Advanced Strategies in MACRA APM Development

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Thirteenth National Value-Based Payment and Pay for Performance Summit
MARCH 1, 2018

Agenda

- Overview of upcoming changes in QP status determination
- Other payer Advanced APM criteria
- Other payer Advanced APM determination process
- Key success factors and potential pitfalls

Overview

Upcoming changes in QP determination process

What is MACRA, and how will it affect my Medicare payments?

MACRA Legislation

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 414 and 495

[CMS–5517–P]

RIN 0938–AS69

Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under the PFS. This proposed rule would establish the MIPS, a new program for certain Medicare-enrolled practitioners. MIPS would consolidate components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare

comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of

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MACRA: Overview for providers

Colleen Norris, FSA, MAAA
Mary van der Heijde, FSA, MAAA

The Medicare Access and CHIP
(MACRA)[1] represents a tectonic
reimbursed for the services they
for-service (FFS) beneficiaries. M
financial certainty of fee-for-serv
provider reimbursement based o
measures, IT utilization, perform
activities, use of resources relativ
in "Alternative Payment Models"
of legislation that will reshape th
paid for. Furthermore, with MAC
on January 1, 2017, providers need
to-be implemented law will impa

Q: How does MACR

MILLIMAN WHITE PAPER

Advanced APMs and Qualifying APM Participant status

Lynn Dong, FSA, MAAA
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Introduction

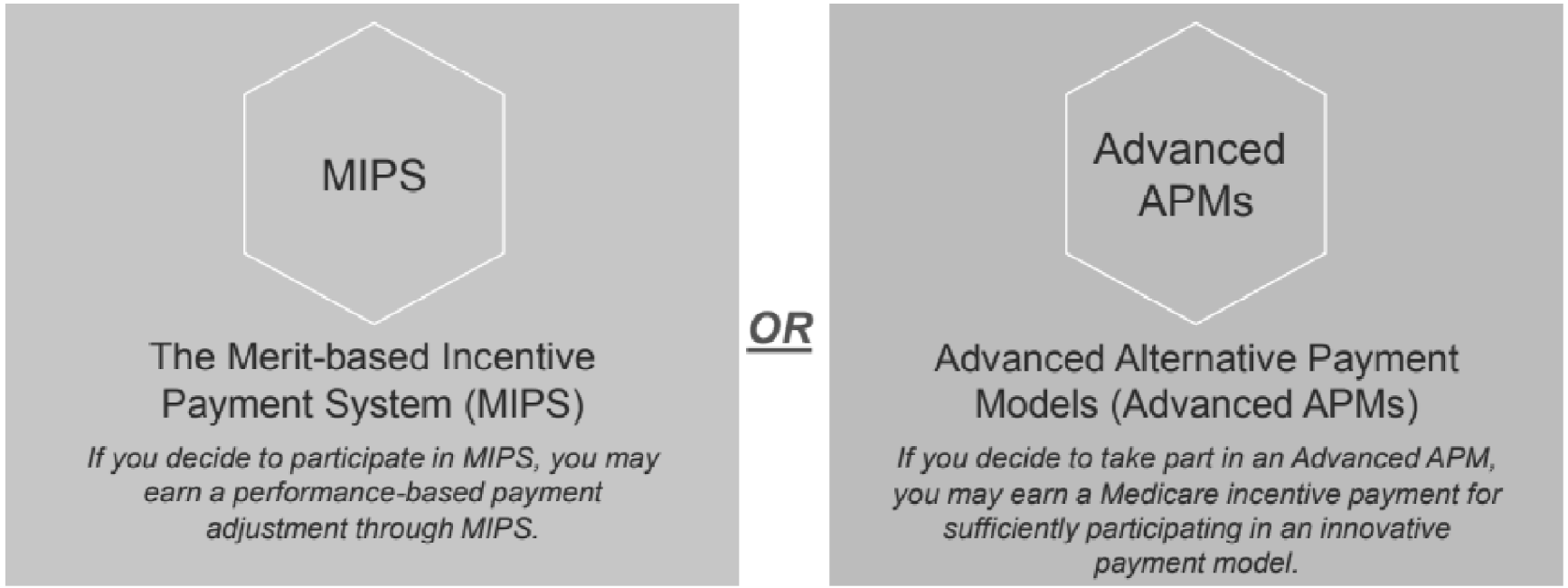
Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA)[1] in April 2015, which was followed by a Notice of Proposed Rulemaking released by the Centers for Medicare and Medicaid Services (CMS) in May 2016.[2] In addition to repealing the Sustainable Growth Rate (SGR), MACRA made a number of changes to how physicians and other clinicians are paid under fee-for-service (FFS) Medicare. MACRA ties clinicians' payments to greater

