Medicare Access and CHIP Reauthorization Act of 2015: An Overview of Alternative Payment Models

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Agenda

- MACRA Overview
  - What is it?
  - What does it do?
  - Who does it affect?
- Alternative Payment Model
  - Definition
  - Different Types
  - Performance Categories/Weights
  - Scoring Methodology
  - Incentive Payments

Agenda

- Physician Focused Payment Models
  - Definition
  - Governance Structure
  - Relationship to APMs
  - APM-Qualifying Criteria
- Resources
- Q&A

Learning Objectives

- Define an APM
- Explain the difference between an APM, an Advanced APM, and an APM Entity
- List three things providers can be doing now to prepare for the transition to MIPS

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Abbreviations

ACI	Advancing Care Information
ACO	Accountable Care Organization
APM	Alternative Payment Model
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEHRT	Certified EHR Technology
CMS	Centers for Medicare & Medicaid Services
CPIA	Clinical Practice Improvement Activities
CQM	Clinical Quality Measure
EH	Eligible Hospital
EHR	Electronic Health Record

Abbreviations

EP	Eligible Provider
ESRD	End-Stage Renal Disease
FFS	Fee-for-service
LDO	Large Dialysis Organization
MACRA	Medicare Access & CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MSSP	Medicare Shared Savings Program
MU	Meaningful Use
NPI	National Provider Identifier
NPRM	Notice of Proposed Rulemaking

Abbreviations

OCM	Oncology Care Model
ONC	Office of the National Coordinator for Health IT
PFS	Physician Fee Schedule
PQRS	Physician Quality Reporting System
QCDR	Qualified Clinical Data Registry
QP	Qualifying APM Participant
QPP	Quality Payment Program
SGR	Sustainable Growth Rate
VM	Value-based Payment Modifier

MACRA

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The Medicare Access & CHIP Reauthorization Act of 2015

- What is it?
- What does it do?
- What are its goals?
- Who does it affect?

MACRA Regulation: Two Tracks

- CMS is implementing MACRA as the Quality Payment Program (QPP)

- Quality Payment Program
  - Merit-Based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)

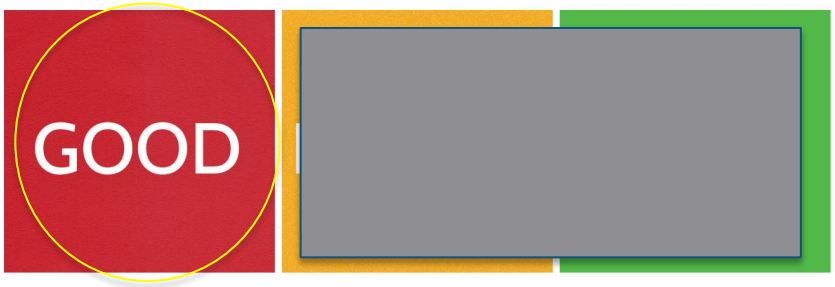

The Alternative Payment Model Track

What's in a name?

- APM
  - Model under which payment is being made
- APM Entity
  - Organization that participates in an APM through a direct agreement with CMS or other non-Medicare payer
- Eligible Clinician
  - Medical professional that meets the definition of an eligible clinician under §414.305 and works in an APM entity
- Qualifying APM Participant (QP)
  - An eligible clinician determined by CMS to have met or exceeded relevant payment amount or patient count threshold

What is an APM?

- Section §1115A of The Social Security Act (the Act)
- Shared Savings Program under §1899 of the Act
- Demonstration Project under §1866C of the Act
- A demonstration required by Federal law
- Other Payer



What is a MIPS APM?

- APM entities that participate in an APM under an agreement with CMS;
- APM entities that have ≥ 1 MIPS Eligible Clinician(s) on a Participation List; *and*
- APM bases payment incentives on performance related to cost or utilization and quality measures

MIPS APM Scoring Standards

MIPS GROUP STANDARDS	MIPS APM STANDARDS
≥ 2 MIPS Eligible Clinicians	May be comprised of single MIPS Eligible Clinician
All MIPS Eligible Clinicians must use the same TIN and must have assigned billing rights to that TIN	May include more than one TIN
All MIPS Eligible Clinicians must report under the group	May include some MIPS Eligible Clinicians who report as part of the APM and some MIPS Eligible Clinicians who do not
Composite Performance Score = Scores for all MIPS Eligible Clinicians aggregated to create single CPS for entire group	Composite Performance Score = Scores for all MIPS Eligible Clinicians reporting under the APM Entity aggregated to create single CPS for entire APM Entity

