshold (LVT) determination expanded to include covered professional services (as required by BBA of 2018)**	-1,651	749,847
Policy Change 2: Expansion of eligible clinician types to include physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists and registered dieticians or nutrition professionals	20,240	770,087
Policy Change 3: Cumulative change of opt-in policy with policy changes 1 and 2***	27,903	797,900

* This table does not consider the impact of the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration waiver. (*Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program, CMS 1693-P, display copy page 1078*)

** LVT definition is: *To be excluded from MIPS, clinicians or groups would need to meet one of the following three criterion: have ≤ $90K in Part B allowed charges for covered professional services, provide care to ≤ 200 beneficiaries, OR provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)*

***Model assumption is 33 percent clinicians who are eligible will elect to opt-in.
Extracted from Table 98, page 220, 2019 PFS Final Rule (CMS 1683-F, display copy)

2019 MIPS Timeline

There is a time delay between performance of activities and performance feedback as well as a time delay from when payments are impacted. This delay may impact the ability of clinicians to evaluate their performance and implement changes before the start of the next performance year.

2019 Performance Year	Data Submission	Performance Feedback	Payment Adjustments
January – December, 2019	The deadline for data submission is March 31, 2020	July 2020	Jan. 1, 2021

MIPS Performance Threshold Increased

CMS is increasing the MIPS performance threshold from 15/100 points to 30/100 points

- The “performance threshold” represents the score that is needed to receive a neutral to positive payment adjustment for the year
- A score below the performance threshold will result in a negative payment adjustment; a score above the payment threshold will result in a positive payment adjustment (a score at the payment threshold will result in a neutral payment adjustment)
- MACRA also authorized an additional $500 million each year from 2019 to 2024 to award “exceptional performance” bonuses to MIPS providers with the highest composite performance scores

Performance Year	Performance Threshold	Exceptional Performance Threshold
2019	30	75
2018	15	70
2017	3	70

Performance Category Weights

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

- ✓ CMS increased the Cost Performance Category weight from 10 to 15 percent in 2019
- ✓ BBA of 2018 gives CMS the discretion to set the Cost Performance Category through MIPS Year 5 (never less than 10 percent or never more than 30 percent)
- ✓ For the Cost and Quality Performance Categories, data is collected for the full year; for the Improvement Activities and Promoting Interoperability Performance Categories, data is collected for at least a continuous 90-day period

Highlights of Key Changes

- Quality
  - CMS will add eight new quality measures and remove 26
- Cost
  - Currently the Cost Performance Category is based on two measures: Total Per Capita Cost and Medicare Spending Per Beneficiary; in the final rule, CMS is adding eight recently developed episode-based cost measures
- Facility-based scoring
  - CMS is implementing facility-based scoring for 2019, where facility-based clinicians can use their facility's Hospital Value-based Purchasing (VBP) score as a proxy for their Quality and Cost Performance Categories
- Advancing Care Information
  - 2015 Certified EHR requirements required for MIPS in 2019
  - Measures and objectives updated for 2019
- Improvement Activities
  - Adding six new activities, modifying five activities and removing one existing activity

Meaningful Measures Initiative

The Meaningful Measures Initiative launched in October 2017 with the aim of identifying the highest priority areas for quality measurement and quality improvement to advance the agency's work to improve patient outcomes. Since then, CMS has been reviewing quality measures across Medicare and Medicaid under the lens of this initiative. CMS has also indicated that as part of its review, it is considering whether collecting information is valuable to clinicians and whether it is worth the cost and resources. Stakeholders have raised concerns about the number and pace of quality measures being removed from the program. They have urged CMS to ensure there are a sufficient number of meaningful measures available for various specialties to participate in MIPS.

MIPS Wrap Up

- The MIPS-related policies in the CY 2019 Final Rule continue the incremental approach to full implementation of MIPS
- Agency-wide initiatives/goals such as the Meaningful Measures Initiative or Patients over Paperwork will impact program design and focus
- While CMS has focused on policies to reduce the reporting burden and streamline participation, the complexity of the program still raises challenges for many eligible clinicians, especially small practices and rural providers
- As a budget neutral program, MIPS policies that make it easier to avoid a negative payment adjustment (lower performance threshold), also limits the pool of funds available to provide positive updates

Quality Payment Program - Advanced APMs

Advanced APM Landscape

- MACRA included a five percent incentive payment to encourage participation in advanced APMs
- To date, participation options have been limited and heavily rely on Medicare Accountable Care Organizations (ACOs)
- The final rule contains modest modifications – overall dynamics largely unchanged

Advanced APM Refresher

Qualifying Model

- Model Type (e.g., CMMI model)
- Quality measures comparable to MIPS
- Use of CEHRT
- More than nominal financial risk or expanded medical home

Participation Thresholds

- Medicare Option: 50 percent of payments or 35 percent of patients
- All Payer Combination Option: 25 percent traditional Medicare APM plus other payer advanced APM participation