- *The shared savings program under section 1899 of the Act* (the Medicare Shared Savings Program)
- *A demonstration under section 1866C of the Act* (the (the Health Quality Demonstration Program)
- *A demonstration required by federal Law*

Under MACRA, only a subset of APMs (referred to as Advanced APMs) count for purposes of becoming a Qualifying APM Participant (QP), evaluated under the Advanced APM track. An Advanced APM must meet certain additional criteria,

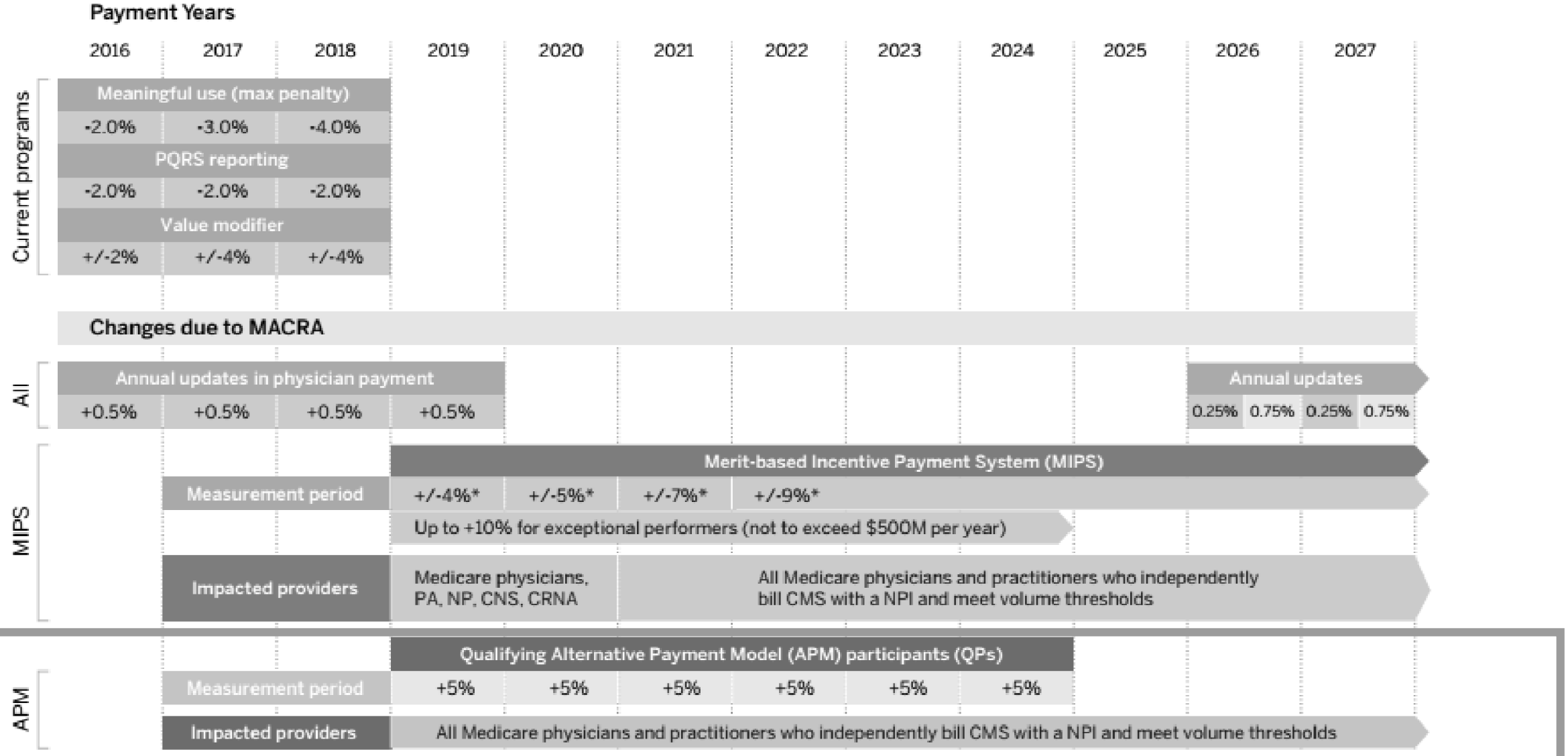
Key MACRA Implications

- Repeal the sustainable growth rate (SGR) formula, a problematic way to calculate annual payment updates for the Medicare Physician Fee Schedule that was used starting in 1997
- Create a unified quality reporting system to replace the multiple physician modifier programs
- Multiple tracks for physicians to choose from:
  - MIPS
  - Advanced APMs



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Proposed-Rule-for-the-Quality-Payment-Program-Year-Two-Slides.pdf

Key MACRA Timeframes



*The multiplier on these adjustments can be up to 3x to ensure budget neutrality.

