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AMA President Answers Top Questions About the Quality Payment Program

Dr. Birnholz:

New rules issued by the Centers for Medicare and Medicaid Services are intending to provide physicians with a smoother transition to the Quality Payment Program, or QPP, but understanding just what these changes are within a system of this size and magnitude can be challenging, so we'll address them head-on with a leading voice from the AMA in today's program.

This is Inside Medicare's New Payment System on ReachMD, and I'm Dr. Matt Birnholz. Joining me to share updates on CMS's Quality Payment Program changes in 2018 is Dr. David Barbe, President of the American Medical Association. Dr. Barbe is a board certified family physician and in his clinical practice serves as Vice-President of Regional Operations for Mercy Clinic in Springfield, Missouri.

Dr. Barbe, it's great to have you on the program.

Dr. Barbe:

Thank you very much. I appreciate the opportunity and look forward to sharing some information with your audience.

Dr. Birnholz:

All right. Well, with that, let's get started. But before we start examining the QPP changes in detail, can you just share some initial thoughts on the AMA's general position toward these changes and where you think we're headed?

Dr. Barbe:

Sure. I think as most of your listeners know, the QPP, Quality Payment Program, came out of the MACRA legislation that was passed in 2015, so we've known it was coming. We've worked with CMS, or Centers for Medicare and Medicaid Services, since that time to help develop the implementation of MACRA into this first performance year. The first performance year was 2017and we were pleased that CMS gave physicians quite a bit of latitude going into that first year. Much of that came from recommendations that the AMA has made. So during the first year, we began looking forward to the second year, and CMS was looking at what rules they were going to put into place for the 2018 performance year, and we are very pleased that CMS did adopt many of the recommendations that the AMA had brought forward. Unfortunately, as in most rules and regs, we didn't get everything we asked for, and there are some pieces of this that we don't support, but the vast majority of the changes going into 2018 are consistent, I think, with the AMA's recommendations for a second transition year.

It's important to remember that CMS estimates that 97% of eligible clinicians will not have a penalty based on their 2018 performance, and of course that penalty is applied two years down the line, so for 2017, whatever a physician's performance was will be applied to the 2019 payments; then into this year of 2018 performance, that will be applied to the 2020 payments. I've also heard many physicians say that they think this is fairly complicated. And while there are still, you know, it still takes a little effort to understand the program. I would suggest to them that QPP is a significant improvement over those Legacy programs that came into place prior to MACRA. They came in kind of in a, I'll say, a haphazard way over ten years. We had PQRS that was one program, and we had Meaningful Use that was another, and we had the Value-Based Payment System or Value-Based Modifier that was a third, none of which were ever designed or even contemplated to work together. MACRA brought those three programs together, have been harmonizing these programs; they have had elimination of some of the overlapping measures so that we're not penalized twice for the same thing. The pass/fail approach of those Legacy programs has been eliminated. Physicians can get partial credit. They don't have to get 100% score to avoid penalties. So, while it's still complicated and it does require some effort, which is part of the reason we're talking today, we do believe

that this is a significant step in the right direction to try to make the various Value-Based Payment Programs more relevant to physicians and quite honestly easier to be successful at participation.

Dr. Birnholz:

That's a great overview, Dr. Barbe. And on that last point, I want to tackle some of the components of this complicated system that you just talked about and understand them better in turn. So, first off, are there any general changes to the MIPS program in 2018?

Dr. Barbe:

So there were several fairly significant changes, and I'll be brief on these, and we can go back and talk about them in more detail if we need to. There has been an exclusion for very small practices. This current year, 2017, a practice was excluded from the program if their allowed charges for Medicare patients were under $30,000 or if they had fewer than 100 Medicare patients. Those thresholds will be expanded now, and it goes up to 200 Medicare patients or $90,000 of allowed charges, so if your practice is smaller than that, you are excluded or exempt from participation in the MIPS or QPP program. So that will exclude a fairly sizable number of additional small practices. In fact, CMS estimates that only about 37% of all clinicians who bill Medicare will actually be subject to MIPS' part of the QPP.

Some other significant changes are that small practices, which means 15 or fewer eligible clinicians, will actually receive five bonus points right out of the gate, and they get that before they even start working on their other metrics, and if a practice treats complex patients, they can receive up to an additional five bonus points over and above their general performance. So those are good things.

Probably one of the other big changes is that in the first performance year, quality was weighted at 60%, and the cost component was rated at 0%, so there was not a penalty or a bonus for the cost part of this first year. The AMA and other organizations advocated to keep it that way because we believe some of these cost measures really are not ready for primetime yet. In one of the areas that we didn't agree with CMS on, CMS felt that it needed to go ahead and dial in some on the cost, so the cost piece of QPP for 2018 is at 10%, and the quality piece is reduced to 50%, so that's a pretty important point.

And the last thing I'll mention is that CMS did create an automatic extreme and uncontrollable circumstance hardship exemption for physicians affected by, for instance, the recent hurricanes and the wildfires that happened in 2017. So those are some of the general changes to the program looking forward to next year.