Shared Savings Program

MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Performance Category Weight
Quality	Shared Savings Program ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to determine the MIPS quality performance category score at the ACO level.	50%
Resource Use	The Shared Savings Program ACO participating MIPS eligible clinicians would not be assessed on Resource Use.	N/A	0%
Clinical Improvement Performance Activities	All MIPS eligible clinicians participating in the APM Entity group submit under this category according to the MIPS requirements and have their CPIA performance assessed as a group through their billing TINs associated with the ACO.	All ACO participant group billing TINs will receive a minimum of one half of the total possible points. Additionally, any ACO participant TIN that is determined to be a patient-centered medical home or comparable specialty practice will receive the highest potential score. All of the ACO participant TIN scores for MIPS eligible clinicians in the APM Entity group will be aggregated, weighted and averaged to yield one ACO level score.	20%
Advancing Care Information	All MIPS eligible clinicians participating in the APM Entity group submit under this category according to the MIPS requirements and have their performance assessed as a group through their billing TINs associated with the ACO.	All of the ACO participant group billing TIN scores will be aggregated as a weighted average to yield one ACO group score.	30%

Next Gen ACO

MIPS Performance Category	Alternative Payment Entity Reporting Requirement	Performance Score	Performance Category Weight
Quality	ACOs submit to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to develop the ACO MIPS quality score.	50%
Resource Use	The ACO and its participating MIPS eligible clinicians are not assessed on resource use.	N/A	0%
Clinical Improvement Performance Activities	All MIPS eligible clinicians in the APM Entity group submit individual level data for this category.	All MIPS eligible clinicians in the APM Entity group will receive a minimum of one half of the total possible points. Additionally, any MIPS eligible clinician that participates in a patient-centered medical home or comparable specialty practice will receive the highest potential score. All of the MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	20%
Advancing Care Information	All MIPS eligible clinicians in the APM Entity group submit individual level data for this category	All of the MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	30%

Other MIPS APMs

MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Performance Category Weight
Quality	The APM Entity group would not be assessed on quality under MIPS in the first performance period. The APM Entity group would submit quality measures to CMS required by the APM.	N/A	0%
Resource Use	The APM Entity group would not be assessed on resource use under MIPS in the first performance period.	N/A	0%
Clinical Improvement Performance Activities	All MIPs eligible clinicians in the APM Entity group would submit individual level data for this performance category	All MIPS eligible clinicians in the APM Entity group would receive a minimum of one half of the maximum score. Additionally, any MIPS eligible clinician in the APM Entity group participating in a patient-centered medical home or comparable specialty practice would receive the highest potential score. All APM Entity group eligible clinician scores will be aggregated and averaged to yield one APM Entity score. Any MIPS eligible clinician in the APM Entity group who does not submit data for this category would contribute a score of zero.	25%
Advancing Care Information	All MIPS eligible clinicians in the APM Entity group would submit individual level data for this performance category.	All APM Entity group eligible clinician scores would be aggregated and averaged to yield one APM Entity score. Any MIPs eligible clinician in the APM Entity group who does not submit data for this category would contribute a score of zero.	75%

What is an Advanced APM?

- ≥ 50% of participants required to use CEHRT
- Provides payment for Medicare Part B based on quality measures comparable to those of MIPS
- Must bear more than a “nominal” amount of risk for monetary losses **OR** be a Medical Home Model expanded under 1115A of the Social Security Act

An Advanced APM by any other name…

- Alternative Payment Model
- Medicare Medical Home Payment Model
- Combination All Payer and Medicare
- Other Payer Alternative Payment Model

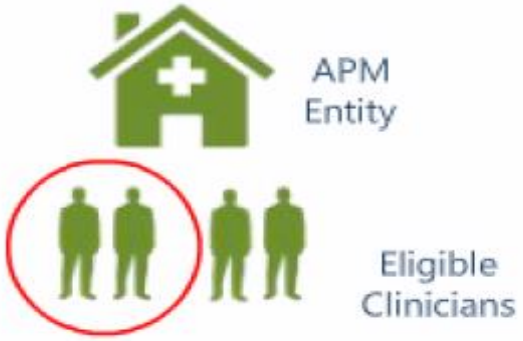
Current APMs Graduating to Advanced APMs in 2017

- ✓ Shared Savings Program (Tracks 2 and 3)
- ✓ Next Generation ACO Models
- ✓ Comprehensive ESRD Care (CEC)
- ✓ Comprehensive Primary Care Plus (CPC+)
- ✓ Oncology Care Models (OCM)

Advanced APM Criterion 1: CEHRT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 50% of an APM Entity's eligible clinicians must use CEHRT.



