The Next Decade: Medicare Value-Based Payment Model Trajectory

- Single-site Bundling/Multi-site Bundling
- Medical Homes: Basic/Medical Homes: Advanced
- Shared Savings ACO
- Shared Risk ACO
- MACRA

Source: Centers for Medicare & Medicaid Services
CMS Sets Explicit Goals to Shift Medicare Payment Away from the Traditional Fee-for-Service (FFS)

- 50% of Medicare payment will be tied to APMs by 2018
- The key question is: Does CMS have the policy tools necessary to meet its goals, and if so, does it have the “political will” to use them?

Target Percentages for Medicare FFS Payments Linked to Quality and Alternative Payment Models in 2016 and 2018

- All Medicare FFS (Categories 1 – 4)
- FFS linked to quality (Categories 2 – 4)
- Alternative payment models (Categories 3 – 4)

2016 All Medicare FFS
- 30%
- 85%

2018 All Medicare FFS
- 50%
- 90%

Source: U.S. Department of Health and Human Services
Track 1: Upside Risk Only
Track 2, 3, Next Gen: Upside & Downside Risk
MACRA
MEDICARE ACCESS CHIP Reauthorization Act of 2015

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

- MIPS APM
  (Track 1 ACO)
MACRA
(MEDICARE ACCESS CHIP Reauthorization Act of 2015)

**MIPS (Merit-based Incentive Payment System)**
- Will receive positive or negative adjustment based on performance four categories
- Two-year lag between performance measurement and payment adjustment (2019 based on 2017)
- High performers: Additional bonus 2019-2024

**APM (Alternative Payment Model)**
- Stronger financial incentives
- Higher annual updates
- Several year guaranteed bonus
- Key Qualifying Criteria:
  - Financial risk
Generally Applicable MIPS Category Weighting

2017 Performance Year 2019 Payment Year
- Quality: 60%
- Advancing Care Information: 25%
- Improvement Activities: 15%

2018 Performance Year 2020 Payment Year
- Quality: 50%
- Cost: 25%
- Advancing Care Information: 15%

2019 Performance Year 2021 Payment Year
- Quality: 30%
- Improvement Activities: 25%
- Advancing Care Information: 15%
- Cost: 30%

Confidential: This material is intended solely for informational purposes.
Weighting of Performance Categories for MIPS APMs

MSSP & Next Gen ACOs

- Quality: 20%
- Advancing Care Information: 30%
- Improvement Activities: 50%

Other MIPS APMs

- Advancing Care Information: 25%
- Improvement Activities: 75%
Merit-Based Incentive Payment System ("MIPS")

**Measure Performance**
- Two year look-back: performance measurements begin in 2017 for 2019 adjustments
- 4 weighted categories:
  - Quality, Cost, Advancing Care Information, Improvement Activities
- EHR MU, PQRS, and VBM - sunset in 2018, with many measures incorporated into new MIPS categories

**Composite Score**
- Participants receive an annual final score between 0-100
- Score will be publicly available via Physician Compare

**Threshold Comparison**
- Each clinician's score compared against a Performance Threshold to determine payment adjustments
- Beginning in 2019, performance threshold will be based on the median of MIPS scores

**Additional Adjustments**
- Adjustments are budget neutral - upward adjustment can be scaled up or down, with the scaling factor not to exceed 3 times the baseline adjustment
- Additional exceptional performance adjustment offered to small number of best performers

Confidential: This material is intended solely for informational purposes
Quality Performance Category: 60% - 30%

Care Coordination:
- Readmissions/Transition Care Management
- Seamless care among health professionals
- Team care (Patients, caregivers & families)

Patient & Caregiver Centered Experience:
- Patient & caregiver engagement
- Individual & population level data

Community/Population Health:
- Preventative services: Improve population health

Effective Clinical Care:
- Evidence-based medicine
- Clinical practice guidelines

Patient Safety:
- Processes to reduce risk (Diagnostic accuracy, medication errors)
- Measure the occurrence of adverse events/complications of interventions
Clinicians/groups choose from 90+ activities in the following categories:

**Defined in Legislation:**
- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety & Practice Assessment
- Participation in an APM, including medical homes

