Navigating Medicare’s Quality Payment Program:
Advanced Alternative Payment Models

Physicians Advocacy Institute
MACRA Educational Series
April 2017
About the Physicians Advocacy Institute

The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges.

PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI can be found at physiciansadvocacyinstitute.org.
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Healthsperien is a Washington, D.C.–based consulting and legal services firm focused on strategic issues operating at the intersection of public policy, business strategies, operations, and government affairs.

The idea behind the firm is to work across and integrate diverse disciplines and experiences to help organizations navigate the complexities and challenges of health care policy, politics, and regulation in a systematic way, with a focus on both health care coverage and payment/delivery system reform. Healthsperien derives from health, inspiration, and experience, and reflects the firm’s commitment to help clients find an innovative way forward in a complex and changing health care environment.

Information about Healthsperien can be found at http://healthsperien.com/.
Guide to the PAI MACRA Educational Series

• **Overall purpose** – Program of materials and resources that provide context, an overview of core concepts and requirements, and an in-depth discussion of important topics

• **MACRA overview** – Foundational presentation and associated webinars to include a focus on meeting requirements for the 2017 transition period. Includes different sections on aspects of MACRA’s Quality Payment Program.

• **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting

• **In development** – Guide to additional resources in physician communities
Acronyms

• ACI – Advancing Care Information Category
• APMs – Alternative Payment Models
• CEHRT – Certified EHR Technology
• EHR/EMR – Electronic Health Registry; Electronic Medical Record
• MACRA – Medicare Access and CHIP Reauthorization Act
• MIPS – Merit-Based Incentive Payment System
• PQ – Partially Qualifying Advanced APM Participant
• QCDR – Qualified Clinical Data Registry
• QP - Qualifying Advanced APM Participant
• QPP – Quality Payment Program
What to find in this presentation . . .

1) **MACRA at 30,000 feet** (slide 8)
2) **Payment Adjustments Timeline** (slide 12)
3) **Advanced Alternative Payment Models** (slide 13)
   - **Advanced APMs under the QPP** (slide 15)
   - **Criteria for Medicare and Other Payer Advanced APMs** (slide 17)
   - **APM Entities Must be Responsible for Risk in Advanced APMs** (slide 18)
   - **APM Entities and Participation in Advanced APMs** (slide 22)
   - **When Physicians Participating in Advanced APMs are Exempt from MIPS** (slide 23)
   - **Participation Thresholds** (slide 24)
   - **Advanced APMs Available in 2017 and Proposed for 2018** (slide 27)
4) **Reporting Timeline** (slide 30)
5) **Next Steps and Looking Forward** (slide 31)
MACRA’s QPP at 30,000 feet
From SGR to MACRA

• MACRA = Medicare Access and CHIP Reauthorization Act of 2015
• Next phase of Medicare fee-for-service payments under Part B
• What does the new system do?
  • Replaces annual updates under Sustainable Growth Rate (SGR) with the Quality Payment Program (QPP)
  • Introduces new opportunities for positive and negative payment adjustments of Medicare Part B payments
  • Combines three quality performance programs (PQRS, value-based payment modifier, meaningful use) into a single program under the QPP
• Regulations finalized in November 2016; final rule went into effect January 1, 2017
• Payment changes begin in 2019 (based on 2017 performance)
Goals of the new payment system

1. Create a new Medicare payment system for physicians (and certain other eligible clinicians) across all specialties that is meaningful and flexible
2. Improve patient outcomes and engage patients
3. Encourage physicians to improve performance with “carrots and sticks”
4. Increase the availability of and participation in risk-based models of care
5. Support broad physician participation, including small/solo practices
6. Simplify complex and multiple reporting and performance systems

Source: CMS MIPS and APM final rule
Two pathways for physicians to choose from

<table>
<thead>
<tr>
<th>Merit-based Incentive Payment System (MIPS)</th>
<th>Advanced Alternative Payment Models (APMs)</th>
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<tbody>
<tr>
<td>• Fee-for-service annual updates</td>
<td>• Enhanced fee-for-service annual updates</td>
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<tr>
<td>• New set of positive and negative payment adjustments</td>
<td>• Exempt from MIPS participation</td>
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<tr>
<td>• 4 performance categories</td>
<td>• Payment incentive for participation in risk-based payment models</td>
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<tr>
<td>• Cost</td>
<td>• CMS has identified eligible models</td>
</tr>
<tr>
<td>• Quality</td>
<td>• More models to evolve</td>
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<tr>
<td>• Improvement activities</td>
<td>• May earn a 5% payment incentive each year 2019-2024</td>
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<tr>
<td>• Advancing care information</td>
<td>• May earn a 0.75% annual Medicare Part B physician fee schedule update for successful participation in Advanced APMs beginning 2026</td>
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<tr>
<td>• Opportunities to participate in alternative payment models (MIPS APMs)</td>
<td>• Those who do not participate successfully in Advanced APMs would receive a 0.25% annual update and may also be subject to MIPS reporting requirements and payment adjustments</td>
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Medicare payment adjustments depend on the pathway selected...