- ✓ An Advanced APM must **require at least 50% of the eligible clinicians in each APM Entity to use CEHRT** to document and communicate clinical care. The threshold will **increase to 75%** after the first year.
- ✓ For the **Shared Savings Program only**, the APM may apply a **penalty or reward** to APM entities based on the degree of CEHRT use among its eligible clinicians.

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Advanced Criterion #2: Quality Measures

Quality Measures

- ✓ An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

- ✓ **Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:
  - Quality measures that are endorsed by a consensus-based entity; or
  - Quality measures submitted in response to the MIPS Call for Quality Measures; or
  - **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**

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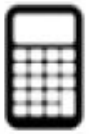
Advanced Criterion #3: Financial Risk



Financial Risk

An Advanced APM must meet **two standards**:

Financial Risk Standard

APM Entities must bear risk for monetary losses.

&

Nominal Amount Standard

The risk APM Entities bear must be of a certain magnitude.

- ✓ The Advanced APM financial risk criterion is **completely met** if the APM is a **Medical Home Model** that is **expanded under CMS Innovation Center Authority**
- ✓ Medical Home Models that **have not been expanded** will have **different financial risk and nominal amount standards** than those for other APMs.

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Advanced Criterion #3: Financial Risk

Nominal Risk

↓

Marginal Risk ≥ 30% of Expected Expend.

+

MLR ≤ 4% of Expected Expenditures

+

Total Risk ≥ 4% of Expected Expenditures

Advanced Criterion #3: Financial Risk

Budgeted Expen.	Actual Expend.	Marginal Risk (40%)	Min Loss Ratio (4%)	Potential Risk (15%)	Outcome
$1,000.000	$1,200,000	$80,000	$4,000	$150,00	APM Entity owes CMS $100,00

Becoming a QP

- How do I qualify
  - Be an eligible clinician practicing in an Advanced APM entity that meets the patient count or payment amount threshold
- What are the benefits?
  - Receive 5% lump sum payment for years 2019-2025
  - Effective 2026 receive higher PFS update
  - Exempt from MIPS requirements
- Must requalify every year

Keeping it Simple

Basic APM = MIPS

Payment/Patient Thresholds

Payment Year	Payment Amount Method	Patient Count Method
2019/2020	**25%**	20%
2021/2022	**50%**	35%
2023/2024+	**75%**	50%

Two Types of QPs

- For Advanced APMs, there are two types of QPs
  - Fully qualified
    - Meets higher thresholds for qualification
    - Entitled to 5% lump sum payment
    - Excluded from MIPS payment adjustment
  - Partially qualified
    - Meets lower thresholds for qualification
    - Not entitled to any portion of the 5% payment
    - May choose to be subjected to MIPS payment adjustment (could be positive or negative)

APM Options Expand in 2021

- 2019 and 2020: Eligible clinicians may become QPs only through participation in Advanced APMs

- 2021 and later: Eligible clinicians may become QPs through a combination of participation in Advanced APMs and APMs with other payers (Other Payer Advanced APMs)
  - Other Payer Advanced APMs are developed by non-Medicare payers, such as private insurers or state Medicaid programs
  - Other Payer Advanced APMs also include Medicaid Medical Home Models

Eligible Clinicians aren't the only ones getting paid

3 types of payments made to Advanced APMs

1. Financial Risk Payments
2. Supplemental Service Payments
3. Cash Flow Mechanism Payments

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Physician-Focused Payment Model

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What is it?

- Targets quality and cost of physician services, such as physician behavior and/or clinical decision-making
- Must include individual practitioners as well as physician group practices; may also include facilities
- Designed to be tested as APM or Advanced APM with Medicare as payer
- Could include other payers in mode, but would not include Other Payer APMs.