**Additional Proposed Domains:**
- Achieving Health Equity
- Emergency Preparedness and Response
- Integrated Behavioral & Mental Health

**FULL CREDIT FOR PARTICIPATION IN AN ACO/PCMH ACCREDITATION**
Advancing Care Information: Overview

Scoring:
- **Base Score**: Yes/no or numerator/denominator measures that clinicians must meet
- **Performance Score**: Clinicians select from a set of measures that best fit their practice, around patient electronic access, patient engagement, health information exchange

**Even more flexibility built in:**
- 155 total possible points - need 100 for maximum score
- 50% base score; 90% for performance measures; 5% bonus for reporting to additional public health registries; 10% for use of CEHRT in certain Improvement Activities
- 90-day minimum performance year for 2017 and 2018, then increasing to full year
Advancing Care Information: Base & Performance Scores

**Base Score**

- To receive the base score, clinicians must provide the numerator/denominator or “yes”/“no” for each measure around 6 objectives:
  - (1) Protecting patient health information
  - (2) Electronic prescribing
  - (3) Patient electronic access
  - (4) Patient engagement
  - (5) Health information exchange
  - (6) Public health/clinical data registry reporting

- Clinicians/groups will need to achieve the base score requirements in order to receive a score for the category

**Performance Score**

- Clinicians will select the measures that best fit their practice from the following objectives:
  - (1) Patient electronic access
  - (2) Coordination of care through patient engagement
  - (3) Health information exchange
Advancing Care Information: Performance Score

Clinicians will select the measures that best fit their practice from the following objectives:

- **Patient Electronic Access**
  - Provide patient access*
  - Patient-specific education

- **Health Information Exchange**
  - Send summary of care*
  - Request/accept summary of care*
  - Clinical information reconciliation

- **Coordination of Care Through Patient Engagement**
  - VDT
  - Secure messaging
  - Patient-generated health data

- **Public Health and Clinical Data Reporting**
  - Immunization registry reporting

Clinicians can earn bonus points for participating in additional public health registries, and for submitting certain Improvement Activities using CEHRT.
Advancing Care Information: Scoring Methodology

**BASE SCORE**
- Full credit for answering "yes" and submitting numerators >1 for each measure under the 5 objectives
- Clinicians/groups not meeting submission criteria for any measure in the base score will receive category score of 0

- **50 points**

**PERFORMANCE SCORE**
- Clinicians/groups receive 1-10 points for each of 8 measures, based on their performance rate above the base score
- Clinicians/groups receive 10 points for reporting to an immunization registry

- **90 points available**

**BONUS POINTS**
- Clinicians/groups may earn 5 bonus points in the category for reporting to any additional public health or clinical data registry
- Clinicians/groups can earn 10 bonus points for achieving at least one Improvement Activity through use of CEHRT

- **15 points available**

Confidential: This material is intended solely for informational purposes
Advancing Care Information: Scoring

\[ \text{Advancing Care Information Domain Score} = \text{Base Score (50 points)} + \text{Performance Score (90 points)} + \text{Bonus (15 points)} \]

If clinicians/groups earn $\geq 100$ points, they receive maximum score.

If clinicians/groups earn $< 100$ points, their overall score in MIPS declines proportionately.
Cost: Overview

- Domain eliminated for 2017 due to attribution & scoring differences from (clinicians/groups will still receive feedback)

- Cost measures finalized as proposed

- CMS will continue to develop new care episode, patient condition, and patient relationship codes, to be included in claims beginning on or after 1/1/2018
  - List of patient relationship codes will be posted by 4/2017 & list of codes for care episodes and patient conditions will be posted by 12/2017
  - New codes will likely not immediately factor into Cost measures in 2018—CMS will need time to evaluate
Cost: Measures

Measures include:
- Total per capita costs (Parts A and B) for all attributed beneficiaries
- Medicare spending per beneficiary (“MSPB”)
- Episode-based measures

