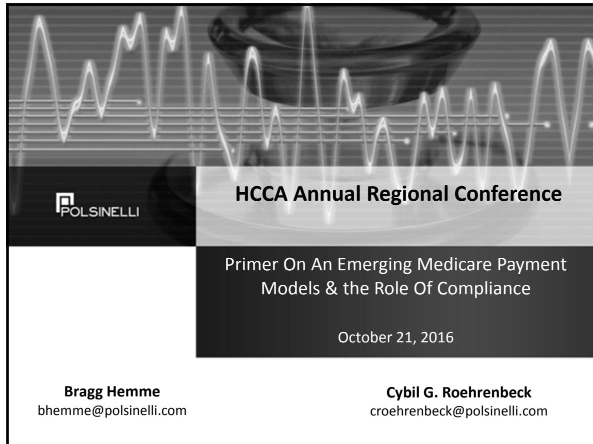
POLSINELLI
HCCA Annual Regional Conference
Primer On An Emerging Medicare Payment Models & the Role Of Compliance
October 21, 2016
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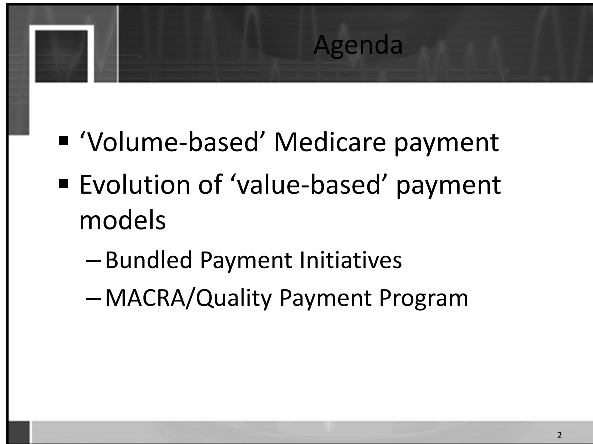
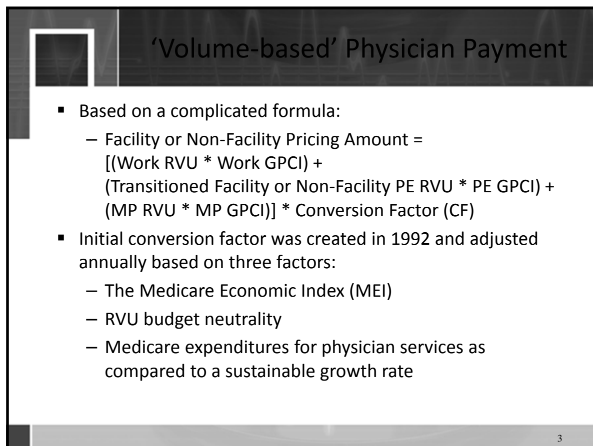
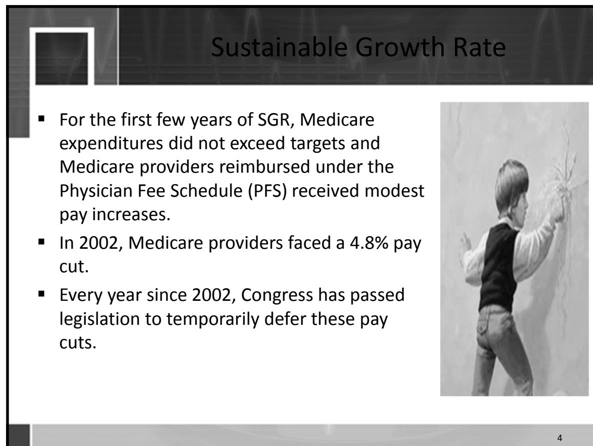

Agenda
▪ 'Volume-based' Medicare payment
▪ Evolution of 'value-based' payment models
– Bundled Payment Initiatives
– MACRA/Quality Payment Program
2


'Volume-based' Physician Payment
▪ Based on a complicated formula:
– Facility or Non-Facility Pricing Amount =
[(Work RVU * Work GPCI) +
(Transitioned Facility or Non-Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor (CF)
▪ Initial conversion factor was created in 1992 and adjusted annually based on three factors:
– The Medicare Economic Index (MEI)
– RVU budget neutrality
– Medicare expenditures for physician services as compared to a sustainable growth rate
3