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<tr>
<td><strong>Annual fee schedule updates</strong> <em>(all physicians)</em></td>
<td>+0.5%</td>
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<td>Non-APM: 0.25%</td>
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<tr>
<td><strong>MIPS</strong></td>
<td>+/- 4%</td>
<td>+/- 5%</td>
<td>+/- 7%</td>
<td>+/- 9%</td>
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<tr>
<td><strong>Advanced APMs (Qualifying Participants)</strong></td>
<td>+5%</td>
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*Annual physician fee schedule updates may be downwardly adjusted by other budgetary requirements

**Due to CMS transition relief policies in 2017, available funds may be insufficient to grant a full 4% incentive payment in 2019; additionally, physicians have the potential to receive an additional positive payment adjustment for exceptional performance for payment years 2019-2024
Advanced Alternative Payment Models (Advanced APMs)
What are alternative payment models (APMs)?

• An APM is a payment and delivery approach where participants in the model have financial incentives to provide efficient, high-quality care

• Include elements that diverge from fee-for-service – such as bundled payments or gain-sharing – but may have fee-for-service elements

• Include performance measurement and payment linked to quality and outcomes

• Participants may be at risk for some or all of the costs of care for a population or a service, but there are variations in characteristics and level of financial incentives

• May apply to services for specific conditions, episodes of care, or populations

• Primary care medical home models are often considered APMs

• There are Medicare APMs as well as commercial APMs and multi-payer APMs
What are Advanced APMs under the QPP?

• Subset of broader category of APMs
  
  • *Physicians participating in Advanced APMs must meet the quality and reporting requirements that are subject to participation in the APM (this is separate and distinct form the Advanced APM criteria)*

• Characteristics and criteria for participation defined in MACRA – intention was to set a high bar for model where participants are accountable for cost and quality

• Participating physician may earn a 5% incentive payment – and are exempt from MIPS
  
  • *The 5% incentive payment physicians would receive under QPP would be separate and distinct from the payments for services they receive through the APM*

• Physicians and/or their organizations (called an APM entity) decide whether to participate in the Advanced APM
What types of Advanced APMs are available under the QPP?

Medicare Advanced APMs

- Primary focus of QPP in short-term
- CMS has identified several for 2017 and 2018

Non-Medicare Other Payer Advanced APMs

- Will be implemented beginning with 2019 performance year
- Will potentially include APMs by private payers and state Medicaid payments arrangements and Medicare Advantage
## Criteria for Medicare and Other Payer Advanced APMs

### Advanced APMs

- The APM is a certain CMMI, Shared Savings Program tracks, or certain federal demonstration programs.
- The APM requires participants to use CEHRT.
- The APM bases payments for services on quality measures comparable to those in MIPS.
- The APM is a Medical Home Model expanded under CMMI; or the APM requires participants to bear more than nominal financial risk for losses.

### Other Payer Advanced APMs

- The APM requires participants to use CEHRT.
- The APM bases payments for services on quality measures comparable to those in MIPS.
- The APM requires participants to bear either more than nominal financial risk for losses; or the APM is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models.
Advanced APM Entities must be responsible for performance and risk

- CMS requires APM Entities to take on some risk to help ensure that participants have a vested interest in costs and quality

- To qualify under the QPP, an APM Entity must take on payment risks for years when the APM Entity’s actual expenditures under the Advanced APM exceed its expected expenditures

- Level of risk:
  - The level of risk taken on by the APM Entity must be more than nominal
  - The more than nominal risk determination is based on total Medicare Parts A and B revenues or expenditures

Note – The APM Entity, as a whole, is responsible for taking on the risk; not each individual physician in the APM Entity. The QPP establishes criteria for determining when an APM qualifies as an Advanced APM. How the APM functions in relation to e.g., risk adjustment or related topics of calculated savings/losses is governed by the underlying APM’s rules
To qualify under the QPP, an APM Entity must assume responsibility for performance years when actual expenditures exceed expected expenditures.

