



# MACRA/QPP: What's New in 2020

Performance Year 4

# Agenda

- Briefly review pertinent Quality Payment Program background information
- Present what's new for the MIPS Pathway
  - Introduce the MIPS Value Pathways (PY2021)
- Present what's new for the Advanced APM Pathway
- Present the status of Public reporting

# MACRA

## Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Legislation creating new Medicare physician reimbursement methodology

Annual 0.5% increase in Physician Reimbursements 2015 thru 2019

2019 thru 2023

**Merit-Based Incentive Payment System (MIPS)**

**Advanced Alternative Payment Model**

# MACRA

## Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- CMS responsible for developing the detailed regulations to implement the MACRA legislation
- Named the **Quality Payment Program** (QPP)
- The CMS regulations must conform to legislative requirements

### 2020 is Performance Year 4 for the program

- Participation Statistics
  - PY2019 participation data not yet available
  - 98% of eligible clinicians participated in MIPS in PY2018
    - 95% participated in PY2017
  - 183,306 Qualified participants in advanced APM path in PY2018
    - 99,076 in PY2017
- 2020 reimbursement will be linked to 2018 performance in the program
  - 2019 was the first year that Eligible Clinician reimbursement determined by MACRA performance
    - Based on performance in 2017

## 2018 Legislative Changes to MACRA

### Bipartisan Budget Act of 2018

- Provided additional authority to continue a more gradual transition process to the state required by the MACRA legislation through Performance Year (PY) 2021
  - Must be compliant with the parameters delineated in the original statute by PY2022
- Allows Cost Category to be between 10 and 30%
  - The 30% weight levied in the original legislation delayed until PY2022
- Allows lower performance threshold
  - Versus the mean or median final score from the prior period – which was delayed until PY2022

# Quality Payment Program

## 2020 Final Rule

- CMS **Quality Payment Program** Final Rule for the 2020 Performance Year was released November 1, 2019
  - Published in Federal Register November 15, 2019

## What's new for MIPS in 2020 Final Rule

- Confirmed the increased bonus/penalty percentage of 9% as planned
- Established the Performance Threshold at 45 points for PY2020
  - Will be 60 in PY2021
  - Was 30 in PY2019, 15 in PY2018, and 3 in PY2017
- Established the Exceptional Performance Threshold at 85 points for PY2020 and 2021
  - Was 75 points in PY2019 (was proposed to be 80 points) and 70 in 2018 and 2017

# Quality Payment Program

## 2020 Final Rule – MIPS Path

- **Quality Performance Category**

- Remains weighted at 45% of Final Score
- Data completeness increased to 70% of eligible patients (up from 60%)
- Continuing to remove topped out and low-bar process measures as par of the Meaningful Measures framework
- Added new specialty sets - particularly for new clinician categories added in 2019
- Revising Qualifying Clinical Data Registries (QCDR) requirements for PY2021
  - Must report all performance categories – not just quality
  - Must provide more robust feedback to participants – how compare to others in QCDR and more frequently (e.g., quarterly)
  - Must work with each other to ensure fully developed and consolidated measures

# Quality Payment Program

## 2020 Final Rule – MIPS Path

- **Improvement Activities Performance Category**

- Remains weighted at 15% of Final Score
- Added 2 new Activities
- Modified 7 existing Activities
- Removed 15 existing Activities
  - Promulgated specific criteria for activity removal
- Requires 50% of clinicians in group to have participated in the same reported activity for a continuous 90-day period during the performance year
  - Previously only required 1 member of the group to participate
- Revised PCMH designation criteria to eliminate recognition by only four national organizations



# Quality Payment Program

## 2020 Final Rule – MIPS Path

- **Promoting Interoperability Performance Category**
  - Remains weighted at 25% of Final Score
  - Adjusted hospital-based group reweighting criteria from 100% of group being hospital-based to only 75% of group
  - For PY2019
    - The optional Query of PDMP measure changed to yes/no response instead of numerator/denominator
    - Redistributing points for Support Electronic Referral Loops by Sending Health Information measure to Provide Patients Electronic Access to their Health Information measure if an exclusion is requested
  - For PY2020
    - Removing Verify Opioid Treatment Agreement measure
    - Including optional Query of PDMP measure with yes/no response

