Alternative Payment Models (APMs) and the Merit-Based Incentive Payment System (MIPS)

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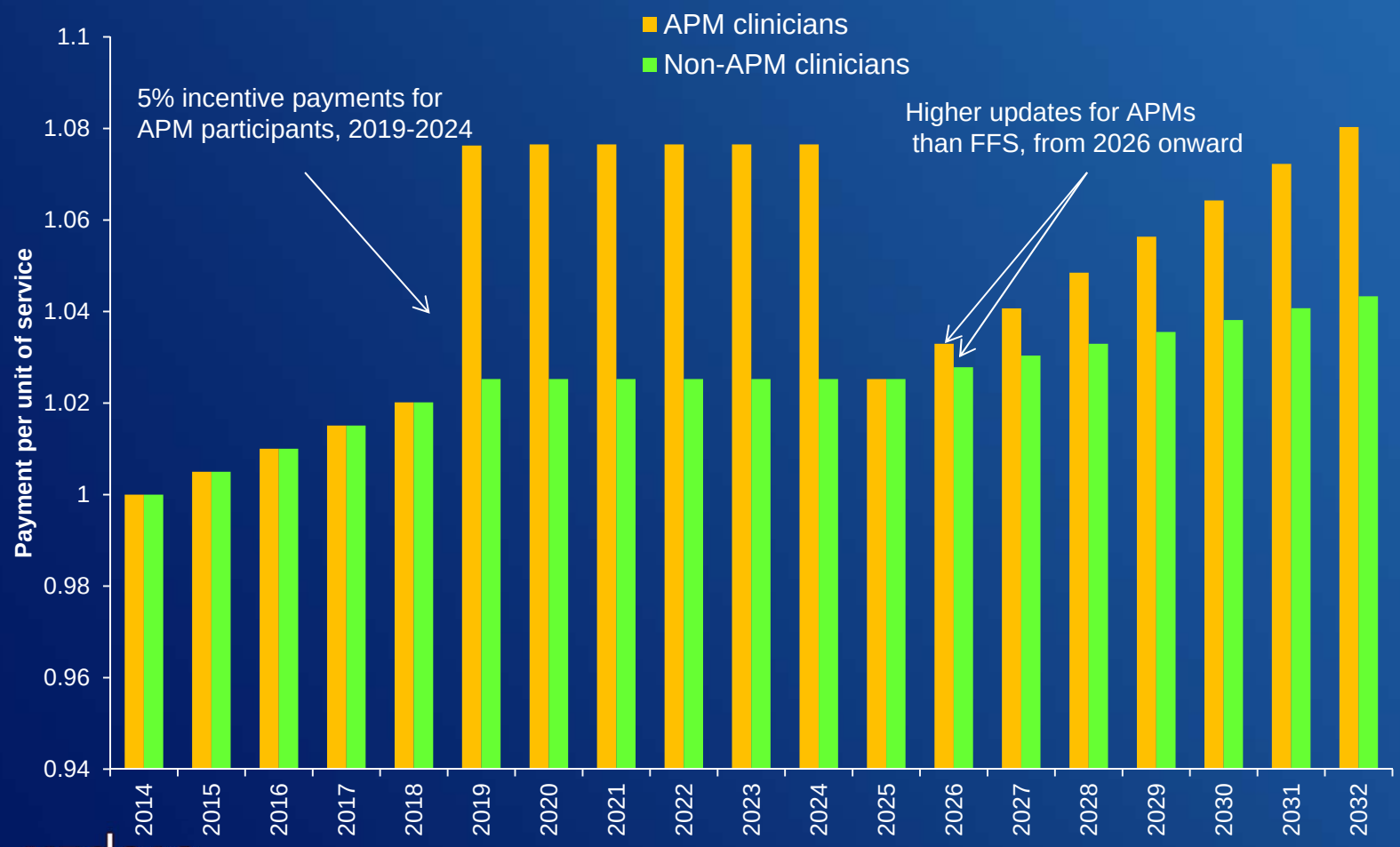
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Repeals SGR and establishes two paths of statutory payment updates for clinicians
- Incentive payments and higher updates for clinicians who participate in eligible Alternative Payment Models (APMs) than for others
- Merit-Based Incentive Payment System (MIPS) for clinicians not meeting APM criteria

Two payment update paths



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Note: 2014=1.0.

