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When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram
KEY TOPICS:

1) The Quality Payment Program and HHS Secretary’s Goals
2) The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs)
3) Medicaid and Private Payers
4) Next Steps
In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare.

**Medicare Fee-for-Service**

**GOAL 1:**
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

30%

**GOAL 2:**
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018.

85%

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals
Quality Payment Program

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- **Provides incentive payments** for participation in Advanced Alternative Payment Models (APMs)

The Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs)

- First step to a fresh start
- We’re listening and help is available
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric
MERIT-BASED INCENTIVE PAYMENT SYSTEM
MIPS: First Step to a Fresh Start

✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs** to work as one and to ease clinician burden.
  - Adds a fourth component to **promote ongoing improvement and innovation to clinical activities**.

✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**
Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. FIRST year of Medicare Part B participation

2. Below low patient volume threshold

3. Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS does not apply to hospitals or facilities
How much can MIPS adjust payments?

Note: MIPS will be a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

-4% to +9%

*Potential for 3x adjustment
INCENTIVES FOR ADVANCED APM PARTICIPATION
APMs are new approaches to paying for medical care through Medicare that incentivize quality and value.

As defined by MACRA, APMs include:

- CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law
Advanced APMs meet certain criteria.

As defined by MACRA, Advanced APMs must meet the following criteria:

- The APM requires participants to use certified EHR technology.
- The APM bases payment on quality measures comparable to those in the MIPS quality performance category.
- The APM either: (1) requires APM Entities to bear more than nominal financial risk for monetary losses; OR (2) is a Medical Home Model expanded under CMMI authority.
NOTE: MACRA does NOT change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.
How do I become a **Qualifying APM Participant (QP)**?

You must have a *certain %* of your patients or payments through an **Advanced APM**.

QPs will:

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026.
1. QP determinations are made at the Advanced APM Entity level.

2. CMS calculates a “Threshold Score” for each Advanced APM Entity.

3. The Threshold Score for each method is compared to the corresponding QP threshold.

4. All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.

✓ The period of assessment (QP Performance Period) for each payment year will be the full calendar year that is two years prior to the payment year (e.g., 2017 performance for 2019 payment).

✓ Aligns with the MIPS performance period.
MEDICAID AND PRIVATE PAYERS
What about Medicaid or private payers APMs? Can they help me qualify to be a QP?

Starting in 2021, some arrangements with other non-Medicare payers can count toward becoming a QP.

IF the “Other Payer APMs” meet criteria similar to those for Advanced APMs, CMS will consider them “Other Payer Advanced APMs”: Certified EHR use, Quality Measures, Financial Risk.
Medicaid Medical Home Models:

- Have a **unique financial risk criterion** for becoming an Other Payer Advanced APM.
- Enable participants (who are not excluded from MIPS) to receive the maximum score in the MIPS CPIA category.

A Medicaid Medical Home Model is an Other Payer APM that has the following features:

- Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- **Empanelment of each patient** to a primary clinician; and
- **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.
PROPOSED RULE
Other Payer Advanced APM Criterion 1: Requires use of CEHRT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 75% of an APM Entity’s eligible clinicians must use CEHRT.

✓ An Other Payer Advanced APM must require at least 75% of the eligible clinicians in each APM Entity to use CEHRT to document and communicate clinical care.
PROPOSED RULE

Other Payer Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

- An Other Payer 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 Other Payer 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.
PROPOSED RULE

Other Payer Advanced APM Criterion 3: Requires APM Entities to Bear More than Nominal Financial Risk

An Other Payer 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 Other Payer Advanced APM financial risk criterion is **completely met** if the APM is a **Medicaid Medical Home Model** that meets criteria comparable to Medical Home Models **expanded under CMS Innovation Center Authority**.
- Medicaid Medical Home Models that **have not meet the standard above** will have **unique financial risk and nominal amount standards**.
PROPOSED RULE