When that happens, the APM must provide for one of the following consequences:

- Withholding payments for services to the APM Entity or the APM Entity's participating clinicians; or
- Reducing payment rates to the APM Entity or the APM Entity's participating clinicians; or
- Requiring the APM Entity to owe payment to CMS
The financial risk must be “more than nominal”

In order to ensure that the risk an APM Entity takes on is more than nominal risk, the total amount an APM Entity potentially owes CMS, or foregoes, under an APM must be at least equal to either:

- 8% of the APM Entity’s average estimated total Medicare Parts A and B revenues of the APM Entity
- 3% of the APM Entity’s expected total Parts A and B expenditures for which the APM Entity is responsible for under the Advanced APM
Required elements for receiving the Advanced APM incentive payment

1. APM meets criteria for Advanced APM
2. APM Entity participates in Advanced APM
3. Threshold of participation - Eligible clinicians in an APM Entity must collectively meet QP threshold

Source: CMS MIPS and APM final rule
APM Entities and participation in an Advanced APM

• Participation in an Advanced APM is determined at the APM Entity level

• An APM Entity could include:
  o A sole MIPS physician (a solo practitioner);
  o An organization of physicians and other eligible clinicians with multiple tax-identification numbers (TINs) – but eligible clinicians are identified as participants by their unique APM identifier, or
  o An organization of physicians and other eligible clinicians with APM identifiers with national provider identifier (NPI)/TIN combinations; only some eligible clinicians are APM participants while others are not
When are APM Entity physicians exempt from MIPS?

• To be considered part of an APM Entity and receive credit for Advanced APM participation, physicians must be either:
  o Qualifying Advanced APM Participants (QPs)
  o OR Partially Qualifying Advanced APM Participants (PQs)

• QP and PQ determinations are made based on 2 methods:
  o Medicare patient count method
  o OR Medicare payments method

• What is the difference between QPs and PQs?
  o QPs have higher payment or patient count thresholds than PQs
  o QPs are automatically exempt from MIPS and are eligible to receive a 5% incentive payment
  o PQs have the option to be exempt from MIPS or participate in MIPS and earn a positive payment adjustment; PQs are not eligible for the 5% incentive payment
## Participation thresholds

### Qualifying Advanced APM Participants (QPs)

- 2017 and 2018 thresholds:
  - 25% of the APM Entity’s Medicare payments through an Advanced APM
  - 20% of the APM Entity’s Medicare patients through an Advanced APM
- Eligible for the 5% APM incentive payment
- Exempt from MIPS

### Partially Qualifying Advanced APM Participants (PQs)

- 2017 and 2018 Thresholds:
  - 20% of the APM Entity’s Medicare payments through an Advanced APM
  - 10% of the APM Entity’s Medicare patients through an Advanced APM
- Exempt from MIPS but not eligible for the 5% APM incentive payment
- BUT— have the option to participate in MIPS and be eligible to receive a positive payment adjustment

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**Note** - Participation thresholds are determined for each APM Entity as a whole. An APM Entity could comprise of a sole physician, or comprise of multiple physicians and/or other eligible clinicians under the same or different TINs
Participation threshold calculations

- **Medicare Payment Count Method**
  - The percentage of Medicare Part B payments that are made to all the eligible clinicians in the Advanced APM Entity for all beneficiaries attributed to the Advanced APM Entity
  - Aggregate of all Medicare Part B payments for the attributed beneficiaries, divided by the total Medicare Part B payments for all “attribution-eligible” beneficiaries

- **Medicare Patient Count Method**
  - The percentage of Medicare attribution-eligible beneficiaries who are actually attributed to the Advanced APM Entity
  - The number of unique beneficiaries who are attributed to the Advanced APM Entity, divided by the total number of attribution-eligible beneficiaries

- Attribution under each method – payment and patient – is determined by each Advanced APM’s underlying attribution rules

- **Payments for Part B services to attributed beneficiaries**

- **Payments for Part B services to attribution-eligible beneficiaries**

- 
  \[ \text{Payments for Part B services to attributed beneficiaries} \div \text{Payments for Part B services to attribution-eligible beneficiaries} \geq 25\% \text{ for QP} \]

- 
  \[ \text{\# of attributed beneficiaries provided Part B services} \div \text{\# of attribution-eligible beneficiaries provided Part B services} \geq 20\% \text{ for QP} \]
CMS will make 3 QP/PQ determinations throughout the year

- CMS will make 3 evaluations each performance year to determine whether physicians meet the QP thresholds
- Evaluations will be made at the APM Entity level and will be applied to each physician in the APM Entity
- The three evaluations for 2017 performance will be: March 31, June 30, and August 31
  - Will ensure that physicians who only participate in an Advanced APM and meet the QP thresholds for part of the year still receive their Advanced APM participation credit
  - APM Entities and physicians who meet the QP thresholds during any of these three review periods will be exempt from MIPS and receive the 5% incentive payment
- If an APM Entity meets only PQ thresholds, then the APM Entity can elect whether to be subject to MIPS (using the APM scoring standard for MIPS APMs), or be exempt
- If an APM Entity does not meet QP or PQ thresholds, then they will be subject to the MIPS APM scoring method
How do we know what Advanced APMs are available?