Merit-Based Incentive Payment System (MIPS)

- Four components to MIPS
  - Quality
  - Resource use
  - Meaningful use of eHR
  - Clinical practice improvement activities
- Replaces three existing payment adjustments
- Starting in 2019 applies to clinicians who do not qualify as APM participants, maximum adjustment factor:
  - 4 percent in 2020
  - 7 percent 2021
  - 9 percent 2022 and after
- Eligible APMs must have comparable quality measures to MIPS

Difficult to measure individual clinician performance

- MIPS designed to assess clinician's performance at the individual level
- But many quality and resource use measures not reliable at the individual clinician level
- Most clinicians will look average
- May be able to identify persistent outliers only

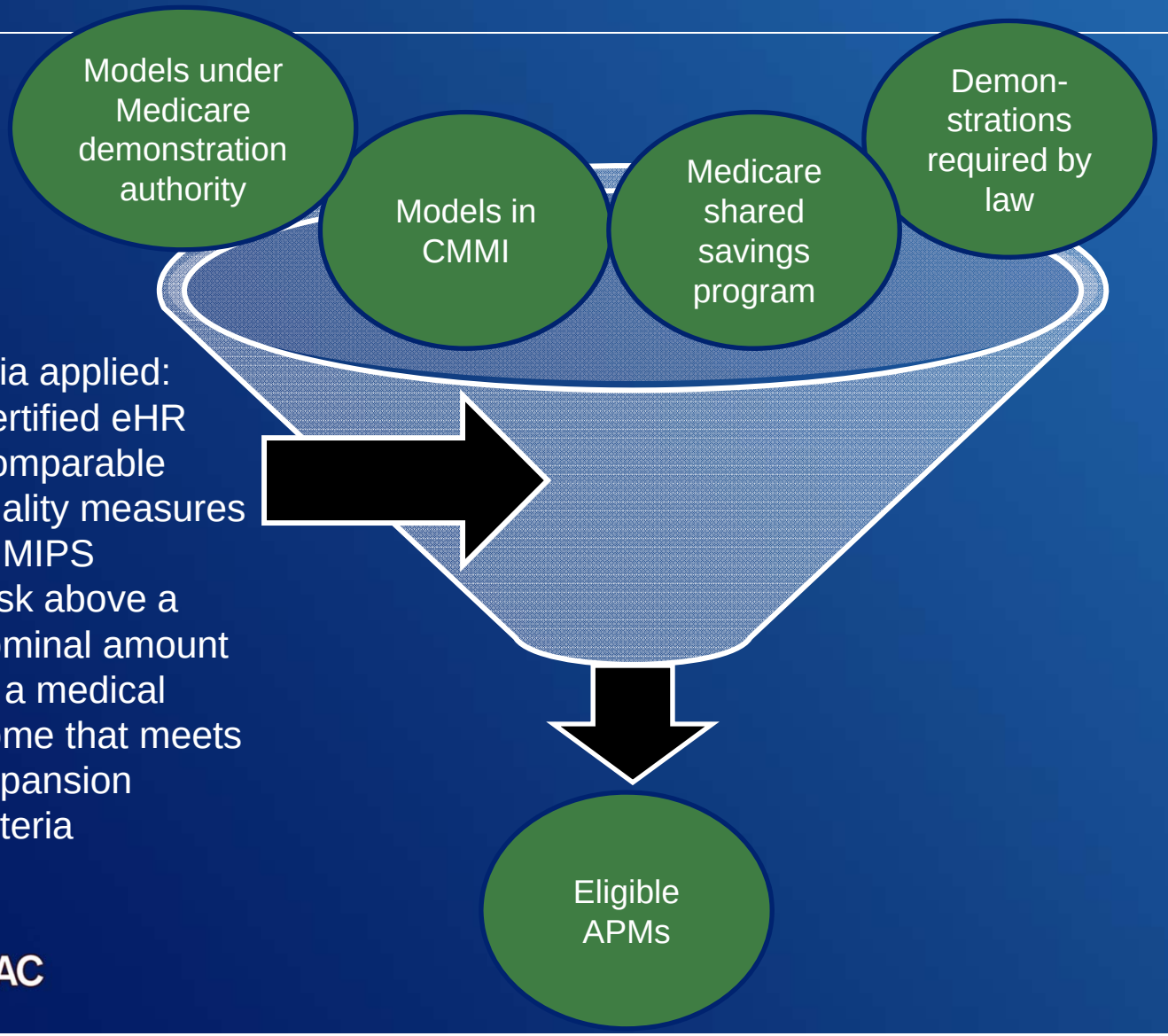
MIPS concerns

- MIPS will likely use some measures from Physician Quality Reporting System (PQRS) and eHR and add more factors
- PQRS weighted towards process measures
- Overbuilt system would add to burden on providers and CMS
- APMs have to use comparable quality measures to MIPS, could preclude use of more meaningful approach

Overview of Alternative Payment Model (APM) provisions

- Clinicians will receive additional payment if they participate in an eligible alternative payment model (APM)
  - Additional payments are 5% per year from 2019 to 2024
  - Higher update in 2026 and later
  - Excluded from MIPS
- Law establishes requirements for “eligible” APMs and the level of participation that allows clinicians to qualify for the incentive payment