CMS finalized 10 of the proposed 41 episode-based measures:
- Mastectomy
- Aortic/Mitral Valve Surgery
- Coronary Artery Bypass Graft
- Hip/Femur Fracture or Dislocation Treatment, Inpatient-based
- Colonoscopy and Biopsy
- Transurethral Resection of the Prostate for Benign Prostatic Hyperplasia
- Lens and Cataract Procedures
- Hip Replacement or Repair
- Knee Arthroplasty
- Cholecystectomy and Common Duct Exploration
Resource Use: (Cost Category) 0%-30%

Improvement on current VM (Value Modifier) which uses 6 measures:

- Total per capita costs for all attributed beneficiaries
- Medicare spending per beneficiary (MSPB)
- Total per capita costs for all attributed beneficiaries

**Condition Specific:**
- COPD
- CHF
- CAD
- DM

Resource use changes:

- 2 out of 6 measures: Total per capita costs & MSPB
- Episode-based measures rather than condition specific
## MACRA Physician Payment Timeline

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Updates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan-Jun</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>MIPS: .25%</td>
</tr>
<tr>
<td>Jul-Dec</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS, MU, VBM Max Penalties</td>
<td>-3.5%</td>
<td>-6%</td>
<td>-9%</td>
<td>TBD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PQRS, MU, VBM Measures Incorporated into MIPS

#### MIPS Baseline Payment Adjustment

- (+/-) 4%
- (+/-) 5%
- (+/-) 7%
- (+/-) 9%
- (+/-) 9%
- (+/-) 9%
- (+/-) 9%
- (+/-) 9%

#### MIPS Maximum Possible Payment Adjustment

- 12%
- 15%
- 21%
- 27%
- 27%
- 27%
- 27%
- 27%

#### MIPS Exceptional Performance Adjustment

- $500 Million Provided Annually by HHS
  - Not to Exceed 10%

#### APM Bonus Payment

- APM Participants Excluded from MIPS
- 5%
- 5%
- 5%
- 5%
- 5%
- 5%

*Source: The Health Management Academy*
MIPS Eligibility Likely to Expand Over Time

In first 2 years, eligible providers include:
Physicians (MD, DO, DDS, DMD, DPM, OD, DC), PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such professionals.

After year 2, HHS can determine other eligible professionals to subject to MIPS
Physical/occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dieticians/nutritional professionals.

3 Exclusions to MIPS participation
1. Falls below “low-volume threshold”
2. First year of Medicare Part B participation
3. Qualification for Advanced APM Track (or Partial Qualifying)
## MIPS Reporting Options

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>GROUP</th>
<th>APM ENTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reports at individual level for each of the 4 performance categories</td>
<td>- A group, defined by TIN, would be assessed as group across all 4 performance categories</td>
<td>- Option available to MIPS clinicians practicing in an APM deemed a “MIPS APM”</td>
</tr>
<tr>
<td>- Receive individual score/payment adjustment at TIN/NPI level</td>
<td>- Receive score/payment adjustment at TIN/NPI level</td>
<td>- All scores aggregated at APM Entity level</td>
</tr>
<tr>
<td></td>
<td>- All MIPS clinicians in group receive the same annual score</td>
<td>- All individuals in APM Entity receive the same annual score</td>
</tr>
<tr>
<td></td>
<td>- CMS will ultimately allow reporting through virtual groups, though not in 1st performance year</td>
<td></td>
</tr>
</tbody>
</table>
MIPS APMs, Favorable Scoring

- Some APMs that are not advanced APMs will be MIPS APMs
- MIPS APMs receive favorable scoring
  - Quality reported through APM program
  - No resource use
  - Full credit for CPIAs
Advanced APM Qualification: Not All Value-Based Models Are Eligible

Necessary Criteria for Qualification:
- Authorized quality measures comparable to MIPS
- Certified EHR utilized
- Participant in an APM entity that bears "more than nominal" financial risk (or a medical home that meets expansion criteria)

Included:
- MSSP Track 2, MSSP Track 3, Next Generation ACO, ESRD Care Model
- To Be Included As Models Become Active: CPC+, Oncology Care Model (two-sided)
- Not Included: MA, MSSP Track 1, Bundles

Eligible APMs

Confidential: This material is intended solely for informational purposes. Source: The Health Management Academy