# Quality Payment Program

## 2020 Final Rule – MIPS Path

- **Cost Performance Category**
  - Remains weighted at 15% of Final Score
    - Versus proposed 20%
    - Must be 30% in PY2022
  - Revised the Total Per Capita Cost (TPCC) measure and attribution process
  - Revised the Medicare Spending Per Beneficiary (MSPB) measure, renamed to Medicare Spending Per Beneficiary Clinician (MSPB-C), and revised the attribution process to have different methodologies for medical and surgical episodes
  - Ten episode-based measures added to the 8 initial ones from 2019
    - Case Minimum requirements
      - 10 for procedural episodes
      - 20 for acute inpatient medical condition episodes
  - Improvement scoring delayed until 2024 by the Bipartisan Budget Act of 2018

# Quality Payment Program

## 2020 Final Rule – MIPS Path

- Areas with no changes include
  - Low volume thresholds
  - Eligible clinician types
  - CEHRT requirements (2015 edition)
  - Bonuses for high priority measures and end-to-end electronic reporting
  - Small Practice Bonus
    - Applies to groups of  $\leq 15$  ECs reporting under single TIN
    - Will receive 6 bonus points added to Quality score

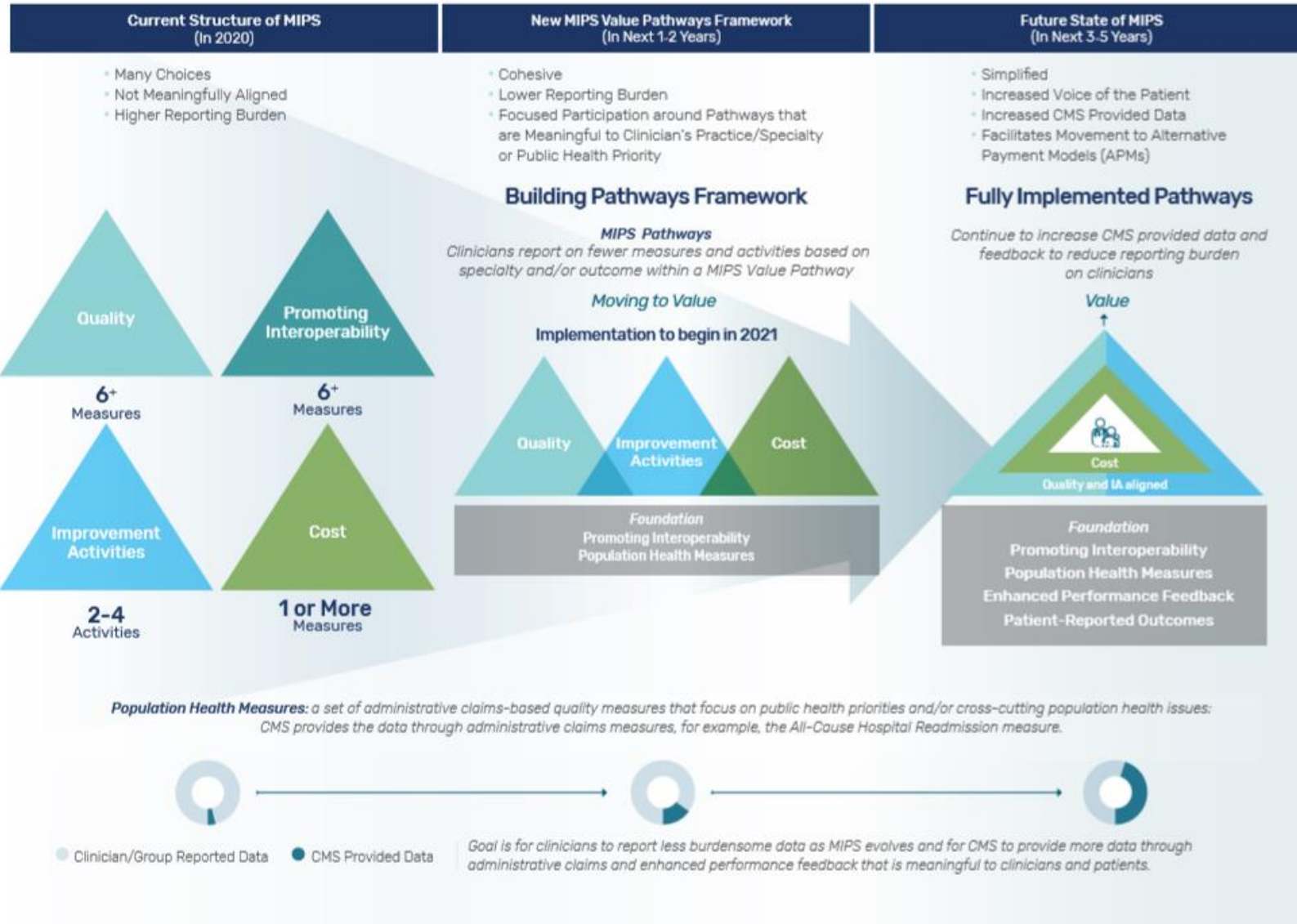
# Quality Payment Program

## 2020 Final Rule – MIPS Path










- **MIPS Value Pathways**

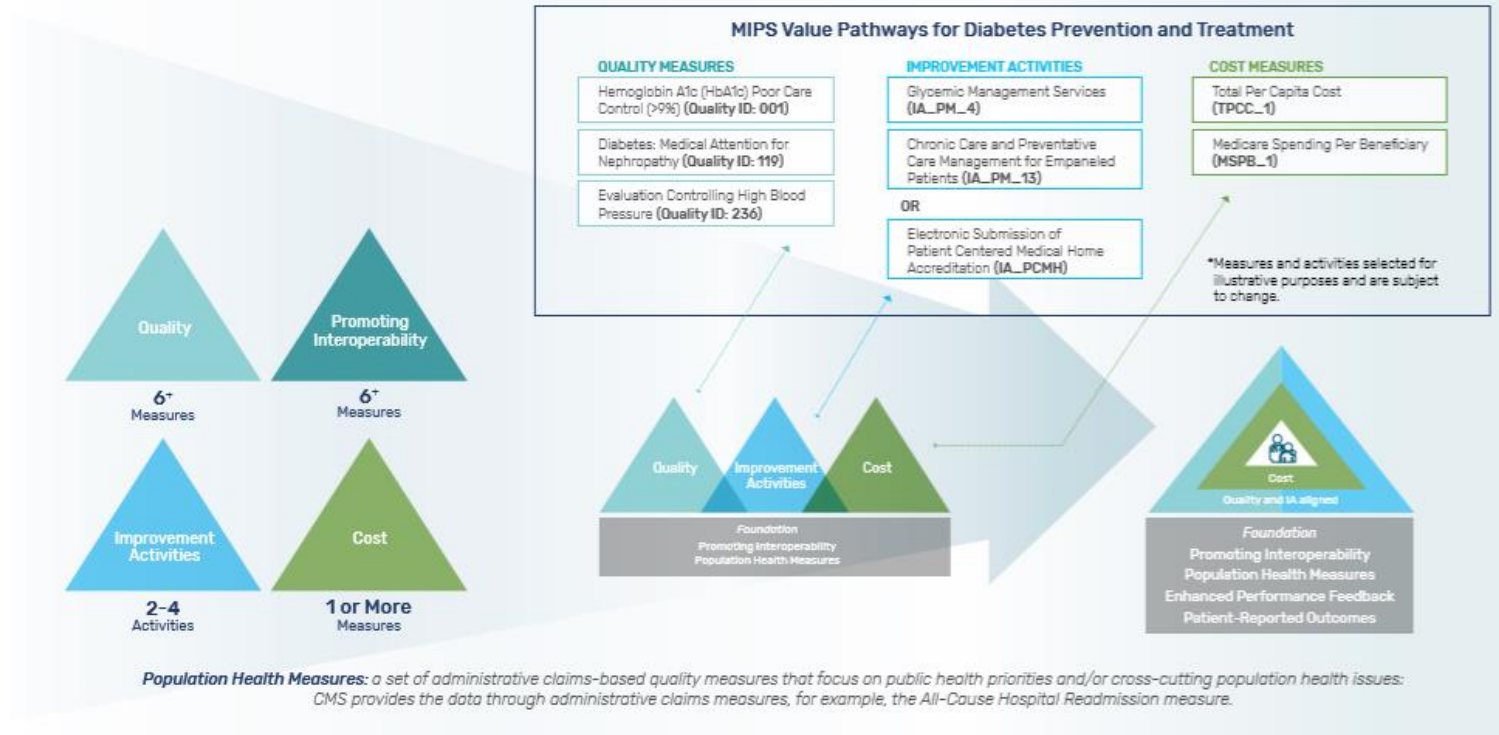
- New framework **to be implemented in PY2021**
- To align and connect measures and activities across the four MIPS performance categories (Quality, Cost, Promoting Interoperability, and Improvement Activities) for different specialties and conditions
- Integrated approach to performance measurement
- Will be based on administrative claims-based quality measures focused on population health/public health priorities, which is designed to decrease reporting burden
- Will include enhanced data and feedback given to providers
- Details to be developed
- Plan diagram, video, and additional details available on QPP website at <https://qpp.cms.gov/mips/mips-value-pathways>

