The 2021 QPP Final Rule: A Warning Bell for ACOs and a Wake-Up Call for MIPS Participants

written by Dave Halpert | December 3, 2020

In a mere 2,165 pages, CMS has solidified the provisions of the 2021 Physician Fee Schedule and Quality Payment Program (QPP) Final Rule. The Final Rule strongly resembles the Proposed Rule, and the implications, particularly for ACOs, are staggering.

Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs) and the Alternate Payment Model (APP) Pathway

The most substantial change is that 2021 will mark the introduction of the Alternate Payment Model (APM) Performance Pathway, known as the APP. The APP aligns MIPS and APM participation more effectively in the Quality Payment Program (QPP). The APP is a pre-defined set of measures for all APMs, including ACOs, and will replace the 10 measures reported through the Web Interface. APMs will be scored on 2 utilization measures that CMS will score through an internal administrative

claims analysis, a patient experience measure, and 3 measures reported by the ACO or other APM:

- Hemoglobin A1c control for patients with diabetes;
- Blood pressure control for patients with hypertension;
- Screening for clinical depression and follow-up.

On the surface, a decrease from 10 reported measures to 3 sounds like a reprieve. The truth is, the manner in which the measures are reported and calculated makes for a dramatic shift.

As they stand today, ACO measures are reported through the CMS Web Interface, and CMS presents a sample of 248 patients per measure category. In other words, even the largest ACOs have a capped the number of patients for whom quality data must be reported, and this can handily be accomplished by teams of chart reviewers at the end of the year.

The APP only requires APMs (including ACOs) to report on 3 measures, but there's a catch: the measures are reported in the MIPS CQM (Clinical Quality Measure) fashion. That means three massive changes to quality reporting:

- Organizations must report on at least 70 percent of the TOTAL measure denominator.
- The measure denominator includes ALL patients—not just Medicare patients.
- The measures may only be submitted by Qualified Registries or QCDRs.

Let's look at this in practical terms. For a large ACO, a

measure for, say, depression screening (triggered by any office visit during the year) could mean tens of thousands of patients. This exponential increase from 248 patients is multiplied further, as these measures must be reported for ALL patients, not just patients with Medicare Part B coverage. When the measure spec says “all patients aged 18 years and older,” that is the literal denominator. So, even though the number of measures has decreased by 70 percent, the number of required data points has exploded.

ACOs will not be able to rely on a set timeframe for chart review based on a capped number of eligible patients; there is insufficient time to start at the end of the year, even if (and that’s a big if) all of the clinicians and practices within the ACO are documenting the three measures consistently, particularly the depression screening measure.

CMS did grant a brief extension on the availability of its Web Interface. In the Proposed Rule, CMS announced plans to remove the Web Interface for the 2021 performance year. However, based on stakeholder feedback, CMS ruled that the Web Interface will remain live for 2021, giving ACOs a one-year option of reporting the existing 10 measures before the mandatory shift to the APP measure submission.

While this may seem like a stay of execution, strategically inclined ACOs will recognize that running a tandem approach to quality reporting in 2021 is the safest decision. Here’s why:

1. It's been shown that experience is the greatest indicator of ACO success.

ACOs that have integrated data amongst their practices by using CMS claims files (as opposed to data collection and integration) will find this insufficient for meeting reporting requirements, as all patients are included in APP reporting. Those who begin working with Qualified Registries experienced in data aggregation from multiple EHRs (even if those EHRs aren't ONC-certified) can help identify gaps—whether they are gaps in care or gaps in data—that can be addressed before APP reporting is the only option. Those who don't meet this challenge in advance will find themselves playing catchup among their peers.

2. It will take longer than expected to set up templates for data collection.

To succeed in quality reporting under the APP, a blitz of end-of-year chart reviews is simply not feasible. This means that the only way to succeed at the end of the year is to collect data throughout the year. Providers will need to change their workflows in order to ensure that the information required for the measure is (a) present in the record and (b) documented in a manner that it can be transmitted via data interface. This means NO "FREE-TEXTING" in a notes section—the information must be collected in a discrete manner to be useful.

While blood pressures are commonly collected discretely (numbers entered into a defined field) and hemoglobin A1c may be captured via electronic interface with a lab (beware of scanned documents!), the biggest hurdle will be the depression screening measure. Providers will need to know how to collect

this information in a “machine-readable way,” and to understand why it is important—without their buy-in, the information will not be collected to the necessary degree. ACOs will need to factor in the time it will take to build and implement EHR templates, train providers, and identify issues. It’s going to take time, and trying to implement this process during the performance period is akin to fixing an airplane midflight.

