Quality Payment Program Year 3: Proposed Rule

Lauren Sloan MHA, RD, LD
Director of Regulatory Affairs
Goals of QPP
Year 3

- Continue proposing policies that protect the safety of beneficiaries and strengthen the quality of the healthcare they receive
- Support a pathway to participation in Advanced APMs
- Identify low-value or low-priority process measures, which will be recommended for removal, and focus on meaningful quality outcomes for patients and streamlining reporting for clinicians
Proposals Pertinent to Radiology

- Adding a third element to the low-volume threshold determination
- Starting in Year 3, clinicians or groups would be able to opt-in to MIPS if they meet or exceed one or two of the low-volume threshold criteria

**Proposed Low-Volume Threshold Criteria for Year 3**
- Dollar Amount ($90,000)
- Number of Beneficiaries (200)
- Number of Covered Professional Services (200)
Proposals Pertinent to Radiology

- Adding new episode-based measures to the Cost performance category
- Restructuring the Promoting Interoperability (formerly Advancing Care Information) performance category
- Creating an option to use facility-based Quality and Cost performance measures for certain facility-based clinicians
- Allowing the use of a combination of collection types for the Quality performance category
Proposals Pertinent to Radiology

- Retaining bonus points in the scoring methodology
  - Care of complex patients
  - Small practices
    - including in the Quality performance category score instead of as a standalone bonus

- Option to use facility-based scoring for facility-based clinicians with no data submission requirement
New MIPS Terms

- **Collection type** a set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS clinical quality measures (CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey measure; and administrative claims measures.
- **Submitter type** as the MIPS eligible clinician, group, or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.
- **Submission type** as the mechanism by which the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. There is no submission type for cost data because the data is only submitted for payment purposes.
Bipartisan Budget Act of 2018

- Changing the application of MIPS payment adjustments, to apply only to covered professional services paid under the Physician Fee Schedule
- Providing flexibility in the weighting of the Cost performance category in the final score; not more than 30% for Years 3, 4, and 5
Changes for Year 3

- Additional eligible clinician types:
  - Physical therapist
  - Occupational therapist
  - Clinical social worker
  - Clinical psychologist

- Low-Volume Threshold
  - provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)

- Streamlined MIPS Determination Period
  - 1st 12-month segment: Oct. 1, 2017 – Sept. 30, 2018
Changes for Year 3

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Performance Category Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>45%</td>
</tr>
<tr>
<td>Cost</td>
<td>15%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>25%</td>
</tr>
</tbody>
</table>
Quality Category

- 45% in Year 3
- Maintain reweighting criteria as Year 2
- Maintain data completeness requirements as Year 2
  - Zero points starting with PY 2020
- Individual eligible clinicians would be able to submit a single measure via multiple collection types and be scored on the data submission with the greatest number of measure achievement points
- Measures impacted by clinical guideline changes
Quality Category

- Bonus Points same as Year 2
  - High-priority/Outcome measures, after first required measure
    - Discontinue for CMS Web Interface reporting
  - End-to-end electronic reporting
  - Improvement scoring
Improvement Activity Category

- 15% in Year 3
- 6 new Improvement Activities
- 5 modified Improvement Activities
- 1 removed Improvement Activity
- Removal of criteria “Activities that may be considered for a Promoting Interoperability bonus”
Promoting Interoperability Category

- 25% in Year 3
- Reweighting same as Year 2 and extended to additional clinician types
- Must use 2015 Edition CEHRT
- Proposing new scoring methodology
Promoting Interoperability Category

- One objectives and measure set based on the 2015 Edition CEHRT
- Four objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange
- Proposing to add two new measures to the e-Prescribing objective
  - Query of Prescription Drug Monitoring Program (PDMP)
  - Verify Opioid Treatment Agreement
Cost Category

