Alternative Payment Models (APMs): Potential principles and implementation issues

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Outline

- Review Alternative Payment Model (APM) and Merit-based Incentive Payment System (MIPS) provisions in MACRA
- Potential incentives under APMs and MIPS
- Draft principles for eligible alternative payment entities
- Implementation issues
- Discussion

Key definitions

- Alternative payment model (APM) **"Model"**
  - Any of the following: A model under section 1115A (other than a health care innovation award), the shared savings program /…/; a demonstration under section 1866C, or a demonstration required by Federal law.
- Eligible alternative payment entity **"Entity"**
  - /…/ An entity that participates in an alternative payment model that: requires participants in such model to use certified EHR technology; provides for payment for covered professional services based on quality measures comparable to [MIPS] measures and bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount (or) is a medical home expanded under section 1115A(c).
- Qualifying APM participants **"Participants"**
  - /…/ An eligible professional for whom the Secretary determines that at least [25 percent] of payments under this part for covered professional services furnished by such professional during the most recent period /…/ were attributable to such services furnished under this part through an eligible alternative payment entity.

Review of APM provisions

- From 2019 to 2024, clinicians who are qualifying APM participants will receive 5% additional payment per year for each year that they qualify
- Clinicians who are qualifying APM participants will also receive a higher update in 2026 and later
- Clinicians must have a specified share of FFS revenue (or beneficiaries) in an eligible alternative payment entity to qualify for the incentive payment and higher update
- In general, clinicians will be qualifying participants in APM entities or subject to MIPS

Review of MIPS provisions

- An individual or group-level adjustment based on performance in four areas
  - Quality
  - Resource use
  - Clinical practice improvement activities
  - Meaningful use of eHR
- CMS may use current quality measurement systems (like those used in the value modifier)
- Maximum MIPS adjustments
  - 4 percent in 2019 rising to 9 percent in 2022 and subsequent years
  - Basic adjustments are budget-neutral, upward adjustment can be scaled up or down to achieve budget neutrality
  - Additional $500 million a year for exceptional performance

Timeline

2016
- Spring: Proposed rule
- Fall: Final rule
- November: CMS release list of MIPS measures
- November: CMS release criteria for physician-focused payment models

2017
- Models defined, entities form and apply (are accepted/certified)
- MIPS performance year starts

2018
- January: New codes on claim
- Measurement period for assessing whether clinicians are qualifying participants (25% threshold for 2019 incentive)

2019
- MIPS adjustment applies
- Qualifying APM participant incentive paid

Estimated timeline given statutory requirements

Comparison of APM and MIPS incentives: Assumptions

- APM assumptions
  - Entity responsible for all A&B spending
  - Clinicians share all savings/losses
  - 60% savings rate, 40% to program
  - Incentive payment for qualifying participants of 5% (set by law)
- Range of performance
  - Entity savings/loss: +/- 5%
  - MIPS performance range: +/- 5% (maximum downside adjustment in 2020)
  - Upside MIPS exceptional performance: +5% (limited by statute to 10%)
- Spending assumptions
  - Per beneficiary spending: $10,000
  - Average clinician professional services revenue: $75,000
  - 120 patients per panel attributed to clinician in entity

Draft, subject to change

Comparison of incentives: APM

APM incentives (dollars per clinician)	Upside	Likely	Downside
Incentive payment for qualifying participant	$3,750	$3,750	$3,750
Entity shared savings / loss	$36,000	$0	-$36,000
Total	*$39,750*	*$3,750*	*-$32,250*

- The qualifying APM participant would get the $3,750 bonus regardless of the entity's performance (5% set in law)
- Entity shared savings/loss much higher than incentive payment if performance equals +/- 5%, but that level is unlikely to be achieved