Not all APMs will be “eligible” APMs



Criteria applied:

- Certified eHR
- Comparable quality measures to MIPS
- Risk above a nominal amount or a medical home that meets expansion criteria

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Clinician qualification for the APM incentive payment

- Clinician must have a specified share of FFS revenue (or beneficiaries) in an eligible APM to qualify for the incentive payment
  - 25% of spending in 2019 and 2020
  - 50% in 2021 and 2022
  - 75% in 2023 and later
- MA revenue not part of the calculation
- All-payer calculation option in 2021 and later

APM incentive payment: 5% each year from 2019 to 2024

- Delivered yearly in a lump sum based on prior year professional services revenue
- CMS shall establish processes for practitioners in APMs that do not use FFS payment
- 5% payment will not be included in shared savings calculations

Key implementation issues for CMS

- What spending is the APM responsible for ?
  - Only the services the APM's clinicians bill for
  - Spending in a bundle
  - Total Part A and Part B spending for a beneficiary
- How are clinicians and beneficiaries attributed to APMs?
- What is quality comparable to MIPS?
- What is risk above a nominal amount?

Option 1. APM responsible for *spending its clinicians bill for*

- Clinician likely to be in one APM
- Beneficiary could be in multiple APMs
- Unlikely to have sufficient ‘n’ to measure changes in spending or quality
- No incentive to coordinate care
- No incentive to control total spending
- No incentive to improve quality outcomes