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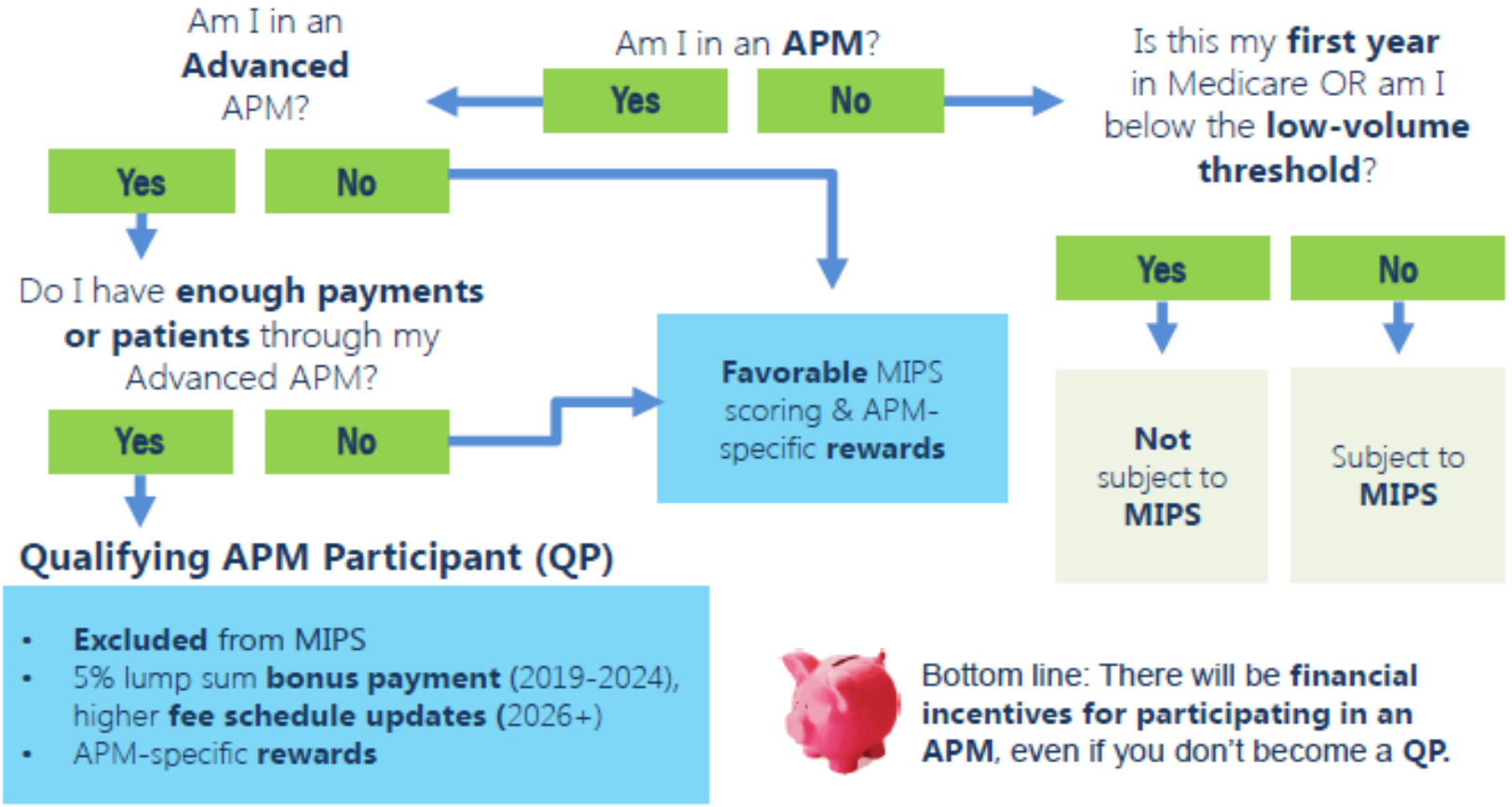
Three PCPM APM Criteria

1. Pay for value over volume
2. Better care coordination, patient safety & patient engagement
3. Information availability

As a Medicare Clinician, what are my Options under MACRA?