- 15% in Year 3
- Total Per Capita Cost: 20 case minimum
- Medicare Spending per Beneficiary: 35 case minimum
- 8 episode-based cost measures
  - 10 case minimum for procedural episodes
  - 20 case minimum for acute inpatient medical condition episodes
<table>
<thead>
<tr>
<th>Measure Topic</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Outpatient Percutaneous Coronary Intervention (PCI)</td>
<td>Procedural</td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td>Procedural</td>
</tr>
<tr>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
<td>Procedural</td>
</tr>
<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</td>
<td>Procedural</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>Procedural</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
<td>Acute inpatient medical condition</td>
</tr>
</tbody>
</table>
Facility-based scoring is an option for clinicians that meet certain criteria beginning with the 2019 performance period.

- Allows for certain clinicians to have their Quality and Cost performance category scores based on the performance of the hospitals at which they work.
Facility-Based Scoring

- **Individuals**
  - MIPS EC furnishes 75% or more of their covered professional services in inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period.

- **Group**
  - Facility-based group would be one in which 75% or more of eligible clinicians billing under the group’s TIN are eligible for facility-based measurement as individuals.
Facility-Based Scoring

- Attribution
  - Facility-based clinician would be attributed to hospital where they provide services to most patients
  - Facility-based group would be attributed to hospital where most facility-based clinicians are attributed

- If unable to identify facility with the Hospital Value-based Purchasing (VBP) score to attribute clinician’s performance, that clinician would not be eligible for facility-based measurement
Facility-Based Scoring

- **Election**
  - *Automatically* apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score
  - No submission requirements for individual clinicians in facility-based measurement
  - Group would need to submit data for the Improvement Activities and/or Promoting Interoperability performance categories in order to be measured as a facility-based group
Facility-Based Scoring

- **Measures**
  - CMS proposed to adopt all measures for the Hospital VBP Program into MIPS
  - 12 measures across 4 domains
  - Some measures include multi-year performance periods

- **Pertinent to Radiology?**
  - Interventional radiology – clinical outcomes domain
  - HCAHPS
  - Medicare Spending Per Beneficiary
Facility-Based Scoring

- Scoring
  - Quality and Cost performance scores based on how well the clinician's hospital performs compared to others

- No Total Performance Score?
  - Facility-based clinicians required to participate in MIPS via another method
2021 Payment Adjustment

- Application of payment adjustment on Medicare paid claims remains the same
- MIPS ECs who qualify for a group final score will have a modified determination period to include:
  - 15-month window that starts with the second 12-month determination period (October 1 prior to the MIPS performance period through September of the current MIPS performance period)
- MIPS EC who joins TIN in 1st or 4th quarter
2021 Payment Adjustment

- Performance threshold: 30 points
- Exceptional performance threshold: 80 points
- Payment adjustment: +/- 7% multiplied by scaling factor
## Year 3 (2019) Proposed

<table>
<thead>
<tr>
<th>Final Score 2019</th>
<th>Payment Adjustment 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80 points</td>
<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>30.01-79.99 points</td>
<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td>Not eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>30 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>7.51-29.99 points</td>
<td>Negative payment adjustment greater than -7% and less than 0%</td>
</tr>
<tr>
<td>0-7.5 points</td>
<td>Negative payment adjustment of -7%</td>
</tr>
</tbody>
</table>
Public Reporting on Physician Compare

- Newly created Quality and Cost measures will not be reported for 1st 2 years
- Reporting will indicate EC or group with “successful” performance under the Promoting Interoperability performance category
- Achievable Benchmark of Care (ABC) methodology
Advanced APM Policies

- Largely the same as in Year 2
  - Increase the CEHRT use criterion so that an Advanced APM must require at least 75% of eligible clinicians in each APM Entity use CEHRT
- Focus on all-payer models now available for PY 2019
Questions?

Lauren Sloan MHA, RD, LD | Director of Regulatory Affairs
ADVOCATE Radiology Billing
10567 Sawmill Parkway, Suite 100 | Powell, Ohio 43065
lauren.sloan@radadvocate.com | www.radadvocate.com