AGENDA

• General Program Updates
• CPC+
• MACRA
• Metrics
• Questions
Updates

• Electronic Measures, Remediation
• Enrollment for 2017
• Shared Savings Determination for 2015
• Activities
• Quality Metrics
CPC+

- 5 Year Program, Starts January 2017
- AR Application submitted
  - Decision in Early July
- Practices Apply July 15 to September 1
- Bonuses By Practice, Not Region
  - Must Have 150 Medicare Patients
- Key Functions
  - Access/Continuity, Care Management, Coordination, Engagement, Population Health
CMS and Partner Payers Will Support Practices in Both Program Tracks

CMS will solicit applications from practices within the regions chosen, beginning July 15, 2016, with applications due by September 1, 2016 at 11:59pm ET.

**Track 1**
- Up to 2,500 primary care practices.
- Choice for practices ready to build the capabilities to deliver comprehensive primary care.

**Track 2**
- Up to 2,500 primary care practices.
- Choice for practices poised to increase the comprehensiveness of care through enhanced health IT, improve care of patients with complex needs, and inventory resources and supports to meet patients' psychosocial needs.
Practice Eligibility Requirements Vary by Track

- CMS will solicit applications from practices within the regions chosen, beginning July 15, 2016, with applications due by September 1, 2016 at 11:59pm ET.
- Practices will apply directly to the track for which they are interested and believe they are eligible.

Track 1

- Use of CEHRT
- Payer interest and coverage
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.

Track 2

- Use of CEHRT
- Payer interest and coverage
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community-based resources.
- Letter of support from health IT vendor that outlines the vendor’s commitment to support the practice in optimizing health IT.
### Care Management Fee: Medicare and Payer Alignment

**Medicare Approach**

#### Medicare Care Management Fee:

<table>
<thead>
<tr>
<th>Risk Methodology</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC risk scores</td>
<td>HCC risk scores; claims data for high-risk diagnoses</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Risk Tiers</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBPM Amount</td>
<td>$15 average ($6 to $30)</td>
<td>$28 average ($9 to $100)</td>
</tr>
<tr>
<td>Purpose</td>
<td>Staffing and training related to the model requirements, according to the needs of the attributed Medicare patient population</td>
<td></td>
</tr>
</tbody>
</table>

**Aligned Payer Approach**

- Offer non-fee-for-service support to allow Track 1 and 2 practices to provide care management, care coordination, and similar “wraparound” services to all patients, agnostic of payer.

- Increase support for Track 2 compared to Track 1 to reflect advancement in practice transformation and care of patients with complex needs.
Alternative to FFS for Track 2 Practices: Medicare and Payer Alignment

Medicare Approach

Medicare Hybrid FFS and “Comprehensive Primary Care Payment” (CPCP):

- Based on past E&M payments - increased 10%
- Paid upfront and partially reconciled
- FFS E&M reduced proportionately
- Practices select the pace of transition to one of two hybrid payments
- Compensates for traditional clinical care yet allows flexibility for care delivery in/outside an office visit

Aligned Payer Approach

- By the end of the first performance year, change the cash flow mechanism for reimbursing practices via at least a partial alternative to traditional FFS payment.
  - Examples: partial, full, or sub-capitation without downside risk, episodic payment, etc.
- Goals:
  - Compensate for proactive, comprehensive care previously require to be furnished in an office setting.
  - Allow practices to provide care in a way that best meets patient needs, including by email, phone, patient portal, or other alternative visit modalities.
CMS Will Provide Three Payment Innovations To Support Practice Transformation

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
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<tbody>
<tr>
<td>Care Management Fee (PBPM)</td>
<td>$28 average; including $100 to support patients with complex needs</td>
</tr>
<tr>
<td>Performance-Based Incentive Payment</td>
<td>$4.00 opportunity</td>
</tr>
<tr>
<td>Underlying Payment Structure</td>
<td>Standard FFS</td>
</tr>
<tr>
<td></td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>
Performance-Based Incentive Payment: Medicare and Payer Alignment

Medicare Approach

Practices at risk for two prospectively paid practice-level performance components; incentives partially or wholly reconciled retrospectively based on performance.

