



## Value-Based Care in Uncertain Times: Navigating the Quality Payment Program

By: Consensus Health





## Although the Affordable Care Act (ACA) remains in place, changes are likely to continue.

However, the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), which replaced the Sustainable Growth Rate with a roadmap toward value-based payment, is a separate law that was passed with 92 percent bi-partisan support in 2015. Within the MACRA legislation, the Quality Payment Program (QPP) is a complicated yet considered step by CMS toward delivery system reform. The QPP updates the Physician Fee Schedule (PFS) and introduces two interrelated pathways that determine Medicare Part B adjustments: The Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM). MIPS

introduces an amalgam of quality incentive programs for clinicians or groups under the PFS, and APMs expand risk-based payments for various modalities of clinician groups.

Though there are many unknowns regarding how future administrations may affect policy, there is bipartisan support for lowering costs and increasing quality, and the healthcare industry is firmly on the path to value-based care. In the QPP design, CMS has made it clear that greater participation by eligible clinicians in Advanced APMs is its long-term goal. Still, many provider organizations have not yet developed a strategy. In this

whitepaper, we will review the 2018–2019 regulations, and we will present a process to identify existing organizational clinical priorities and strengths that build upon the framework of MIPS to ensure future success in Advanced APMs.

### MACRA: A Moving Target

The 2017 transition year allowed clinicians to pick their pace and choose their level of participation. Those stakeholders who were paying close attention had no shortage of concerns and suggestions, and for its part, CMS was listening.

## Notable changes to the final rule include:

### 1 Increased weight of cost category

Clinicians participating in MIPS are now accountable for the cost of their Medicare patients' care. Previously weighted at 0%, the cost category now accounts for 15% of the final score and is legally mandated to ramp up to 30% in 2022.

### 2 A higher threshold for exemption

CMS has expanded the low-volume threshold to exclude providers with less than \$90,000 in Medicare Part B charges or less than 200 Part B beneficiaries annually.

### 3 Changes to the Quality category

The performance period for the quality category is extended from 90 days to a full calendar year. Participants must submit data for at least six measures for the 12-month performance period. Weighting has been adjusted to 50%.

### 4 Greater push toward APMs

The MIPS Track is intended to foster advancement of Eligible Clinicians into Alternative Payment Models (APM) to help meet CMS' Triple Aim goals. CMS has included the Medicare ACO Basic Track Level E and the Enhanced Track as Advanced APMs. In the aggregate, Advanced APM bonuses are expected to total about \$600–\$800 million for the 2021 payment year.

### 5 Introduction of Virtual Groups

Providing further relief to small practices, CMS now allows solo practitioners and physicians in groups of 10 or fewer to band together virtually, no matter their geographic location or clinical specialty, to report on MIPS measures. As a group, they are assessed and scored collectively.

## Quality & Cost Performance:

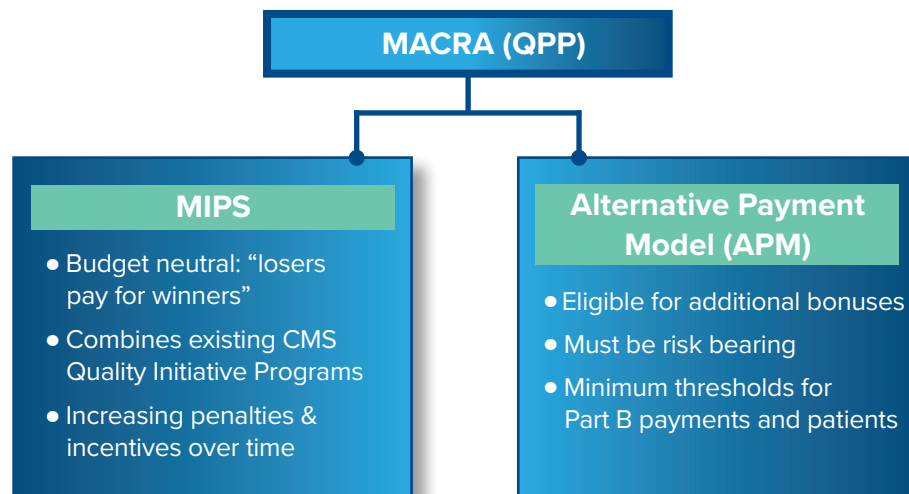
### Key Determinants of High-Performing MIPS Clinicians

■ Due to changes to the final rule, providers must prioritize their quality performance improvement and cost control efforts in order to succeed under MIPS. The quality and cost categories have been reweighted from their original weights of 60% and 0% to 45% and 15% respectively.