Other Payer Advanced APM Criterion 3: Financial Risk Criterion

Financial Risk Standard

- ✓ Direct payment from the APM Entity

OR

- ✓ Reduction in payment rates to the APM Entity or eligible clinicians

OR

- ✓ Withhold of payment to the APM Entity or eligible clinicians

The Other Payer Advanced APM requires one or more of the following if actual expenditures exceed expected expenditures:
The amount of risk under an Other Payer Advanced APM must at least meet the following components:

- **Total risk** of at least 4% of expected expenditures
- **Marginal risk** of at least 30%
- **Minimum loss ratio** (MLR) of no more than 4%.
An APM consists of a **two-sided** shared savings arrangement:

- If the APM Entity’s actual expenditures exceed expected expenditures (the “benchmark”), then the APM Entity **must pay CMS 60% of the amount that expenditures exceed the benchmark**.

- The APM Entity **does not have to make any payments** if actual expenditures exceed the benchmark by **less than 2%** of the benchmark amount.

- There is a **stop-loss provision** so that the APM Entity could pay up to but no more than a **total amount equal to 10%** of the benchmark.
PROPOSED RULE

Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Financial Risk Criterion

The Medicaid Medical Home Model requires one or more of the following if actual expenditures exceed expected expenditures:

- Direct payment from the APM Entity
- Reduction in payment rates to the APM Entity or eligible clinicians
- Withhold of payment to the APM Entity or eligible clinicians
- Reduces an otherwise guaranteed payment or payments
To be an Other Payer Advanced APM, the **amount of risk** under a Medicaid Medical Home Model must be at least the following amounts:

- 4% of payer revenue (2019)
- 5% of payer revenue (2020 and later)

The Medicaid Medical Home Model standards **only apply to APM Entities with ≤ 50 eligible clinicians** in the APM Entity’s parent organization.
All-Payer Combination Option

How do I become a Qualifying APM Participant (QP)?

You must have a certain % of your patients or payments through an Advanced APMs and Other Payer Advanced APMs.

QPs will:

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2021-2024; then QPs receive higher fee schedule updates starting in 2026
Eligible Clinicians submit information to CMS regarding their participation in Other Payer Advanced APMs.

CMS calculates a "Threshold Score" for each Advanced APM Entity, including Medicare and All-Payers (2 stages).

The Threshold Score for each method is compared to the corresponding QP threshold.

All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.

The period of assessment (QP Performance Period) for each payment year will be the full calendar year that is two years prior to the payment year (e.g., 2019 performance for 2021 payment).

Aligns with the MIPS performance period.
PROPOSED RULE
All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 1
✓ QP determinations are made at the Other Payer Advanced APM Entity level.
✓ All participating eligible clinicians are assessed together.
STEP 2

✓ CMS will calculate a percentage “Threshold Score” for each Advanced APM Entity using two methods (payment amount and patient count).

✓ All-Payer Combination Option is based on the sum of payments for Medicare Part B and payments from all other payers, with exceptions.

✓ Methods are based on professional services and beneficiaries attributed to Advanced APM Entities.

✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

Attributed (beneficiaries for whose cost and quality of care the APM Entity is responsible)

Attribution-eligible (all beneficiaries who could potentially be attributed)
**PROPOSED RULE**

**All-Payer Combination Option**

**2021 - 2022**

- **Yes**
  - **QP**
  - **Is Medicare Threshold Score \( \geq 50\% \)?**
    - **Yes**
      - **QP**
        - **Is All-Payer Threshold Score \( \geq 50\% \)?**
          - **Yes**
            - **QP**
              - **Is All-Payer Threshold Score \( \geq 40\% \) OR is Medicare Threshold Score \( \geq 40\% \)?**
                - **Yes**
                  - **Partial QP**
                - **No**
                  - **MIPS Eligible Clinician**
          - **No**
            - **MIPS Eligible Clinician**
    - **No**
      - **MIPS Eligible Clinician**