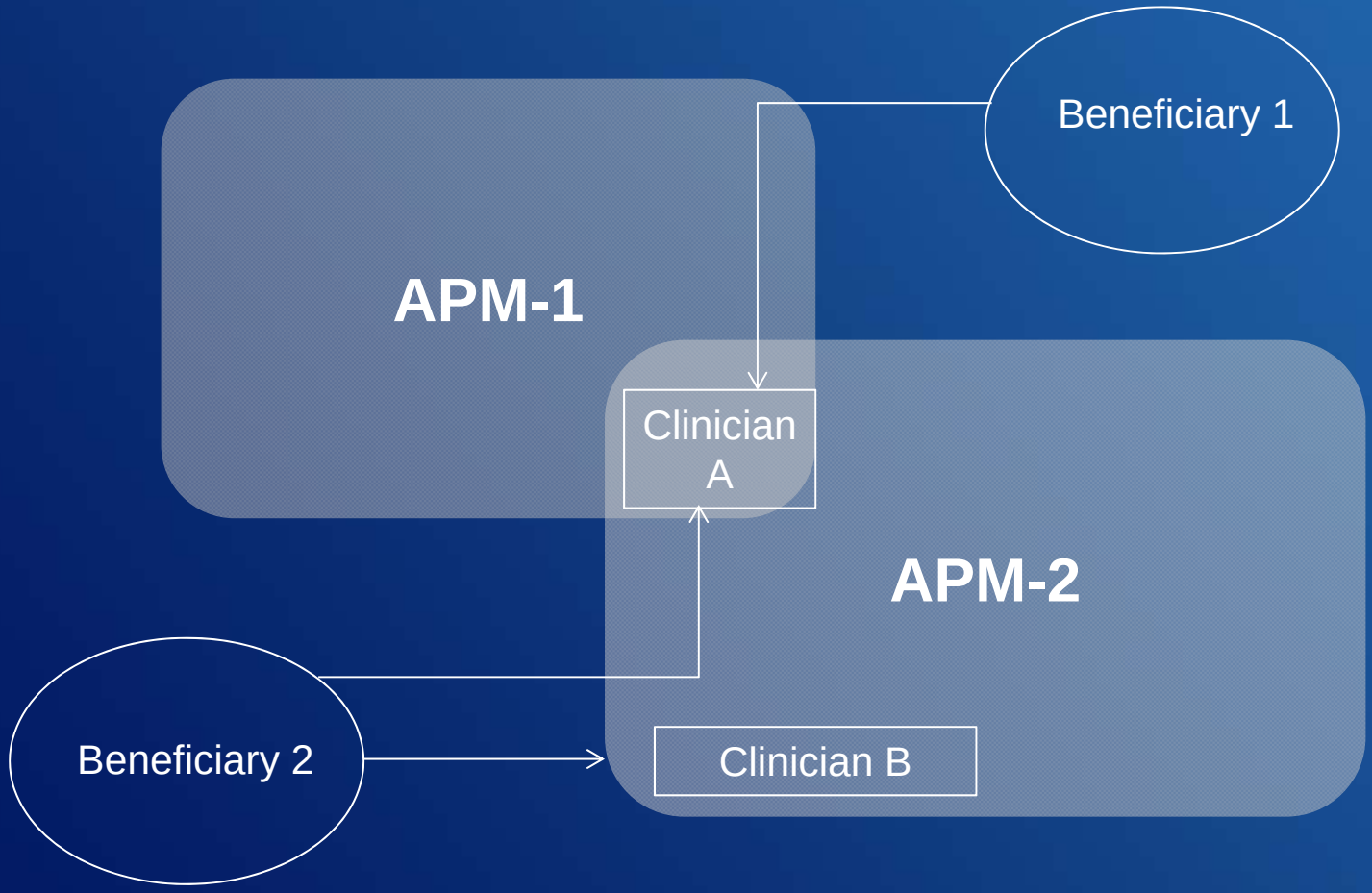
Option 2. APM responsible for *spending within a bundle*

- Clinician could be in multiple APMs
- Beneficiary could be in multiple APMs
- May have sufficient ‘n’ to measure changes in spending or quality
- Some incentive to coordinate care (within bundle)
- No incentive to control total spending
- Some incentive to improve quality outcomes