# MIPS Value Pathways



# MIPS Value Pathways: Diabetes Example

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
 <p>Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area</p>	 <p>Endocrinologist reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment</p>	 <p>Endocrinologist reports on same foundation of measures with patient-reported outcomes also included</p>
 <p>Four performance categories feel like four different programs</p>	 <p>Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice</p>	 <p>Performance category measures in endocrinologist's Diabetes Pathway are more meaningful to their practice</p>
 <p>Reporting burden higher and population health not addressed</p>	 <p>CMS provides more data; reporting burden on endocrinologist reduced</p>	 <p>CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist's reporting burden even further reduced</p>





# MIPS Value Pathways: Surgical Example

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
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MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track



Surgeon chooses from same set of measures as all other clinicians, regardless of specialty or practice area



Surgeon reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with surgical measures and activities aligned with specialty



Surgeon reports on same foundation of measures with patient-reported outcomes also included



Four performance categories feel like four different programs



Surgeon reports on fewer measures overall in a pathway that is meaningful to their practice



Performance category measures in Surgical Pathway are more meaningful to the practice



Reporting burden higher and population health not addressed



CMS provides more data; reporting burden on surgeon reduced



CMS provides even more data (e.g. comparative analytics) using claims data and surgeon's reporting burden even further reduced