How Do I Become a Qualifying APM Participant?

- Participate in **Advanced Alternative Payment Models** (Advanced APMs)
- Three requirements for an APM to be an Advanced APM

Require participants to use certified EHR technology	Provide payment based on quality measures comparable to the MIPS quality performance category	Either (a) be a Medical Home Model expanded under CMS Innovation Center Authority, or (b) require participants to bear more than nominal financial risk

QP and Partial QP Status Thresholds

FIGURE 1: THRESHOLDS FOR QUALIFYING APM PARTICIPANT STATUS

PATIENT COUNT METHOD			
PAYMENT YEAR	MEDICARE OPTION	ALL-PAYER COMBINATION OPTION (MUST MEET BOTH CRITERIA BELOW)	
	MEDICARE FFS	MEDICARE FFS	ALL PAYERS
2019-20	20%	MEDICARE OPTION ONLY IN THESE YEARS	
2021-22	35%	20%	35%
2023 AND SUBSEQUENT YEARS	50%	20%	50%
PAYMENT AMOUNT METHOD			
PAYMENT YEAR	MEDICARE OPTION	ALL-PAYER COMBINATION OPTION (MUST MEET BOTH CRITERIA BELOW)	
	MEDICARE FFS	MEDICARE FFS	ALL PAYERS
2019-20	25%	MEDICARE OPTION ONLY IN THESE YEARS	
2021-22	50%	25%	50%
2023 AND SUBSEQUENT YEARS	75%	25%	75%

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http://www.milliman.com/uploadedFiles/insight/2016/advanced-apms-qualifying-apm-status.pdf

Starting in performance year 2019 (for payment year 2021), Other Payer Advanced APMs can contribute to QP status determinations

Other Payer Advanced APM Criteria

What Counts as an ‘Other Payer’?

- Title XIX (Medicaid)
- Medicare Health Plans (including Medicare Advantage)
- CMS Multi Payer Models
- Other commercial and private payers

Requirement 1: Use of Certified EHR Technology

- Other payer payment arrangements must require at least 50% of eligible clinicians in each participating APM Entity Group to use CEHRT to document and communicate clinical care information.

Requirement 2: Quality Measurement

- Payments for covered professional services must be based on quality measures that are comparable to those used in the MIPS quality performance category.
  - This means the quality measures have to be evidence-based, reliable, and valid.
  - At least one measure must be an outcome measure, if an appropriate outcome measure is available on the MIPS measure list.

Requirement 3: Nominal Financial Risk

- Participants must bear a certain amount of financial risk (or be a Medicaid Medical home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Social Security Act)
- Depending on the way the APM defines risk, there are two generally applicable nominal financial risk standards used for Other Payer Advanced APMs:
  - To meet the **expenditure-based nominal amount standard,** the nominal risk must be:
    - Marginal risk of at least 30%;
    - Minimum loss rate of no more than 4%; and
    - Total risk of at least 3% of expected expenditures of the APM entity.
  - To meet the **revenue-based nominal amount standard,** the nominal risk must be:
    - Marginal risk of at least 30%;
    - Minimum loss rate of no more than 4%; and
    - Total risk of at least 8% of combined revenues from the payer to providers and other entities under the payment arrangement.

Medicaid Medical Home Models

- Medicaid Medical Home Models have a lower nominal amount standard, such that the total risk the APM Entity potentially owes a payer or forgoes is equal to at least:
  - 3% of average estimated total revenue of the participating providers or other entities under the payer in the 2019 QP performance period
  - 4% of average estimated total revenue of the participating providers or other entities under the payer in the 2020 QP performance period
  - 5% of average estimated total revenue of the participating providers or other entities under the payer in the 2021 QP performance period or later

Key Lessons for APM Development

- **Pay attention to quality metrics**
  - Follow along with the MIPS quality measure list, and note changing requirements continually
- **Use CEHRT**
- **Know how much risk you can reasonably take on, and how much you need to in order to meet nominal risk standards**
  - From a QPP perspective, there's no additional value in taking on additional risk beyond the standard, unless it gets you higher rewards within the APM

Thank you

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