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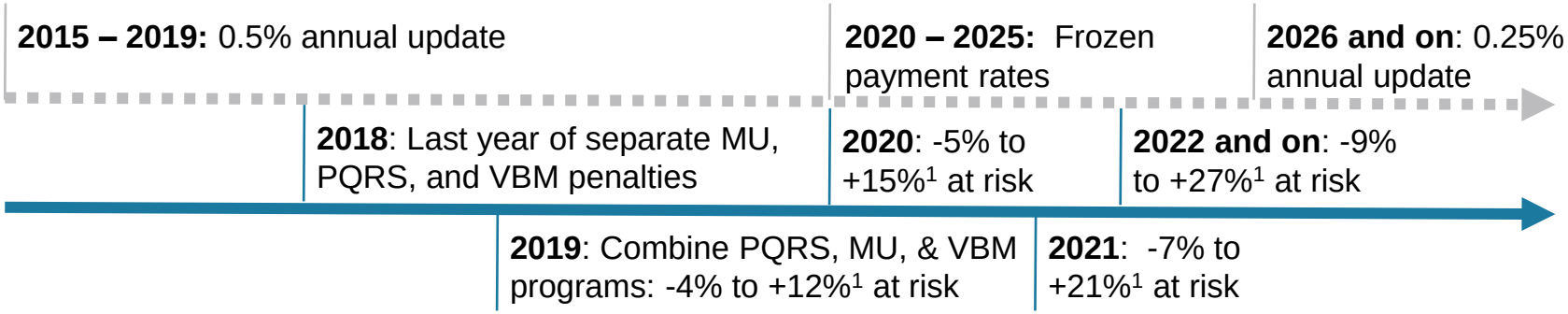
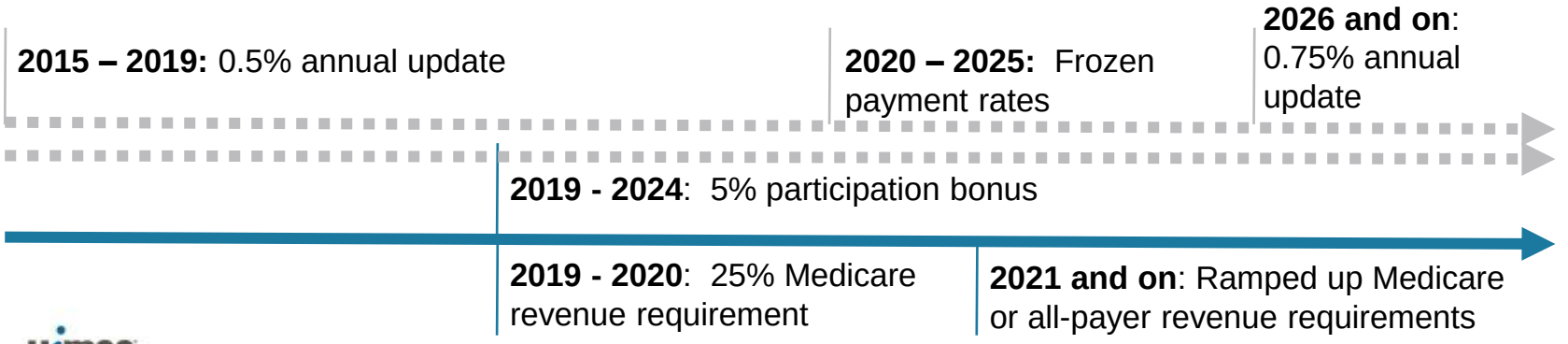
MACRA Creates Two Tracks for Providers

Providers Must Choose either MIPS or APM Track, not both

Merit-Based Incentive Payment System (MIPS)



Advanced Alternative Payment Models (APMs)



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The Challenge

Providers must decide whether to submit MIPS data before they know if they will qualify for APM track.

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What should I be doing now?

- Review current quality metrics reporting requirements for your organization and your performance
- Understand the data you are currently tracking and review existing benchmarks
- If you're not already part of a clinical data registry, consider joining one
- Assess your EHR functionality and certification status
- Make sure you have a clear picture of your current patient population
- Review your business processes – do they support MIPS/APM requirements?

AMA's 5-Step Process

Five-Step Process to Develop an APM

The AMA encourages medical societies to use a simple 5-step process for developing the types of APM proposals that will work effectively for physician practices and that Medicare and other payers can implement under MACRA:

- Establish a committee of physicians who are willing to spend the time needed to develop one or more APMs.
- Identify specific opportunities to improve patient care that are likely to result in specific types of spending reductions, and identify the specific barriers in existing payment systems that make it difficult for physicians to implement these improvements in patient care.
- Identify the payment changes needed to overcome these barriers. Not all APMs actually overcome the barriers, and some have unintended consequences that can create new problems for physicians.
- Analyze whether the benefits for patients and the savings for payers and patients are sufficient to justify any costs associated with appropriate payment changes.
- Design a payment model that removes the barriers to improving care so that physicians can improve outcomes for patients and achieve savings for payers.

Source: http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-alternative-payment-models.page

HIMSS MACRA Resources

- Visit the HIMSS MACRA Resource Center at http://www.himss.org/MACRA-resource-center
  - Link to the NPRM
  - Fact Sheets
  - Webinar Recordings

Be Part of the Conversation

- CMS is soliciting public comment (due June 27)
- HIMSS membership-wide call scheduled
  - Friday, June 3, 2:30-4:00 pm EST
  - Focus will be APMs
- Contact Eli Fleet (HIMSS Director, Federal Affairs) to sign-up at efleet@himss.org

Questions?

Please submit your questions using the Chat Box. Thank you!

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Thank you for your participation

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