Too many payment patches

Law	Cut Year	Score (bil.)
PL 108-7	2003	$54.0
PL 108-173	2004, 2005	$0.2
PL 109-171	2006	-$0.4
PL 109-432	2007	$3.1
PL 110-173	2008 (6 mos)	$6.4
PL 110-276	2008 (6 mos), 2009	$9.4
PL 111-118	2010 (2 mos)	$2.0
PL 111-144	2010 (1 mo)	$1.0
PL 111-157	2010 (2 mos)	$2.0

Law	Cut Year	Score (bil.)
PL 111-192	2010 (6 mos)	$6.0
PL 111-286	2010 (1 mo)	$1.0
PL 111-309	2011	$14.9
PL 112-78	2012 (2 mos)	$3.6
PL 112-96	2012 (10 mos)	$18.0
PL 112-240	2013	$25.2
PL 113-67	Jan-Mar 2014	$7.3
P.L. 113-93	Apr 2014-Mar 2015	$15.8
Total Cost		**$169.5**

Source: Congressional Budget Office 2015

5

'Value-based' goals

Medicare Fee-for-Service

GOAL 1: 30%

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

GOAL 2: 85%

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

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceed HHS goals

Source: Centers for Medicare & Medicaid Services (CMS)

6

'Value-based' goals

CMS Payment Model Framework

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality • 100% volume	Fee for Service Link to Quality • Linkage to quality and/or efficiency	Alternative Payment Models using FFS Architecture • Track 1 MSSP ACO (no risk)	Population-based Payment • At risk Pioneer ACOs and others

CMS' Better Care, Smarter Spending Healthier People (Jan. 2015)

CMMI Models

Categories

- **Accountable Care**
  Accountable Care Organizations and similar care models are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality and efficient service delivery.
- **Episode-based Payment Initiatives**
  Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter.
- **Primary Care Transformation**
  Primary care providers are a key point of contact for patients' health care needs. Strengthening and increasing access to primary care is critical to promoting health and reducing overall health care costs. Advanced primary care practices – also called "medical homes" – utilize a team-based approach, while emphasizing prevention, health information technology, care coordination, and shared decision making among patients and their providers.
- **Initiatives Focused on the Medicaid and CHIP Population**
  Medicaid and the Children's Health Insurance Program (CHIP) are administered by the states but are jointly funded by the federal government and states. Initiatives in this category are administered by the participating states.
- **Initiatives Focused on the Medicare-Medicaid Enrollees**
  The Medicare and Medicaid programs were designed with distinct purposes. Individuals enrolled in both Medicare and Medicaid (the "dual eligibles") account for a disproportionate share of the programs' expenditures. A fully integrated, person-centered system of care that ensures that all their needs are met could better serve this population in a high quality, cost effective manner.
- **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models**
  Many innovations necessary to improve the health care system will come from local communities and health care leaders from across the entire country. By partnering with these local and regional stakeholders, CMS can help accelerate the testing of models today that may be the next breakthrough tomorrow.
- **Initiatives to Speed the Adoption of Best Practices**
  Recent studies indicate that it takes nearly 17 years on average before best practices - backed by research - are incorporated into widespread clinical practice—and even then the application of the knowledge is very uneven. The Innovation Center is partnering with a broad range of health care providers, federal agencies professional societies and other experts and stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

CMMI Models

Bundled Payments – Bundled Payments for Care Improvement

- Bundled Payments for Care Improvement Initiative (began in 2013 and many components still underway)
  - Per CMS BPCI fact sheet (April 4, 2016):

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs; all acute patients	Selected DRGs; hospital plus post-acute period	Selected DRGs; post-acute period only	Selected DRGs; hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

Bundled Payments – Comprehensive Care for Joint Replacement

- Beginning April 2016, mandatory for hospitals in 67 geographic areas
- Applies for patients discharged with joint replacement MS-DRG 469 or 470
- Actual spending compared to episode target prices
  - Hospital recoups savings and repays costs in excess of target

Bundled Payments – Coordinated Cardiac and Hip Fracture Care

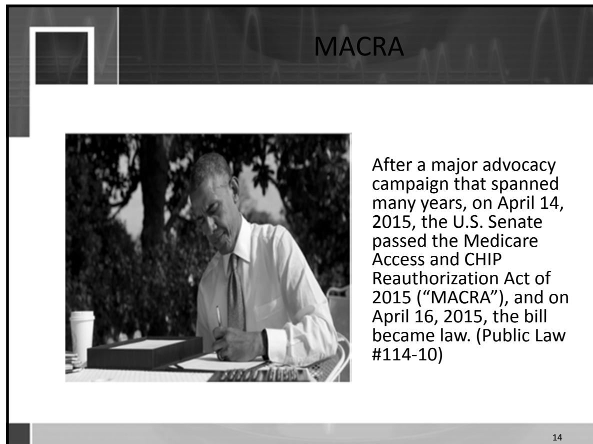
- Bundled Payments for High-Quality, Coordinated Cardiac and Hip Fracture Care
  - Proposed rule issued July 2016, to start July 2017
  - Episode payment models covering heart attack, bypass, or surgical hip/femur fractures
  - Actual spending compared to quality-adjusted target
    - Hospital recoups savings and repays costs in excess of target