The Academy
## Option 2: Advanced APMs Statutory Criteria

### Advanced APM

<table>
<thead>
<tr>
<th>Qualifying Model</th>
<th>Quality Measures Comparable to MIPS</th>
<th>Certified EHR</th>
<th>More Than Nominal Risk OR Expanded Medical Home</th>
</tr>
</thead>
</table>

- **Qualifying Model**
- **Quality Measures Comparable to MIPS**
- **Certified EHR**
- **More Than Nominal Risk OR Expanded Medical Home**
Option 2: Advanced APMs Eligible for 5% MACRA Bonus

<table>
<thead>
<tr>
<th>MODEL</th>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Shared Savings Program, Track 2</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>Medicare Shared Savings Program Track 3</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>Next Gen ACO</td>
<td>CMMI</td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+)*</td>
<td>CMMI</td>
</tr>
<tr>
<td>Oncology Care Model Two-Sided Risk Arrangement</td>
<td>CMMI</td>
</tr>
<tr>
<td>Comprehensive ESRD Care (LDO Arrangement)</td>
<td>CMMI</td>
</tr>
<tr>
<td>Certain Mandatory Bundled Payment Participants</td>
<td>CMMI</td>
</tr>
</tbody>
</table>

*Special rules out organization size limited bonus eligibility in CPC*
# (CMS) “Pick Your Pace”

<table>
<thead>
<tr>
<th>OPTION</th>
<th>PARTICIPATION</th>
<th>FINANCIAL IMPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test the Quality Payment Program</td>
<td>Submit “some data”</td>
<td>Avoid penalties</td>
</tr>
<tr>
<td>Participate for part of the year</td>
<td>Submit data in MIPS categories for part of the year</td>
<td>Could qualify for small positive adjustment</td>
</tr>
<tr>
<td>Participate for all of 2017</td>
<td>Submit data in MIPS categories for full year</td>
<td>Could qualify for modest positive adjustment</td>
</tr>
<tr>
<td>Advanced APM</td>
<td>Join a qualifying advanced APM</td>
<td>5% incentive</td>
</tr>
</tbody>
</table>
### Introduction to Proposed MACRA Rule

<table>
<thead>
<tr>
<th>Proposed Performance Year</th>
<th>Payment Year</th>
<th>Merit-Based Incentive Payment System (MIPS)*</th>
<th>Advanced Alternative Payment Models (APMs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2019</td>
<td>+/- 4%</td>
<td>+5%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td>+/- 5%</td>
<td>+5%</td>
</tr>
<tr>
<td>2019</td>
<td>2021</td>
<td>+/- 7%</td>
<td>+5%</td>
</tr>
<tr>
<td>2020</td>
<td>2022</td>
<td>+/- 9% (and beyond)</td>
<td>+5% (to 2024)</td>
</tr>
</tbody>
</table>

*Additional potential bonus for exceptional performers; scaling factor applies if funds are sufficient
### Range of Payment Adjustments Fairly Small in 2017

<table>
<thead>
<tr>
<th>Final Score Points</th>
<th>MIPS Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 0.75</td>
<td>-4%</td>
</tr>
<tr>
<td>0.76 - 2.9</td>
<td>Negative MIPS payment adjustment greater than -4% and less than 0% on a linear sliding scale</td>
</tr>
<tr>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>3.1 - 69.9</td>
<td>Positive MIPS payment adjustment ranging from greater than 0% to 4% x scaling factor to preserve budget neutrality, on a linear sliding scale</td>
</tr>
<tr>
<td>70.0 - 100</td>
<td>Positive MIPS payment adjustment AND additional MIPS payment adjustment for exceptional performance</td>
</tr>
</tbody>
</table>

($199 million)  

$199 million  

$500 million  

Confidential: This material is intended solely for informational purposes  
Source: Adapted from Centers for Medicare & Medicaid Services
ACO Track 1+ Model

- MSSP with 50% shared savings: Same as Track 1
- Lower downside Risk
  - 8% of fee-for-services revenue or 4% of ACO’s updated benchmark
- Prospective beneficiary assignment
- Option to elect SNF 3-day waiver rule
- Eligible for application
  - Those currently in Track 1
  - Date of initiation 2018
- Will qualify as an Advanced APM
Thank you