■ The Promoting Interoperability (PI) category, formerly the Advancing Care Information (ACI) category [and previously referred to as Meaningful Use (MU)], will continue to be weighted at 25%, and Improvement Activities will still be 15% of the score.

■ In addition, quality reporting has become a bit more challenging for participants. Providers must report a full year of data for at least six measures and one of these measures should be an outcome measure (or high priority measure if the provider does not have an applicable outcome measure).

■ Performance in the cost category will be assessed using the Total Per Capita Cost (TPC) and Medicare Spending per Beneficiary (MSPB) – measures previously used in the value-based modifier program. These will be calculated using claims data, which means there are no additional reporting requirements for providers. In the future, this category will use episode-specific measures to account for differences among specialties. Performance in the cost category will become more important, as by law the weight of the category has increased to 15% in 2019.



It is the right course for CMS to minimize the burden of participation and strive for clinician buy-in. However, the reporting flexibility offered during the transition year of 2017 provided temporary relief. Increasing performance thresholds will continue for both MIPS and APM participants. The net effect of reduced financial penalties in a budget-neutral program will be to lower the overall pool of incentive payments. In other words, any money that may have gone to lower performers in the past, will now be used entirely to fund the high performers. If clinicians are disincentivized to compete for payments, some groups may choose to neglect transformation efforts while others attain maximum incentives

through careful planning. This trajectory will add contrast to a fundamental choice:

***Will an organization choose to chart a course that is incentive-seeking or penalty-avoiding?***

MACRA's long-term objective is higher Advanced APM participation by eligible clinicians. As MIPS adjustment percentages increase over time the performance gap will widen for MIPS participants, creating preferable conditions for many to seek out the “more than nominal” risk-bearing, yet less volatile, payment terms of Advanced APM participation. Organizations will need a strategy to assess existing clinical priorities and strengths that build upon the MIPS framework to position themselves for this benefit structure.



## A Practical Approach to MIPS: What Are You Doing Today?



### How clinicians fare in the QPP is largely dependent on the quality initiative programs they are engaged in today.

By concentrating efforts on existing quality incentive program participation, an organization will position itself to make strategic choices about future engagement.

What did you do in the last 18 months? Did your organization take a more passive approach in avoiding penalties and looking for exclusions? Or did you engage in one of CMS' value based care programs and begin planning for 2019 and beyond? The following are some practical benchmarking exercises that all organizations should be applying today:

#### Quality

- If you participated, which quality measures did you choose and what did you achieve? Are there measures that the individual or group may find to be more clinically relevant than those which are currently being submitted to CMS? Have you evaluated your performance over time and against industry benchmarks?

- Analyze the relative weight of Part B payments across the organization's clinicians. A typical group will have a range of revenue that follows an 80/20 curve, or a small percent of high performers followed by a "long tail." It is important to prioritize quality improvement activities for top earners as this will have the biggest impact on overall adjustments for the group. More importantly, assess how the revenue you are generating is impacting health outcomes; are quality measures improving?

- Does the organization have a track record of administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey? Data from these surveys will help your organization better understand the patient experience and make appropriate changes.

- Is your physician leadership engaged and providing input regarding those quality measures on which you should focus going forward? Provide decision-support data to your providers to validate measures on which you focus moving forward.



#### Promoting Interoperability

- Promoting Interoperability (PI)—formerly ACI and once referred to as Meaningful

Use—objectives that comprise the score include measures aimed at achieving four objectives: Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.

- You must use a 2015 edition Certified Electronic Health Record Technology (CEHRT).