Advanced APM Options

2017	2018	2019
Comprehensive ESRD Care Two Sided Risk (CEC)	CEC	CEC
Comprehensive Primary Care Plus (CPC+)	CPC+	CPC+
Next Gen ACO	Next Gen ACO	Next Gen ACO
Shared Savings ACOs Track 2 and 3	Shared Savings ACOs Track 2 and 3	Shared Savings Program BASIC Level E and ENHANCED
Oncology Care Model (OCM)	OCM	OCM
Comprehensive Care for Joint Replacement (CJR)	CJR	CJR
99,076 QPs	Medicare ACO Track 1+	Medicare ACO Track 1+
	Bundled Payments for Care Improvement Advanced (BPCI Advanced)	BPCI Advanced
	185,000 to 250,000 QPs	Vermont Medicare ACO Initiative
		165,000 to 220,000 QPs

Other Payer Advanced APMs

- Medicaid Models
  - Accountable Care Partnership (MA)
  - Episode based payments model (OH)
  - Retrospective Episodes of Care Model (TN)
  - Community Health Plan of Washington – Community Health Network of Washington Population-based Payment model Option B: Individual Community Health Center Risk (WA)
  - Community Health Plan of Washington – Community Health Network of Washington Population-based Payment Model Stop Loss Option B (WA)
  - Community Health Plan of Washington – Community Health Network of Washington Population-based Payment Model Stop-Loss Option C (WA)
- Multi-Payer Models
  - Payment transformation program, CPC+ (HI)
  - Primary Care Advancement Model Health Maintenance Organization Track, CPC+ (Greater Philadelphia Area)

Changes to Advanced APMs in the QPP

- Stabilizes financial risk criteria through 2024
- Increases thresholds for clinicians using CEHRT
- Modifications to the quality measures “comparable to MIPS”
- Other policies to streamline and simplify the other payer advanced APM option (but complexity remains)

New Models

- New APM development has been modest
  - CMS finalizes the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration (MIPS exemption; no bonus)
- PTAC
  - Proposed rule was silent on PTAC
  - In the final rule, CMS says it is unlikely to finalize PTAC-recommended models
- Secretary Azar forecasts new models
  - Capitated primary care model
  - Mandatory bundles

Medicare Shared Savings Program

- In August, CMS proposes *Pathways to Success*, a revamped Medicare Shared Savings Program (MSSP)
  - Would create new BASIC and ENHANCED tracks, other reforms
  - New tracks would start July 1, 2019
- The PFS/QPP final rule implements some time sensitive aspects of *Pathways to Success*
  - Particularly relevant to 2016 ACO entrants/renewers
  - The remainder of Pathways to Success will be finalized separately
- PFS/QPP final rule also finalizes changes to MSSP quality measurement

APM Wrap Up

- Advanced APM QPP policy remains fairly stable for 2019 performance year
- But we expect to see new models, including mandatory models that may change the landscape for participation
- Stay tuned for final rule on Pathways to Success, pushing MSSP participants to two-sided risk

PFS & OPPS Highlights

PFS and OPPS Highlights from the 2019 FR

- PFS Key Final Policies
  - Proposed E/M overhaul scaled back and delayed
  - CMS establishes payment for virtual check-ins and other technology-based services
  - Input prices for supplies and equipment updated based on survey conducted by outside research firm
- OPPS Key Final Policies
  - Site neutral payments for hospital clinic visits provided in off-campus provider-based departments (PBDs) starting in 2019
  - Non-excepted PBDs paid 40 percent of OPPS payment rate in 2019
  - CMS declines to finalize clinical families policy for non-excepted PBDs

PFS Highlights

CMS delays changes to the coding and payment structure for E/M services until 2021, but will implement several documentation policies in 2019

- CMS finalized the following policies for 2019:
  - Removed the need to justify providing a home visit instead of an office visit
  - Changed the required documentation of the patient's history to focus only on the interval history since the previous visit
  - Eliminated the requirement for physicians to re-document information already documented in the patient's record by practice staff or by the patient

Because E/M services make up approximately 40 percent of allowed charges under the PFS (office/outpatient E/M services comprise approximately 20 percent of allowed charges), any changes would have a wide-ranging impact across different specialties.

PFS Highlights

- CMS finalized the following payment and coding policies but delayed implementation until 2021:
  - Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining a higher payment rate for E/M office/outpatient visit level 5
  - Implementation of several changes allowing greater flexibility and reduced burden in documentation, including allowing clinicians to use medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines
  - Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care (not specialty-specific; reported with level 2–4 codes; generally would not impose new documentation requirements)
  - Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient

CMS declined to move forward on a proposal to reduce payment for office visits when performed on the same day as another service. Nor did CMS establish separate coding and payment for podiatric E/M visits.