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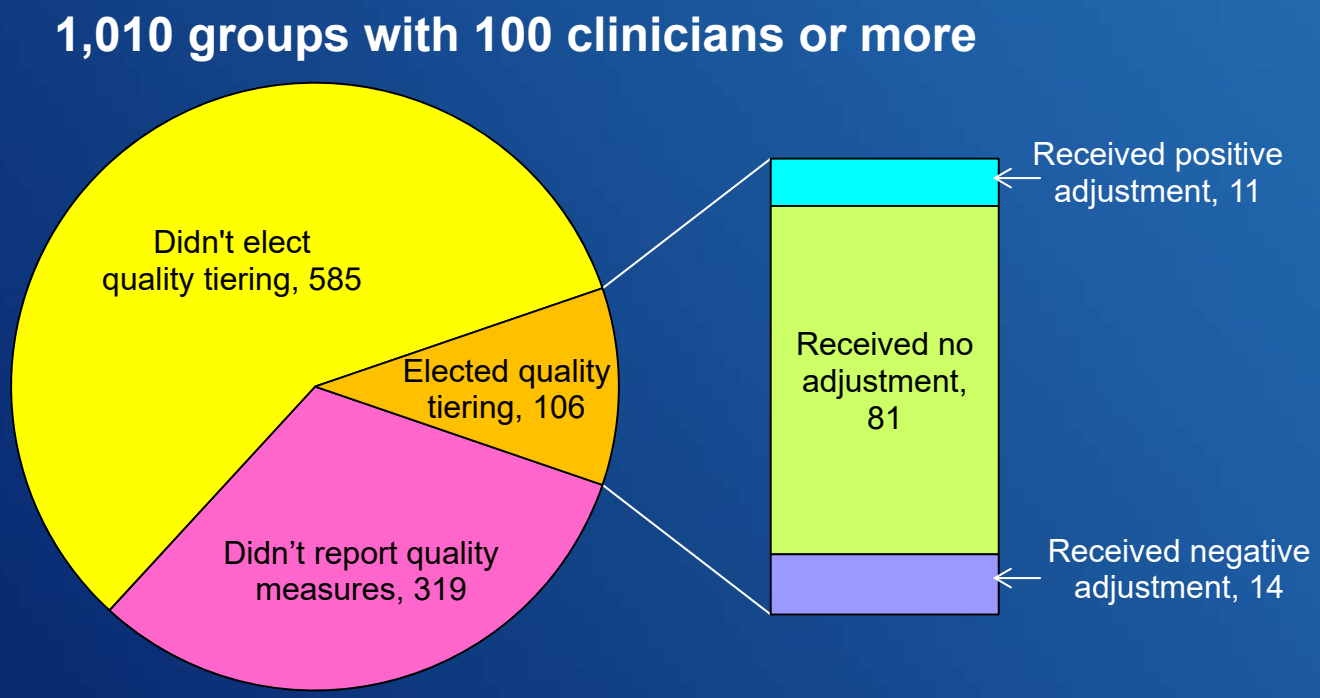
Comparison of incentives: MIPS

MIPS incentives (dollars per clinician)	Upside	Likely	Downside
Basic adjustments	$3,750	$0	-$3,750
Exceptional performance	$3,750	$0	$0
Total	*$7,500*	*$0*	*-$3,750*

- Range could be from $7,500 to -$3,750
- MIPS adjustment can be asymmetric, so gains could be higher
- But most groups unlikely to differ from average based on experience with other clinician-level performance measurement

Draft, subject to change

Most groups subject to the value modifier received no adjustment in 2015



Note: Groups who did not elect quality tiering received a 0% adjustment. This policy is in effect for groups in their first year being subject to the value modifier.
Groups who did not report quality measures received an automatic -1% adjustment. They either did not register for PQRS (288 groups) or did not meet the minimum PQRS reporting requirement (31 groups).
For groups who elected quality tiering, the maximum negative adjustment was -1.0% and the maximum positive adjustment was +4.78%.
Source: CMS value modifier experience report, 2015.

Summary of incentives

- Only certainty is 5% incentive payment
- Actual experience with ACOs tends to be 1-2%
- Experience with value modifier is most get adjustment of zero (even for large groups)
- Risk and reward greater under APM provisions than MIPS, but will depend on level of “risk” and what spending entity is responsible for
- MIPS not yet defined; risk/reward difficult to assess

Draft principles

- Incentive payment for participants only if entity is successful controlling cost, improving quality, or both
- Entity must have sufficient number of beneficiaries to detect changes in spending or quality
- Entity is at risk for total Part A and Part B spending
- Entity can share savings with beneficiaries
- Entity is given regulatory relief
- A single entity must assume risk

Draft principles for performance

- Incentive payment for participants only if entity is successful controlling cost, improving quality, or both
- Entity must have sufficient number of beneficiaries to detect changes in spending or quality
  - If entity at risk, have to be confident in results
  - Key outcome measures require sufficient numbers
- Entity must be at risk for total Part A and Part B spending
  - Needed for care coordination and delivery system reform
  - Being at risk only for own billing counterproductive

Draft principles for administration

- Entity must be able to share savings with beneficiaries
  - Key for engaging beneficiaries
- Entity should be given regulatory relief
  - If entity at risk for total spending, some regulations can be waived
- A single entity must assume risk
  - Allows entity to set reward and penalty based on its priorities and goals
  - Simplifies administration for CMS

Implementation issue: Definition of "risk in excess of a nominal amount"

- Could define as investment risk
  - Pro: limits risk for providers
  - Con: insufficient to motivate clinician improvement and counter FFS volume incentives
- Could define as the difference between actual and expected spending
  - Pro: Motivate system transformation
  - Con: Exposes clinicians to more risk
- Our draft principles tend toward defining risk as actual versus expected spending

Implementation issue: Beneficiary attestation or attribution

- Attestation
  - Pro: Some beneficiary engagement
  - Con: Harder to reach target size
- Attribution
  - Pro: Can achieve higher numbers of aligned beneficiaries
  - Con: Less beneficiary awareness and engagement
- Our draft principles tend toward attribution

Discussion

- Questions on background material
- Comparison of incentives
- Consensus on draft principles
- Implementation issues
  - Defining “risk in excess of a nominal amount”
  - Beneficiary attribution and attestation