Dr. Birnholz:

And I want to come back to the weighting here, especially around the performance categories. I understand that CMS also dropped a number of episode measures that were in place in 2017, and that there were some other changes that affected the weighting from 2017 to 2018. Can you talk to those a little bit?

Dr. Barbe:

The weight changes, as I indicated, really only occurred in the quality program and in the cost program, so the cost does have a factor now and is that 10% of the total program. Unfortunately, the episode measures that were in place in 2017 were dropped because CMS felt they needed additional revision. And while we agree that they needed revision, they were actually probably better than the measures that still remain, because right now going into 2018, the only two cost measures they'll be using will be the total cost of care, which takes all of the Part A and Part B costs for a given patient and attributes those to the physician with the most nonhospital visits. That's the most ambulatory visits. We really don't think that that's the best way to do that, and it runs considerable risk I think for some of those physicians. The second cost score relates more to the inpatient side, and that is the spending per beneficiary from three days before to 30 days after a hospital inpatient stay. All of that inpatient cost is attributed to the physician that has the highest amount of allowed charges during the admission. So, again, we really don't think these are measures that are ready for primetime. We did advocate that the cost category stay zero.

Part of CMS's motivation to increase it, however, was the fact that unless something changes the following year, 2019, the cost category is statutorily dialed in to go up to 30% of the total program, so CMS felt that they had to begin to introduce some cost component into the formula, so that's what we have right now. Just on a side note, we are advocating strongly for legislation that will allow CMS to continue to transition more slowly in 2019 and beyond so that they don't have to go up to 30% in the cost category in 2019.

Dr. Birnholz:

And the advocacy element is a good lead-in to my next question, which circles back to small practices. I know the AMA has been a very strong advocate for helping to accommodate small practices within the QPP changes, but what specific accommodations are being

made for small practices heading into 2018?

Dr. Barbe:

You know, and as I go around the country, probably one of the most concerning questions I get is from small groups, and there are a lot of small groups out there still. We sometimes think that all physicians have merged into these mega groups, and that is simply not the case. And while it will continue to be challenging for small practices, CMS with the AMA's advocacy has attempted to make it a program under which small practices can be successful. First of all, as I've indicated already, the low volume threshold has been raised, and therefore, more small practices will actually be exempt from the program. But for those who are still in the program, number one, there are five bonus points right off the bat for small practices, again 15 or fewer eligible clinicians. Then there is a new opportunity for small groups to group together in what are called virtual groups that would allow small practices and solo practitioners the option of reporting as a group; and, in fact, that would help them maybe share some expenses of gearing up to do the data-gathering and reporting, gain some economies of scale that they would not have had perhaps in standalone groups, so that's helpful. There are also some more favorable scoring rules for the small practices, especially in the quality category. And then there are hardship exemptions, particularly around the Advancing Care Information or the old-fashioned Meaningful Use, that make it possible for small practices to stay with their current electronic health record, or EHR, and they're not forced or required to move up to newer technology, and that's a big deal for a lot of small practices that have difficulty coming up with the capital to upgrade their EHRs.

Dr. Birnholz:

For those who are just joining us, this is Inside Medicare's New Payment System on ReachMD, and I'm Dr. Matt Birnholz. I'm speaking with Dr. David Barbe, President of the American Medical Association, about changes to the Quality Payment Program.

So, Dr. Barbe, you just gave us a quick rundown of some of the electronic health record requirement changes and the impacts that that are projected to have, specifically protecting physicians who haven't necessarily migrated to new systems yet. Are there other central changes within this Advancing Care Information performance category that you want to talk about?

Dr. Barbe:

Predominantly, it's a matter of physicians being able to stay with the certified technology of 2014 as opposed to having to upgrade to the 2015 certified electronic health record technology. What that also does is allows physicians to continue to report under what they may be familiar with as Stage 2 of the Meaningful Use program as opposed to being required to go up to Stage 3, which is quite a bit of a higher bar. So, we can remain at the modified Stage 2; we can stay on the 2014 certified electronic health record platform. However, if the practice is ready to move up to the 2015 edition and report on Stage 3 measures, there's actually an opportunity for those practices to get an additional ten bonus points by moving up to the higher level of technology. So, while it's not required, there are some incentives for doing that.

Dr. Birnholz:

What about the Improvement Activities Performance category? Were there any changes there?

Dr. Barbe:

So, the Improvements Activities category is the new category under MIPS. I mentioned those other three Legacy programs. Improvement Activities was new and added in the original legislation. It was in place in 2017. These are for activities that are mostly patient-facing and help give patients more access, longer hours, more access to the EHR, that sort of thing. We were pleased that CMS will continue to allow practices to report through simple attestation, which means you can just say, "Yes, we are doing this," and CMS takes you at your word. There will, of course, be an opportunity for audits (inaudible 13:50) in random practices, but you don't have to submit a lot of data to qualify for performance in the Improvement Activities category. Also, there are some additional accommodations in this category for small rural practices, for health professional shortage areas, and if you're a physician that's in a non patient-facing practice, it's easier to adopt these improvement activities. Many of these now are around things that really are more relevant to physicians, things like diabetes prevention programs, simply using or consulting the Appropriate Use Criteria for advanced diagnostic imaging, those sort of things, using or employing digital health tools in your practice. The AMA has been supporting these types of activities for quite some time, and we're glad that they now meet the criteria for improvement activities under QPP.