Bundled Payments – Comprehensive Primary Care Plus Initiative

- 5-year program in 20 regions, with goals to:
  - support patients with serious or chronic diseases;
  - provide 24-hour access to care and health information;
  - provide preventive care;
  - engage patients/families in care; and
  - better coordinate care
- 2 tracks
  - Track 1 –monthly management fee and also FFS payments
  - Track 2 –monthly management fee and a hybrid of reduced FFS and primary care payments
    - Track 2 also provides more comprehensive services for patients with complex medical or behavioral health needs
- Role for state and commercial payors to support use of advanced primary care

13

MACRA



After a major advocacy campaign that spanned many years, on April 14, 2015, the U.S. Senate passed the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”), and on April 16, 2015, the bill became law. (Public Law #114-10)

14

MACRA’s Major Changes

- Repealed the SGR.
- Consolidated Medicare penalty programs, namely, the Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-Based Modifier (VBM) programs.
- Established a path for Medicare provider participation in alternative payment models (APMs).

15

MACRA Rulemaking

- Notice of Proposed Rule Making (NPRM) published in the Federal Register on May 9, 2016 (pre-publication version posted on April 27, 2016). CMS received over 4,000 comments.
- Final Rule with Comment Period (pre-publication version) released on October 14, 2016. 60 day comment period.
- CMS has adopted the term "Quality Payment Program" or "QPP" to describe their implementation of MACRA.

16

Two Tracks

- Merit-Based Incentive Payment Systems (MIPS)
- Advanced Alternative Payment Models (AAPMs)

17

MIPS Overview

- The Merit-Based Incentive Payment System (MIPS) streamlines several existing Medicare penalty programs (PQRS, VBM, MU), creating a single system with consolidated reporting and timelines.
- MIPS-eligible clinicians are:
  - Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and groups that include such professionals.
  - After MIPS' third year, the Secretary has discretion to add more providers to the list (e.g. Physical or Occupational Therapists, Clinical Social Workers, etc.).

18

MIPS Excluded Providers

- Some providers are excluded from MIPS:
  - Qualifying APM participants
  - Partial qualifying APM participants who report data under MIPS
  - **Low-volume threshold clinicians (billing ≥ $30,000 & for ≥ 100 beneficiaries)** – this was improvement to proposed $10,000 threshold
  - Newly-enrolled Medicare participants (report following 1st year enrolled)

QPP / MIPS Timeline

performance year — submit — feedback available — adjustment

2017 — March 31, 2018 — 2018 — January 1, 2019

Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

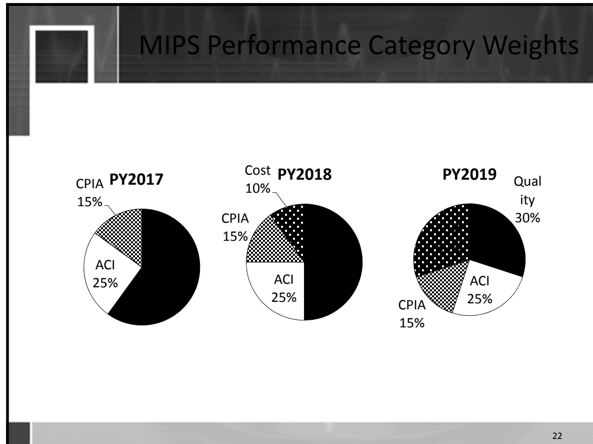
Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

Source: Centers for Medicare & Medicaid Services

MIPS Methodology

- In general, CMS will assign a composite performance score (CPS) based on performance in:
  - **Quality** (replaces PQRS and some parts of VM)
  - **Resource Use** (replaces cost portion of VM) – in final rule, CMS scaled this aspect back for beginning year.
  - **Advancing Care Information** (formerly EHR meaningful use)
  - **Clinical Practice Improvement Activities** (new!)
- CMS will apply an “adjustment factor” to MIPS-eligible clinician scores to determine total performance.