#### Improvement Activities

- Clinical Practice Improvement Activities is a category closely aligned with elements of the Patient-Centered Medical Home (PCMH). Currently-certified PCMH entities will receive full credit for this element.

- CMS added new improvement activities, resulting in over 100 options from which providers may choose to demonstrate their performance.

#### Cost

- Cost is now a fully assessed component of the MIPS score. Has your organization reviewed its Performance Feedback to determine cost and quality scores against the national benchmarks?

- Look closely at two specific cost measures: Medicare Spending per Beneficiary (MSPB) and Total Per Capita Cost (TPC).

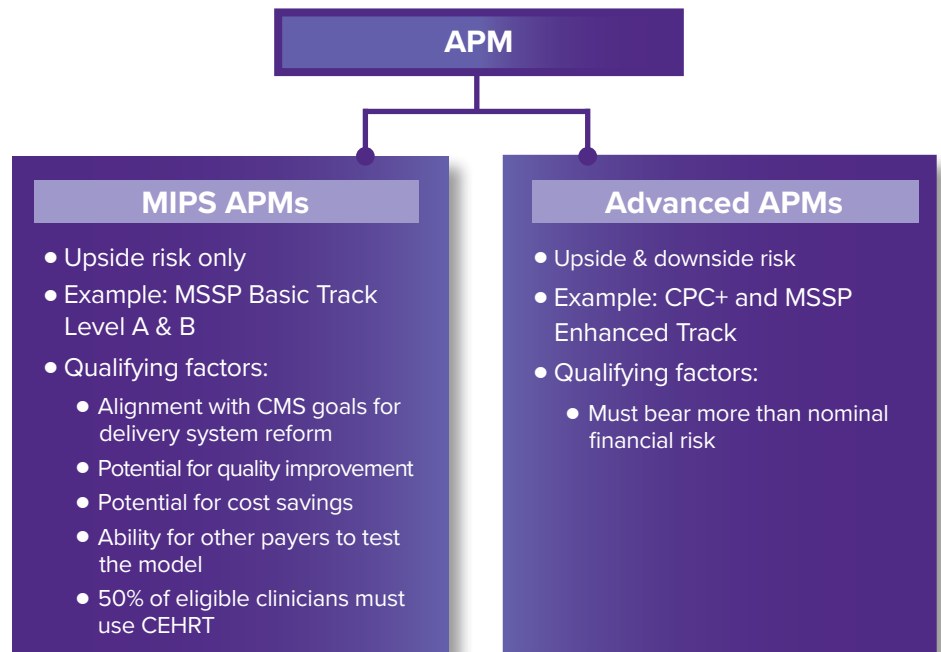
## Ramping up to Advanced APMs

MIPS engagement will be used as a baseline for future APM activity, but is the organization ready to assume financial risk? Are policies, processes, and analytics in place to measure if actual costs will exceed projected expenditures? These are critical questions that must be answered to determine whether the transition to Advanced APMs can happen.

After developing a MIPS-based strategy, an organization can make better-informed decisions about if and how to participate as an APM or Advanced APM entity. Intermediary models such as MSSP Basic Track may provide a means for many to test the waters of performance-based payment arrangements. Using experience in these and other programs, strategies can be aligned to inherent strengths based on historical performance in clinical quality measurement and utilization.

By comparing quality measures that crosswalk between the Performance Feedback report and the QPP Web Interface, a focus on quality improvement can be achieved. Likewise, socialized patient level details and practice level outcomes will guarantee higher performance within the ACO or Medical Home by way of improved care coordination.