Clinical quality and patient experience
- Track 1: $1.25 PBPM
- Track 2: $2.00 PBPM
- Examples: eCQMs, CAHPS

Utilization measures that drive total cost of care
- Track 1: $1.25
- Track 2: $2.00
- Examples: inpatient admissions, ED visits
- Must pass quality benchmark to receive

Aligned Payer Approach

- Track 1 and 2 practices can qualify for performance-based incentive payments, based on a combination of utilization, cost of care, and/or quality metrics.
- Possible approaches include: shared savings, bonuses, or other financial arrangements, either prospectively or retrospectively.
For More Information on CPC+

Visit
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus
for Request for Applications, Payer Solicitation, Payer MOU, FAQs, Fact Sheet, Webinar Information

Email
CPCplus@cms.hhs.gov
Quality Payment Program

✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
✓ **Provides incentive payments** for participation in Advanced Alternative Payment Models (APMs)

The Merit-based Incentive Payment System (MIPS)  or  Advanced Alternative Payment Models (APMs)

✓ First step to a fresh start
✓ We’re listening and help is available
✓ A better, smarter Medicare for healthier people
✓ Pay for what works to create a Medicare that is enduring
✓ Health information needs to be open, flexible, and user-centric
How MACRA’s initial impact breaks down

The first performance year begins Jan. 1 for payments in 2019

761,342
Number of clinicians eligible for the Merit-based Incentive Payment System (MIPS)

30,658-90,000
Number that could be exempt from MIPS and get a bonus for participating in an advanced Alternative Payment Model (APM)

Components of MIPS

10%
Cost

15%
Clinical practice improvement

50%
Quality (replaces Physician Quality Reporting System and Value-based Payment Modifier)

25%
Advancing Care Information (replaces EHR meaningful use)

Maximum bonus or penalty under MIPS in 2019:

+4% -4%

Medicare bonus in 2019 for participating in an advanced APM:

5%

Source: CMS
How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

*Potential for 3X adjustment
MACRA provides **additional** rewards for participating in APMs.

Potential financial **rewards**

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>APM-specific rewards</td>
</tr>
</tbody>
</table>

If you are a **qualifying APM participant (QP)**

+ 5% lump sum bonus
How do I become a qualifying APM participant (QP)?

You must have a certain % of your patients or payments through an eligible APM.

QPs will:

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2019-2024; then will receive higher fee schedule update starting in 2026

25% in 2019 and 2020
What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

Yes, starting in 2021, participation in some of these APMs with other non-Medicare payers can count toward criteria to be a QP.

"Combination all-payer & Medicare threshold option"

IF the APMs meet criteria similar to those for eligible APMs run by CMS:

- Certified EHR use
- Quality Measures
- Financial Risk
Other Payer Advanced APM Criterion 1: Requires use of CEHRT

Example: An Advanced APM has a provision in its participation agreement that at least 75% of an APM Entity’s eligible clinicians must use CEHRT.

✓ An Other Payer Advanced APM must require at least 75% of the eligible clinicians in each APM Entity to use CEHRT to document and communicate clinical care.
An Other Payer Advanced APM must base payment on quality measures comparable to those under the proposed annual list of MIPS quality performance measures;

No minimum number of measures or domain requirements, except that an Other Payer Advanced APM must have at least one outcome measure unless there is not an appropriate outcome measure available under MIPS.

Comparable means any actual MIPS measures or other measures that are evidence-based, reliable, and valid. For example:

- Quality measures that are endorsed by a consensus-based entity; or
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.
PROPOSED RULE

Other Payer Advanced APM Criterion 3: Requires APM Entities to Bear More than Nominal Financial Risk

An Other Payer Advanced APM must meet two standards:

Financial Risk Standard
APM Entities must bear risk for monetary losses.

Nominal Amount Standard
The risk APM Entities bear must be of a certain magnitude.

- The Other Payer Advanced APM financial risk criterion is completely met if the APM is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under CMS Innovation Center Authority.

- Medicaid Medical Home Models that have not meet the standard above will have unique financial risk and nominal amount standards.
The Other Payer Advanced APM requires one or more of the following if actual expenditures exceed expected expenditures:

**Financial Risk Standard**

- **Direct payment** from the APM Entity
- **Reduction in payment rates** to the APM Entity or eligible clinicians
- **Withhold of payment** to the APM Entity or eligible clinicians
PROPOSED RULE

Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Financial Risk Criterion

The Medicaid Medical Home Model requires one or more of the following if actual expenditures exceed expected expenditures:

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
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<tbody>
<tr>
<td>Direct payment</td>
<td>from the APM Entity</td>
</tr>
<tr>
<td>OR</td>
<td>Reduction in payment rates to the APM Entity or eligible clinicians</td>
</tr>
<tr>
<td>OR</td>
<td>Withhold of payment to the APM Entity or eligible clinicians</td>
</tr>
<tr>
<td>OR</td>
<td>Reduces an otherwise guaranteed payment or payments</td>
</tr>
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</table>
Medicaid Medical Home Models:

- Have a unique financial risk criterion for becoming an Other Payer Advanced APM.
- Enable participants (who are not excluded from MIPS) to receive the maximum score in the MIPS CPIA category.

A Medicaid Medical Home Model is an Other Payer APM that has the following features:

- Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- Empanelment of each patient to a primary clinician; and
- At least four of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.
Find additional information about the Quality Payment Program, including fact sheets, upcoming webinars and more at: http://go.cms.gov/QualityPaymentProgram
FAQs
http://www.paymentinitiative.org-medicalHomes/Pages/FAQs.aspx