MIPS Data Submission Mechanisms

TABLE 3: Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI

Performance Category/Submission Combinations Accepted	Individual Reporting Data submission Mechanisms
Quality	Claims QCDR Qualified registry EHR
Cost	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR
Improvement Activities	Attestation QCDR Qualified registry EHR

23

MIPS Data Submission Mechanisms

TABLE 4: Data Submission Mechanisms for Groups

Performance Category/Submission Combinations Accepted	Group Reporting Data Submission Mechanisms
Quality	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) and Administrative claims (For all-cause hospital readmission measure - no submission required)
Cost	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
Improvement Activities	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)

24

Quality Performance Category

- Improvements to existing quality programs:
  - Key change from 9 measures (required in PQRS) to 6; allows partial credit for measures; flexibility if no applicable measures.
  - CMS tried to address concerns about wading through too many measures in the PQRS program to find applicable measures by developing measure sets by specialty.
  - Encourages reporting through QCDRs.

25

MIPS Quality Performance Category

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description[¥]	Measure Steward
* §	0067/006	N/A	Effective Clinical Care	Registry	Process	**Chronic Stable Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who were prescribed aspirin or clopidogrel.	American College of Cardiology/ American Heart Association/ American Medical Association-Physician Consortium for Performance Improvement
§	007 0/007	145 v4	Effective Clinical Care	Registry, EHR	Process	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI OR a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	American Medical Association-Physician Consortium for Performance Improvement/ American College of Cardiology Foundation/ American Heart Association
* §	0083/008	144 v4	Effective Clinical Care	Registry, EHR	Process	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	American Medical Association-Physician Consortium for Performance Improvement/ American College of Cardiology Foundation/ American Heart Association

26

MIPS Quality Performance Category

Measure Type	Description	Scoring Rules
Class 1 – Measure can be scored on performance	Measures that were submitted or calculated that met the following criteria: 1. The measure has a benchmark; 2. Has at least 20 cases; and 3. Meets the data completeness standard (generally, 50%)	• Receive 3 to 10 points based on performance compared to the benchmark
Class 2 – Measure cannot be scored based on performance and is instead assigned a 3-point score	Measures that were submitted, but fail to meet one of the class 1 criteria	• Receive 3 points • Note: Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims-based measures

27

MIPS Resource Use Performance Category

- Replaces Value-Based Modifier
- No additional data submission required
- Calculated from adjudicated claims
- While not part of the final score in 2017, CMS will calculate performance in order to provide feedback to clinician
- Counted toward score starting in 2018

28

MIPS Clinical Practice Improvement Activities (CPIA)

- MACRA specified that the CPIA performance category must include the following activities:
  - Expanded practice access
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety and practice assessment
- By statute, CMS must give at least a 50% score to APM participants and 100% score for patient-centered medical home participants.

29

Example CPIAs

- CMS outlines more than 90 CPIAs, such as:

Subcategory	Activity	Weighting
Population Management	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; Use panel support tools (registry functionality) to identify services due; Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or Routine medication reconciliation.	Medium

30

Advancing Care Information (ACI) aka Meaningful Use

- ACI replaces EHR Meaningful Use for MIPS-eligible clinicians only.
- Proposed Goals:
  - Simplify requirements (from 18 measures to 11)
  - Increase flexibility (i.e., not "all or nothing")
  - Ease burden
  - Facilitate exchange of information, emphasizing interoperability
- Final rule:
  - Lowered required measure reporting from 11 to 5

31

ACI Requirements

- Use certified electronic health record technology (CEHRT).
- Report according to objectives and measures.
- Support information exchange and prevention of health information blocking, and cooperate with authorized surveillance of CEHRT.

Source: Proposed Sec. 414.1375(b)

32

MIPS Payment Adjustments

CY	Max % Gain	Max % Loss
2017	-	-
2018	-	-
2019	+4%	-4%
2020	+5%	-5%
2021	+7%	-7%
2022 & beyond	+9%	-9%

- Beginning in the second half of 2015 and through 2019, PFS payment rates will be updated by 0.5% annually.
- The law then freezes payment rates for five years (2020-2025).
- Beginning in 2026, payment rates will be updated either by 0.25% annually for providers participating in MIPS or by 0.75% annually for providers participating in APMs.

33

MIPS 2017

- "Pick your Pace": Four for 2017 participation:
  - **Test the Quality Payment Program** – Submit "some" data to avoid a negative payment adjustment and test to ensure that data submission works.
  - **Participate for Part of the Year** – Submit data for a reduced number of days based on selected quality measures and improvement activities and qualify for a small positive payment adjustment.
  - **Participate for the Full Year** – Submit data for a full calendar year and qualify for a modest positive payment adjustment.
  - **Participate in an Advanced Alternative Payment Model** – Participate in a qualifying alternative payment model, like a Track 2 or 3 Accountable Care Organization (ACO), and receive a 5 percent payment bonus.
- Must report something or will receive penalty in 2019!