- CMS posted on its website a list of all Advanced APMs for the 2017 performance period.
- At intervals no less than annually, CMS will update the Advanced APM list on its website.
- CMS will include notice of whether a new APM is an Advanced APM in the first public notice of the new APM.

The list of Advanced APMs is available on the CMS Quality Payment Program website: [https://qpp.cms.gov/learn/apms](https://qpp.cms.gov/learn/apms)
Advanced APMs available in 2017

Physicians who have 25% of their Medicare payments or 20% of their Medicare patients through one of the following Advanced APMs will qualify for the 5% APM incentive payment:

- **Comprehensive ESRD Care Model**
  - LDO and Non-LDO two-sided risk arrangements

- **Next Generation ACO Model**

- **Medicare Shared Savings Program ACOs – Tracks 2 & 3**

- **CPC+**

- **Oncology Care Model**
  - Two-sided risk arrangement

- **Vermont Medicare ACO Initiative**
  - As part of the Vermont All-Payer ACO Model

- **Comprehensive Care for Joint Replacement (CJR) Payment Model**
  - Track 1 – CEHRT
### 2018 Proposed Advanced APMs

<table>
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<tr>
<th>Model</th>
<th>Details</th>
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<td>ACO Track 1+</td>
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<td>Cardiac Rehabilitation (CR) Incentive Payment Model</td>
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<td>Comprehensive Care for Joint Replacement (CJR) Payment Model</td>
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<td>Advancing Care Coordination through Episode Payment Models Tracks 1 &amp; 2</td>
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<td>Vermont Medicare ACO Initiative</td>
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<td>Acute Myocardial Infarction (AMI) Model (Track 1 – CEHRT)</td>
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<td>Medicare-Medicaid Accountable Care Organization Model (MMACO Tracks 2 and 3)</td>
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<td>Surgical Hip/Femur Fracture Treatment (SHFFT) Model (Track 1 – CEHRT)</td>
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<tr>
<td>Coronary Artery Bypass Graft (CABG) Model (Track 1 – CEHRT)</td>
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Performance to payment timeline for the 2017 performance year

- **Jan. 1, 2017**: Performance period began
- **March/Spring 2017**: CMS review #2 of Advanced APM Participation List
- **June 30, 2017**: CMS review #3 of Advanced APM Participation List
- **Aug. 31, 2017**: Last day to begin 90-day reporting period for MIPS
- **Oct. 2, 2017**: Last day 2017 claims processed for 2019 adjustment
- **Dec. 31, 2017**: Last day to begin 90-day reporting period for MIPS
- **Late Feb. 2018**: End of performance period
- **March 31, 2018**: 2017 data submission deadline for QCDRs, qualified registries, EHRs, CMS Web Interface, attestation
- **Fall 2018**: CMS feedback reports on 2017 performance and targeted review period to appeal errors
- **Jan. 2019**: CMS applies incentive payment based on 2017 performance
Next steps and looking forward
Next Steps: I AM participating in an Advanced APM

If you are participating in an Advanced APM:

- CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
  - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)

- Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS

- If you meet the QP thresholds, you are exempt from MIPS participation

- If you meet the PQ thresholds, then the APM Entity you are part of could elect to participate in the MIPS APM option
Next Steps: Should I select the Advanced APM pathway?

1. Determine if your practice qualifies for any of the approved Advanced APM options for 2017
   • Can your practice meet the APM participation requirements (these are separate and distinct from the Advanced APM criteria under the QPP)

2. Evaluate whether the practice will meet the necessary participation thresholds for QP/PQ
   • Stay alert for CMS QP/PQ determinations throughout 2017 to see if you have met the thresholds and are exempt from MIPS
   • If you meet PQ, but not QP, thresholds, determine if participating in MIPS under the MIPS APM option would position you to be eligible to earn a positive payment adjustment

3. Consider MIPS or MIPS APM options if an Advanced APM option meeting the necessary thresholds is not currently appropriate.
Next Steps: I am NOT participating in an Advanced APM

• Determine whether you are exempt from MIPS participation

• Pick your quality reporting pace for 2017 by evaluating practice readiness
  • Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice

• Select the best reporting mechanism(s) by evaluating practice resources
  • Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
  • What new processes and workflows will need to be put in place to meet the reporting requirements?
  • Do you have access to an EHR?

• Consider whether the Advanced APM option is feasible before making the final decision
What PAI-Healthsperien resources will be available to help?

• **Follow-on products in 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting and how to meet the minimum reporting requirements for 2017

• **In development** – Guide to additional resources in physician communities

• **FAQ document** – updated on a continuous and ongoing basis with important questions

• **Regular e-mail updates** – Emails will provide updates on new information, materials, and tools available from PAI, Healthsperien, as well as CMS and other organizations
www.PhysiciansAdvocacyInstitute.org