Dr. Birnholz:

And staying on that performance track, what were some of the key changes in the Quality Performance category specifically?

Dr. Barbe:

So we were pleased that we're still only required to report six quality measures. There was quite a bit of discussion about should that be eight or should that be ten, and we were able to convince CMS to stick with six. The reporting threshold does go up a little bit. You have to report now on 60% of the eligible patients in a given category. That was 50% in the first year, so that's gone up just a little bit. There's another part of that quality performance reporting that talks about data completeness. You have to report on at least 20 patients, and as I indicated, at least 60% of your total applicable patients for that particular quality parameter. Now, the good thing is there are many quality performance metrics that you can choose from, so depending on your practice, I strongly encourage physicians to pick a metric that makes some sense for their practice. Physicians really don't like it when they are asked to do something that they don't think is relevant or that doesn't actually improve quality. I encourage physicians to pick something that is relevant to their practice, that they feel will enhance the quality of patient care that they give.

I will say that we're continuing to work with specialty societies. Some of the quality metrics for specialty societies are a little bit thin, but we believe that CMS is progressing in the right direction and at a pace that most physicians can accommodate.

Dr. Birnholz:

And on that note of picking what works for one's practice, it in a circular way brings up the concept of Alternative Payment Models, or APMs, which is a frequently asked area as far as where CMS is headed. Did CMS make any changes for physicians participating in APMs?

Dr. Barbe:

So the APM is the other track to participate successfully under MACRA or the QPP. All of what we've been talking about up to now is basically under the MIPS or Merit-based Incentive Payment System. The MIPS does cover the vast majority of physicians in this country right now. Going forward, we believe that more and more physicians will transition into Alternative Payment Models or Advanced Alternative Payment Models. And CMS I think has a prejudice toward that, so they're trying to make it a little bit easier for physicians to move into—successfully move into APMs. The revenue standard will remain at 8% nominal risk for the next two years, and that's good. There was some discussion about that being raised. And we've actually advocated for it being lowered, but we at least have that held steady at nominal risk. If you're in a medical home, it has a lower financial risk standard, and that will be phased in or ramped up more slowly than we had at first thought. So, for instance, going into 2018, the risk standard from medical homes will be at 2.5%, up from 2% this year.

There are more demonstration projects coming down the line. CPC, or the Comprehensive Primary Care Plus APM is being enhanced and expanded. We hope there are more primary care practices that will be able to take advantage of that. And some ACOs that are Track 1 that have only upside opportunity and no downside risk, those have not qualified as an Advanced Payment Model up to now--an Advanced Alternative Payment Model up to now-- and we're hoping that some of those are going to become a Track 1+ that would allow them to be an Advanced APM going forward. So we think that, again, CMS seems to have an interest in seeing practices move into the Alternative Payment Models and is trying to make it a little more lucrative and easier for practices to do that.

Dr. Birnholz:

And Dr. Barbe, before we close, let's make sure that we cover one of the most pivotal questions on people's minds, which comes back to the idea of avoiding a penalty in 2020. You had mentioned earlier that up to 97% of physicians will be able to avoid a penalty in 2020, if I heard you correctly, but the big question, of course, to many people is: How can their practices go about doing that, especially with 2018 reporting? So can you tell us a little bit about this?

Dr. Barbe:

So these first two years under MACRA are transitional years to allow practices to ramp up and get familiar with the new rules and the new measures. In 2017, the year that's about to close, all a physician had to do to avoid a penalty was report on one patient on one quality metric one time, and that got you out of the penalty phase. So, really, there shouldn't hardly be any physician that can't report on one patient one time. That was in 2017. Although we advocated for something similar in 2018, it shouldn't surprise any of the listeners that CMS wanted to move up a little bit from that, so for the 2018 performance year, physicians must hit 15 points in the total program in order to avoid a penalty. And there are a lot of ways that physicians can do that. Again, this new model allows physicians to participate in the areas that are most relevant to them, so they may do more in the Improvement Activity category and just the least amount possible in the Quality category or vice versa. But if they report on one improvement activity and one quality measure, they should be able to hit 15 points, particularly if you're a small practice because you've got five bonus points coming in. A larger practice needs to report on let's say two quality measures and the Advancing Care Information or the Meaningful Use part, hit their base score on that, that would exempt them from a penalty in 2018. So, the bar isn't real high to avoid a penalty. Now, obviously, you'll have to perform somewhat higher than that to get into a bonus opportunity, but we believe that quite a few practices after this year will be doing that, and

we're very hopeful that some practices will, in fact, get bonuses for their 2018 performance year that would then be paid in 2020.

Dr. Birnholz:

Well, with that, I very much want to thank my guest, Dr. David Barbe, President of the American Medical Association, for joining me today.

Dr. Barbe, this was a great overview of the QPP changes and what we can expect moving forward. Thanks so much for your time.

Dr. Barbe:

Thank you. I appreciate the opportunity.