34

MIPS 2017

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.

−%	0	+%	+%
Don't Participate	Submit Something	Submit a Partial Year	Submit a Full Year
Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.	**Test:** If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.	**Partial:** If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.	**Full:** If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Source: Centers for Medicare & Medicaid Services

35

MIPS 2017

(1) Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year, and maximize the MIPS eligible clinician's chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the first 6 years of the program.

(2) Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

(3) Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.

(4) MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019.

36

Advanced Alternative Payment Models (AAPMs)

- MIPS-Eligible Clinicians who participate in "Advanced Alternative Payment Models" (AAPMs) are exempt from MIPS

APMs

Medicare (only) Option (2019 and beyond)

Other Payer Combination Option (2021 and beyond)

FFS Reimbursement Implications

(2019-2024)
- Not subject to MIPS
- +5% Lump Sum Incentive Payment for Part B Prof. Svs. during Base Period

(2026 and beyond)
- Not subject to MIPS
- Higher Medicare Fee Schedule updates

AAPM Criteria

- Clinicians that participate in Alternative Payment Models (APMs) are eligible to qualify by virtue of their participation in an "Advanced APM" where, during the applicable Performance Period, the APM:
  1. Requires use certified EHR technology
  2. Provides for payment for covered professional services based on quality measures comparable to measures under the MIPS performance category
  3. Bears *financial risk* under the APM that is in excess of a *nominal amount*, or involves a medical home model

38

Eligible AAPM Entities

- Many existing initiatives may qualify as an Advanced APM based on proposed financial risk criterion including:
  - MSSP ACOs in Tracks 2 & 3 (also created ACO Track1Plus model in final rule)
  - NextGen ACOs
  - Comprehensive Primary Care Plus Program
  - Other programs sponsored by CMMI
  - Full capitation arrangements
  - CMS will include & expand to new models moving forward

*CMS will publish full list before Jan. 1.

39

Qualifying AAPM Participation

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, you must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.

Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

40

Recap - MACRA Options

- **Participate in FFS via the Merit-based Incentive Program (MIPs)**
  - Subject to reductions or increases in Medicare reimbursement based on quality performance scores
  - Reduced penalty risk
  - Statutory updates
  - Consolidated reporting
- **Participate in Advanced Alternative Payment Models (APMs)**
  - Potential to earn five percent annual bonus
  - Subject to financial risk
  - Higher updates
  - Exempt from MIPs
  - Preferred treatment for medical homes
  - Specialty models encouraged

41

Recap - Basic MACRA Framework

		2019	2020	2021	2022 + beyond
Merit-Based Incentive Payment System (MIPS)	Adjusts Medicare FFS reimbursement based on performance score linked to: • Quality • Resource use • Clinical practice improvement • Advancing Clinical Improvement (formerly EHR meaningful use)	+-4%*	+-5%*	+-7%*	+-9%* * Possible 3x upward adjustment BUT unlikely
Alternative Payment Models (APM)	New payment approaches that incentivize quality and value, such as: • CMMI Innovation models • MSSP ACOs • Demonstration programs	Most advanced AMPs (those that bear risk): • Not subject to MIPS • 5% lump sum bonus payments (2019-2024) • Higher fee schedule update 2026 and beyond			

Source: Medicare Access and CHIP Reauthorization Act of 2015, Path to Value (CMS)

42

Recap - How will MACRA affect me?

Am I in an **APM**?

Yes → Am I in an **eligible** APM?

- Yes → Do I have enough **payments or patients through** my eligible APM?
  - Yes → **Qualifying APM Participant**
    - 5% lump sum **bonus payment** 2019-2024
    - Higher **fee schedule updates** 2026+
    - APM-specific **rewards**
    - **Excluded** from MIPS
  - No → see below
- No →
  - Subject to **MIPS**
  - **Favorable** MIPS scoring
  - APM-specific **rewards**

No → Is this my **first year** in Medicare OR am I below the **low-volume threshold**?

- Yes → Not subject to **MIPS**
- No → Subject to **MIPS**

Bottom line: There are opportunities for ***financial incentives for participating in an APM****, even if you don't become a* ***QP****.*

Source: Centers for Medicare & Medicaid Services

43

MACRA Resources

- CMS website
  - https://qpp.cms.gov/
- AMA payment model evaluator
  - https://apps.ama-assn.org/pme/#/
- Polsinelli resources
  - http://www.polsinelli.com/intelligence/understanding-the-implications

44

Questions?

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45