Additionally, public reporting of quality



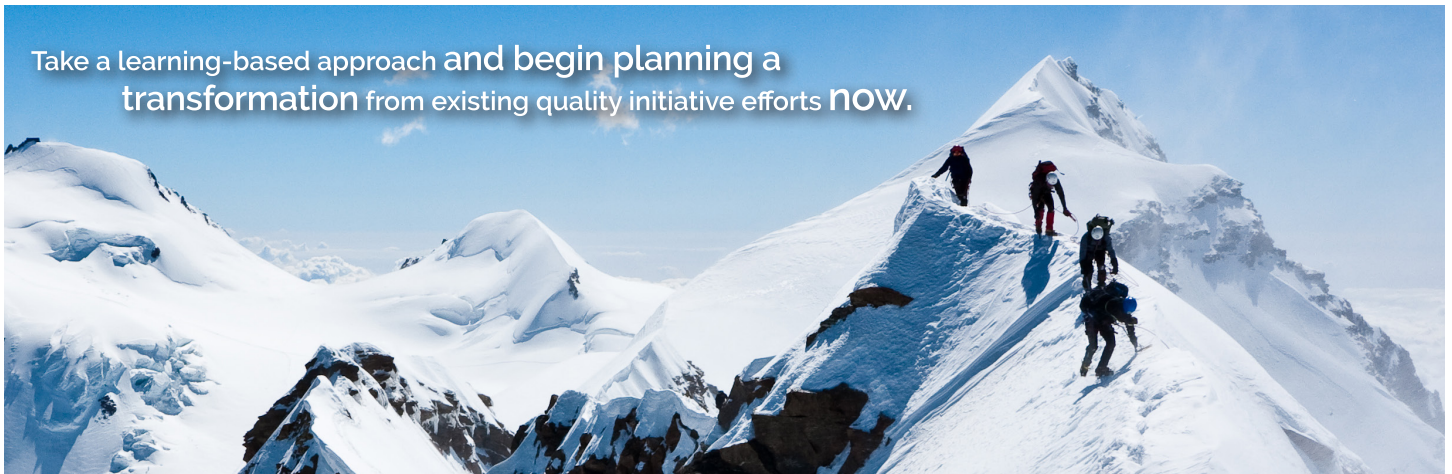
ratings on CMS' Physician Compare website will be a factor in how practices compete in the marketplace, and non-participation will delay any favorable reviews. More than 500,000 clinicians will be published to "Physician Compare" in 2019 to increase transparency and exert further pressure on providers to improve performance. Before dismissing the accuracy or contextual validity of these reviews, organizations would be well-advised to consider the potential future uses. The consumer-generated ratings that CMS makes available on the Physician Compare website will be the same dataset that innovative tech start-ups will have available to them. Consumers shopping for healthcare providers may not be going

straight to the Physician Compare website for reviews, but they may be using a third-party app or website that does.

## Learning by Doing

CMS doesn't expect organizations to make the leap to Advanced APMs overnight. The QPP is designed to reward increased measurement, improvement, and risk assumption over time. Take a learning-based approach and begin planning a transformation from existing quality initiative efforts now. Leverage the analytics and workflow redesign capacity of the EHR to develop a clinically appropriate and cost-saving strategy to value-based care. Lastly, take a cue from CMS and solicit input from customers, in this case patients and caregivers.

Take a learning-based approach and begin planning a transformation from existing quality initiative efforts now.







## Healthcare Reform Will Evolve Over Time

What remains to be seen is how the mechanisms for controlling spending will change. CMS and commercial payers are committed to reducing costs through value-based payment models. The inclusion of Other Payer APMs will accelerate the move away from MIPS and toward integration with commercial payers. Provider groups will need to consider their partners based on the success of population health management strategies that focus on risk stratification.

There will be growing emphasis on bundled payments for episodes of care largely across

specialties such as Orthopedics, OB/GYN, and Oncology.

Criticism of the MIPS program is consistent with the necessary evaluation of any Quality Improvement initiative. It is important to remember, however, that changes to MACRA must be made through Congressional legislation and will depend on the conditions of that process. Regardless of future administrative changes, the fundamental elements of market competition, data transparency, and patient access will remain central to any future legislation.

### About Consensus Health

Consensus Health is a high-performing, physician-owned medical group for New Jersey's independent primary care and specialty providers. By joining other like-minded peers, you'll experience a better, faster and less expensive solution that can substantially improve revenue, job satisfaction and work/life balance. Providers retain autonomy without membership fees or long-term contracts. Consensus Health members also enjoy a full spectrum of proven and scalable practice management and population health services designed to make healthcare more efficient and effective. Learn more at [www.consensushealth.com](http://www.consensushealth.com).

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