Clinician/Group CMS

Clinician/Group CMS

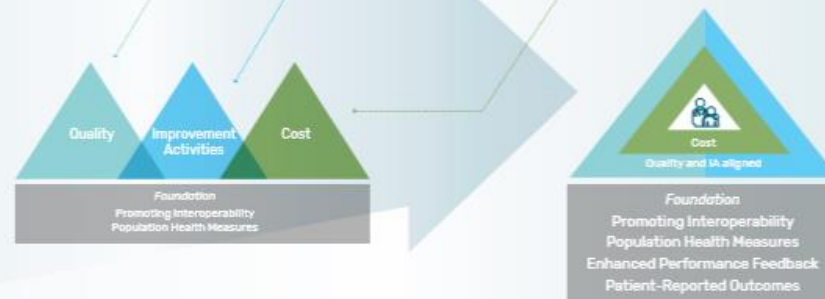
Clinician/Group CMS



### MIPS Value Pathways for Surgeons

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
Unplanned Reoperation within the 30-Day Postoperative Period (Quality ID: 355)	Use of Patient Safety Tools (IA_PSPA_8)	Medicare Spending Per Beneficiary (MSPB_1)
Surgical Site Infection (SSI) (Quality ID: 357)	Implementing the Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop (IA_CC_1)	Revascularization for Lower Extremity Chronic Critical Limb Ischemia (COST_CCLI_1)
Patient-Centered Surgical Risk Assessment and Communication (Quality ID: 358)	OR Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_28)	Knee Arthroplasty (COST_KA_1)

\*Measures and activities selected for illustrative purposes and are subject to change.



**Population Health Measures:** a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

# Quality Payment Program

## 2020 Final Rule – Advanced APM Path

- Finalized a new Aligned Other Payer Multi-payer Medical Home Model definition
  - Must be in conjunction with a CMS agreement
  - Requirements consistent with the Medicaid Medical Home model
- MIPS APMs quality reporting latitude
  - Allowing reporting of MIPS quality measures in fashion similar to Promoting Interoperability measures via NPI or TIN levels (rather than solely via APM)
  - Minimum score of 50% added to Quality score based on APM participation with balance up to 100%



# Quality Payment Program

## 2020 Final Rule – Public Reporting

- Aggregate MIPS PY2018 data available on Physician Compare in late 2019
  - Includes minimum and maximum MIPS scores by performance category
  - Includes minimum and maximum final scores
- Link between Physician Compare and Hospital Compare sites for hospital-based ECs using facility-based measures anticipated in late CY2020

# Quality Payment Program

- For more details about the Quality Payment Program, you can ...
  - Contact me through the information on Slide 2
  - Check out the CMS website [www.qpp.cms.gov](http://www.qpp.cms.gov)

**THANK YOU!**

# Company Overview

## HSG Builds High-Performing Physician Networks so Health Systems Can Address Complex Changes with Confidence.

**Headquarters:** Louisville, KY

**Formed:** 1999

**Client Base:** Non-Profit Hospitals & Health Systems

**Focus:** Health System and Physician Network Strategy and Execution



### Physician Strategy

- Healthcare System Strategic Plans
- Employed Physician Network Strategy
- Growth Strategy
- Shared Vision and Culture Development
- Physician Manpower Plans
- Service Line Strategy
- Co-Management



### Performance Improvement

- Network Performance Improvement
- Performance Improvement Implementation
- Network Revenue Cycle
- Practice Care Model Transformation
- Practice Acquisition



### Physician Leadership

- Shared Vision and Culture Development
- Physician Burnout
- Physician Governance and Leadership



### Network Integrity

- Patient Share of Care
- Patient Flow
- Provider Location and Service Analysis
- Market Insight



### Physician Compensation

- Compensation Plan Design
- Fair Market Value and Commercial Reasonableness Opinions



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### **6 Years at HSG 35 Years in the Industry**

#### **Strengths**

- Shared vision and strategic planning
- Physician alignment and engagement
- Physician leadership structure
- Development of clinical operations, assessments, and transformation

#### **Client Accomplishments**

- Worked with client executives and physicians to create shared visions that led to significant advances in network function and outcomes

### **PROFESSIONAL EXPERIENCE**

After retiring from Naval service, Dr. McWilliams spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, a non-teaching community hospital within a larger academic health system. As CMO, he supervised the Medical Staff Services Office and was additionally responsible for quality of care/patient safety/risk management, clinical information systems, physician recruitment and clinical service line development. At the system level, he was intimately involved in creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

### **EDUCATION**

Terry received his MD from the University of Pittsburgh School of Medicine and completed family medicine residency in the Navy. He completed a Master of Science in Jurisprudence (MSJ) in Hospital and Health Law from Seton Hall University School of Law.