- **No**
  - **Is Medicare Threshold Score \( \geq 25\% \)?**
    - **Yes**
      - **QP**
    - **No**
      - **MIPS Eligible Clinician**

- **Is Medicare Threshold Score \( \geq 20\% \)?**
  - **Yes**
    - **MIPS Eligible Clinician**
  - **No**
    - **MIPS Eligible Clinician**
STEP 2 Exclusions

Excluded Payments and Patients:

- Department of Defense health care programs
- Department of Veterans Affairs health care programs
- Title XIX in a state with no Medicaid Medical Home Model or APM. In order not to adversely impact physicians who have no opportunity to participate, Title XIX payments or patients would be excluded unless:

  1. a state had at least one Medicaid Medical Home Model or APM in operation that is determined to be an Other Payer Advanced APM; and

  2. the relevant Advanced APM Entity is eligible to participate in at least one such Other Payer Advanced APM, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs.
PROPOSED RULE
All-Payer Combination Option
How do you calculate the Medicare Threshold Score?

STEP 2 – STAGE 1
✓ The two methods for calculation are Payment Amount Method and Patient Count Method.
✓ The two stages for calculating are Medicare first, then all-payers.

Payment Amount Method

$$$
\text{for Part B professional services to attributed beneficiaries}
$$$

= \text{Threshold Score %}

$$$
\text{for Part B professional services to attribution-eligible beneficiaries}
$$$

Patient Count Method

# of \text{attributed beneficiaries} \text{given Part B professional services}

= \text{Threshold Score %}

# of \text{attribution-eligible beneficiaries} \text{given Part B professional services}

Payments

Patients
**PROPOSED RULE**

**All-Payer Combination Option**

How do you calculate the All-Payer Threshold Score?

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**STEP 2 – STAGE 2**

- If the Medicare Threshold Score is not above the QP threshold, then calculate the All-Payer Threshold Score.

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<table>
<thead>
<tr>
<th>Payment Amount Threshold Score</th>
<th>Patient Count Threshold Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>$$$ for Part B professional services to attributed beneficiaries</td>
<td># of attributed beneficiaries given Part B professional services</td>
</tr>
<tr>
<td>$$$ under the terms of Other Payer Advanced APMs</td>
<td># of patients given services under Other Payer Advanced APMs</td>
</tr>
<tr>
<td>$$$ for Part B professional services to attribution-eligible beneficiaries</td>
<td># of attribution-eligible beneficiaries given Part B professional services</td>
</tr>
<tr>
<td>$$$ for from all other payers*</td>
<td># of patients given services under all other payers*</td>
</tr>
</tbody>
</table>
**PROPOSED RULE**

**All-Payer Combination Option**

**How do Eligible Clinicians become QPs?**

### STEP 3

- The All-Payer Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

#### All-Payer Combination Option – Payment Amount Method

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QP Payment Amount Threshold</td>
<td>N/A</td>
<td>N/A</td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Partial QP Payment Amount Threshold</td>
<td>N/A</td>
<td>N/A</td>
<td>40%</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
</tbody>
</table>

#### All-Payer Combination Option – Patient Count Method

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QP Patient Count Threshold</td>
<td>N/A</td>
<td>N/A</td>
<td>35%</td>
<td>20%</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td>Partial QP Patient Count Threshold</td>
<td>N/A</td>
<td>N/A</td>
<td>25%</td>
<td>10%</td>
<td>25%</td>
<td>10%</td>
</tr>
</tbody>
</table>
PROPOSED RULE
All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 4

- **All the eligible clinicians** in the Other Payer Advanced APM Entity become QPs for the payment year.

Eligible Clinicians

Other Payer Advanced APM Entities

Advanced APM

QPs

Threshold Scores above the QP threshold = QP status

Threshold Scores below the QP threshold = no QPs
Find additional information about the Quality Payment Program, including fact sheets, upcoming webinars and more at: http://go.cms.gov/QualityPaymentProgram
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