PFS Highlights

CMS finalizes separate payment for multiple communication-technology-based services that would not be subject to the limitations placed on Medicare telehealth services

- *Brief Communication Technology-Based Service,* e.g., *Virtual Check-In (HCPCS code **G2012**):* This code describes brief check-in services furnished using communication technology that are used to evaluate whether an office visit or other service is warranted
- *Remote Evaluation of Pre-Recorded Patient Information (HCPCS code **G2010**):* This code describes physician use of recorded video and/or images captured by a patient in order to evaluate a patient's condition; the follow-up with the patient could take place via phone call, audio/video communication, secure text messaging, email or patient portal communication
- *Interprofessional Internet Consultation (CPT codes **99446, 99447, 99448, 99449, 99451** and **99452**):* These codes describe interprofessional consultations (between the treating practitioner and a consulting physician or a qualified health care professional) performed via communications technology such as telephone or internet
- CMS also finalized policies to pay separately for new coding describing chronic care remote physiologic monitoring (CPT codes 99453, 99454 and 99457)

PFS Highlights

CMS updates PE inputs based on survey from outside research firm

- Physician payment is based on the application of the dollar CF to work, practice expense (PE) and malpractice RVUs, which are then geographically adjusted
- PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service
- CMS finalized a proposal to update input prices for supplies and equipment based upon a large survey conducted by a market research firm under contract to CMS
- CMS will phase in these new inputs over a four-year period beginning in 2019
- Based on public comments, CMS revised inputs for several items from what was originally proposed based on comments received, including invoice data; these changes are summarized in Table 9 of the final rule

OPPS Highlights

- **Clinic visits**
  - Currently CMS pays more for a similar clinic visit in the OPPS environment than in the physician office setting
  - CMS is applying a PFS-equivalent payment rate for the clinic visit service when provided at an off-campus PBD that is paid under the OPPS
  - CMS estimates $380 million in savings for the Medicare program and lower copayments for beneficiaries
- **Excepted PBDs**
  - CMS is not finalizing a policy that off-campus PBDs excepted from Section 603 of the Bipartisan Budget Act of 2015 could continue to be paid at OPPS rates for items and services in each of 19 proposed "clinical families of services" only if a PBD furnished and billed for a service in that clinical family of services prior to November 2, 2015
- **Non-excepted PBDs**
  - Non-excepted PBDs will be paid 40 percent of OPPS payment rate in 2019

Excepted vs Non-excepted PBDs

Excepted PBDs

- Paid under the OPPS
- On-campus
- "Grandfathered" - those furnishing and billing for services before November 2, 2015
- Services furnished by a dedicated emergency department

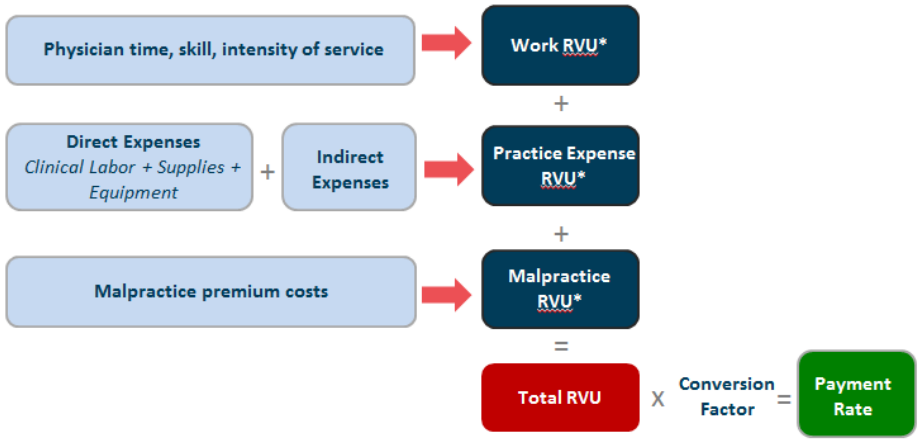
Non-excepted PBDs

- Off-campus PBDs that do not meet one of the above criteria
- Not paid under the OPPS

Major Medicare Physician Fee Schedule Proposal

- CMS proposed to update supply and equipment inputs used to calculate PE RVUs
  - PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service
  - Proposed input prices were based on a survey conducted by a market research firm
  - New inputs would be phased in over a four years starting in 2019
- Final rule slows down implementation, but retains the intent

McDermottPlus has developed a sophisticated tool to help medical specialty societies, health systems and life sciences companies accurately predict payment rates



RVU = relative value unit
*All RVU components subject to a geographic adjustment

Discussion

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Paul brings his experience as a clinician and clinical researcher to his work with professional society and life sciences company stakeholders on MACRA/QPP strategy and implementation issues.

Questions?

- Thank you for your time. If you have any additional questions, wish to speak with one of our consultants or want to join our Payment Innovation listserv for updates delivered directly to your inbox – contact Jennifer Randles at jrandles@mcdermottplus.com

- For additional resources or to view an archive of this presentation, visit our Payment Innovation Resource Center at: https://www.mcdermottplus.com/payment-innovation-resource-center/