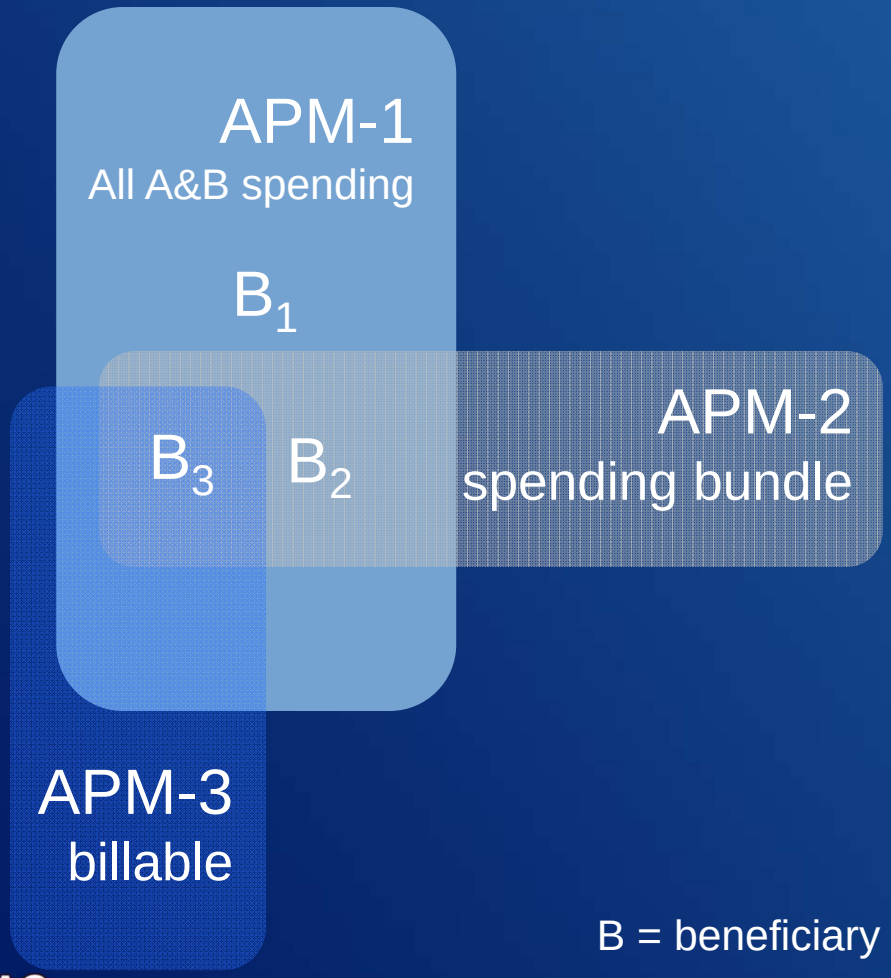
Option 3. APM responsible for *all of a beneficiary's A and B spending*

- Clinician would be in one APM (may differ by specialty)
- Beneficiary would be in one APM
- Likely to have sufficient 'n' to measure changes in spending or quality
- Strong incentive to coordinate care
- Strong incentive to control total spending
- Strong incentive to improve quality outcomes

Clinician/beneficiary/APM relationships could be complicated



APMs responsible for different spending will complicate program



B = beneficiary

If all three APMs have relationship to beneficiary:

- How is share of revenue counted?
- How are savings or losses shared?
- What if clinician is in multiple APMs?

Summary

- Two paths going forward
  - APMs
  - Other (FFS with MIPS)
- Strong interest in APMs
- But, if APMs not responsible for total spending
  - Incentives for care coordination diluted
  - Complexity could increase

Key questions

- How to define MIPS to minimize burden and emphasize outcomes?
- Should APMs be required to lower costs and increase quality?
  - Risk would have to be high enough
  - APMs would have to be large enough
- Balancing scope of spending and variety of APMs
- Should APMs have additional tools such as regulatory relief and sharing savings with beneficiaries?

Hypothetical APM model: based loosely on ACO

- APM would:
  - Be at risk for total spending (Part A and Part B)
  - Have sufficient numbers to detect changes in spending or quality
  - Have ability to share savings with beneficiaries
  - Be given regulatory relief
  - Have a single entity to assume risk
- Beneficiary in one APM per year
- Clinician in one APM per year (may differ by specialty)
- Not suggested definition, example to illustrate issues