Primer On An Emerging Medicare Payment Models & the Role Of Compliance

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Agenda

- ‘Volume-based’ Medicare payment
- Evolution of ‘value-based’ payment models
  - Bundled Payment Initiatives
  - MACRA/Quality Payment Program
‘Volume-based’ Physician Payment

- Based on a complicated formula:
  - Facility or Non-Facility Pricing Amount =
    \[
    [(\text{Work RVU} \times \text{Work GPCI}) +
    (\text{Transitioned Facility or Non-Facility PE RVU} \times \text{PE GPCI}) +
    (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor (CF)}
    \]

- 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

Sustainable Growth Rate

- For the first few years of SGR, Medicare expenditures did not exceed targets and Medicare providers reimbursed under the Physician Fee Schedule (PFS) received modest pay increases.
- In 2002, Medicare providers faced a 4.8% pay cut.
- Every year since 2002, Congress has passed legislation to temporarily defer these pay cuts.
### Too many payment patches

<table>
<thead>
<tr>
<th>Law</th>
<th>Cut Year</th>
<th>Score (bil.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PL 108-7</td>
<td>2003</td>
<td>$54.0</td>
</tr>
<tr>
<td>PL 108-173</td>
<td>2004, 2005</td>
<td>$0.2</td>
</tr>
<tr>
<td>PL 109-171</td>
<td>2006</td>
<td>-$0.4</td>
</tr>
<tr>
<td>PL 109-432</td>
<td>2007</td>
<td>$3.1</td>
</tr>
<tr>
<td>PL 110-173</td>
<td>2008 (6 mos)</td>
<td>$6.4</td>
</tr>
<tr>
<td>PL 110-276</td>
<td>2008 (6 mos), 2009</td>
<td>$9.4</td>
</tr>
<tr>
<td>PL 111-118</td>
<td>2010 (2 mos)</td>
<td>$2.0</td>
</tr>
<tr>
<td>PL 111-144</td>
<td>2010 (1 mo)</td>
<td>$1.0</td>
</tr>
<tr>
<td>PL 111-157</td>
<td>2010 (2 mos)</td>
<td>$2.0</td>
</tr>
<tr>
<td>PL 111-192</td>
<td>2010 (6 mos)</td>
<td>$6.0</td>
</tr>
<tr>
<td>PL 111-286</td>
<td>2010 (1 mo)</td>
<td>$1.0</td>
</tr>
<tr>
<td>PL 111-309</td>
<td>2011</td>
<td>$14.9</td>
</tr>
<tr>
<td>PL 112-78</td>
<td>2012 (2 mos)</td>
<td>$3.6</td>
</tr>
<tr>
<td>PL 112-96</td>
<td>2012 (10 mos)</td>
<td>$18.0</td>
</tr>
<tr>
<td>PL 112-240</td>
<td>2013</td>
<td>$25.2</td>
</tr>
<tr>
<td>PL 113-67</td>
<td>Jan-Mar 2014</td>
<td>$7.3</td>
</tr>
<tr>
<td>PL 113-93</td>
<td>Apr 2014-Mar 2015</td>
<td>$15.8</td>
</tr>
<tr>
<td>Total Cost</td>
<td></td>
<td>$169.5</td>
</tr>
</tbody>
</table>

Source: Congressional Budget Office 2015

### ‘Value-based’ goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 1</td>
<td>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</td>
</tr>
<tr>
<td>GOAL 2</td>
<td>Medicare fee-for-service payments are tied to quality or value (categories 1-4) by the end of 2016, and 90% by the end of 2018</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services (CMS)
‘Value-based’ goals

CMS Payment Model Framework

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

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 integrated 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 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 Eligibles
  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 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.
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):

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

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)
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).

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.
Two Tracks

• Merit-Based Incentive Payment Systems (MIPS)

• Advanced Alternative Payment Models (AAPMs)

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.).
### 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 1\textsuperscript{st} year enrolled)

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### QPP / MIPS Timeline

**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, you 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 Performance Category Weights

<table>
<thead>
<tr>
<th>PY2017</th>
<th>PY2018</th>
<th>PY2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPIA</td>
<td>CPIA</td>
<td>CPIA</td>
</tr>
<tr>
<td>15%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>ACI</td>
<td>ACI</td>
<td>ACI</td>
</tr>
<tr>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

PY2017:
- CPIA: 15%
- ACI: 25%

PY2018:
- CPIA: 10%
- ACI: 25%
- Cost: 15%

PY2019:
- CPIA: 15%
- ACI: 25%
- Quality: 30%
**TABLE 3: Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI**

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Individual Reporting Data Submission Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Claims, QCDR, Qualified registry, EHR</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Attestation, QCDR, Qualified registry, EHR</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation, QCDR, Qualified registry, EHR</td>
</tr>
</tbody>
</table>

**TABLE 4: Data Submission Mechanisms for Groups**

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Group Reporting Data Submission Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td></td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Attestation, QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation, QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>
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.
### MIPS Quality Performance Category

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

### 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
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.

Example CPIAs

- CMS outlines more than 90 CPIAs, such as:

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Activity</th>
<th>Weighting</th>
</tr>
</thead>
</table>
| 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 portal and community health workers where available) to alert and educate patients about services due; and/or  
Routine medication reconciliation. | Medium     |
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

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)
MIPS Payment Adjustments

<table>
<thead>
<tr>
<th>CY</th>
<th>Max % Gain</th>
<th>Max % Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2018</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2019</td>
<td>+4%</td>
<td>-4%</td>
</tr>
<tr>
<td>2020</td>
<td>+5%</td>
<td>-5%</td>
</tr>
<tr>
<td>2021</td>
<td>+7%</td>
<td>-7%</td>
</tr>
<tr>
<td>2022 &amp; beyond</td>
<td>+9%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

- 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.

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!
MIPS 2017

Pick Your Pace in MIPS

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

- **Don't Participate**
  - Not participating in the Quality Payment Program:
  - If you don't send any 2017 data, then you receive a negative 4% payment adjustment.

- **Submit Something**
  - 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.

- **Submit a Partial Year**
  - Partial:
  - If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

- **Submit a Full Year**
  - 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

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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.
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.
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.

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>
<thead>
<tr>
<th>Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs (Clinicians must meet payment or patient requirements)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Year</td>
</tr>
<tr>
<td>Percentage of Medicare Payments through an Advanced APM</td>
</tr>
<tr>
<td>Percentage of Medicare Patients through an Advanced APM</td>
</tr>
</tbody>
</table>
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

Recap - Basic MACRA Framework

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

* Possible 3x upward adjustment BUT unlikely

Source: *Medicare Access and CHIP Reauthorization Act of 2015, Path to Value (CMS)*
Recap - How will MACRA affect me?

1. Am I in an APM?
   - Yes
   - No

2. Am I in an eligible APM?
   - Yes
   - No

3. Do I have enough payments or patients through my eligible APM?
   - Yes
   - No

4. Is this my first year in Medicare OR am I below the low-volume threshold?
   - Yes
   - No

Qualifying APM Participant:
- 5% lump sum bonus payment 2019-2024
- Higher fee schedule updates ≥1.6%
- APM-specific rewards
- Excluded from MIPS

MACRA Resources:

- CMS website
  - https://qpp.cms.gov/

- AMA payment model evaluator
  - https://apps.ama-assn.org/pme/#/

- Polsinelli resources
Questions?

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