3. New ACOs are given an incentive to report through the APP—they will be scored under a “pay for reporting” standard, rather than for performance.

In other words, as long as they meet the data completeness and case minimum thresholds, they will meet the Quality performance standard. Since an ACO may be terminated if they do not meet the Quality standard in two consecutive years or any three years within their agreement with CMS, having the option of a pay-for-reporting year is a huge incentive. Not only will the new ACOs be more prepared for mandatory APP reporting, but also they will have already identified areas for improvement going forward. Established ACOs who choose to wait must recognize that not everyone will go into 2022 as first-time APP reporters, and waiting for the mandatory year to begin puts them at risk for failing to meet the Quality reporting standard.

The Pressure Mounts on MIPS Participants

Interestingly, CMS begins its section on the Quality Payment Program and MIPS by describing its desire to move MIPS participants into Alternate Payment Models. CMS notes that, as it exists today, MIPS does not provide the sort of data-driven

comparisons required for meaningful performance measurement. MIPS Value Pathways (MVPs) are meant to address these two concepts. While COVID-19 has pushed MVPs back a year (finalized for 2022, rather than 2021), they will be a critical component as MIPS evolves.

The MVP timeline and structure is moving on as proposed, with some additional clarifications to the MVP definition. CMS has published a template for future MVP proposals from organizations, and clarified some of the MVP guiding principles:

- MVPs should consist of limited and connected measures and activities, which will reduce burden and align scoring.
- MVPs should generate comparative performance data that enables patients and caregivers to make informed decisions when seeking care.
- MVPs should choose measures that reflect the Patient Voice, if possible, while drawing from the Meaningful Measures framework.
- MVPs should use APM quality and cost measures whenever feasible, so as to prepare organizations for a jump to an APM.
- MVPs should support the transition to digital quality measures.

MVPs are designed as APP springboards, rather than mandatory frameworks. Of course, program rules tend to begin with voluntary participation options before advancing into mandatory requirements (or at least, as a necessary step to clear the highest tier for incentives). Savvy organizations will recognize this discussion of MVPs as an opening salvo, and

should prepare for mandatory MVP participation—even if MVPs aren't mandated by Rule, the question is academic; organizations are being steadily guided into comprehensive value-based care arrangements—whether MVPs or APPs—and will be reimbursed as such. Even though they will not be available for reporting until 2022, just like APPs, those who don't begin the process now will be doomed to chase the pack.

Even those who choose to forgo MVP participation for now face new challenges.

The performance threshold is set to 60 points, which was initially mandated in the 2020 Final Rule. This minimum standard was decreased in the Proposed Rule, but CMS reestablished 60 points as the minimum standard. Anyone who scores below that threshold is subject to a negative payment adjustment (read: penalty) in 2022.

In developing a MIPS strategy, a minimum threshold of 60 points will make it nearly impossible to ignore either the Quality or Cost portions of MIPS. In prior years, organizations could safely clear the minimum performance threshold without performing well on both Quality AND Cost. The prior 45-point threshold enables clinicians to score well on either Quality OR Cost (along with moderate performance on Promoting Interoperability and Improvement Activities) without incurring a penalty. However, in 2021, without scoring well on both Quality (40 points) and Cost (20 points), achieving the minimum 60 points will be a challenge, and the 85-point Exceptional Performance bonus will be nearly impossible.

Meeting the minimum threshold will become even more challenging

in future years, as Quality and Cost must each account for 30 points of the Total MIPS score by 2022. In other words, there will be a substantial step up in terms of Cost weighting next year, from 20 percent to 30 percent.

Key Takeaway

CMS is creating a backdrop that will substantially separate MIPS and APM participants, and there will be winners and losers. While a one-year reprieve from the close of the Web Interface may seem worthy of a sigh of relief, ACOs should recognize that delaying a move into the APP in 2021 could spell disaster in 2022. Likewise, MIPS participants who do not prepare for their MVP submission by defining their goals and identifying how they'll ask to be scored will face an uphill battle to remain competitive with groups who move from MIPS to APMs or develop data-driven strategies to succeed in MVPs. Value-based care is here, and to succeed in 2021 and beyond, organizations will need to plan and execute a long-term plan that begins with a short-term push.

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