Alternative Payment Models: How They're Changing Healthcare Finance

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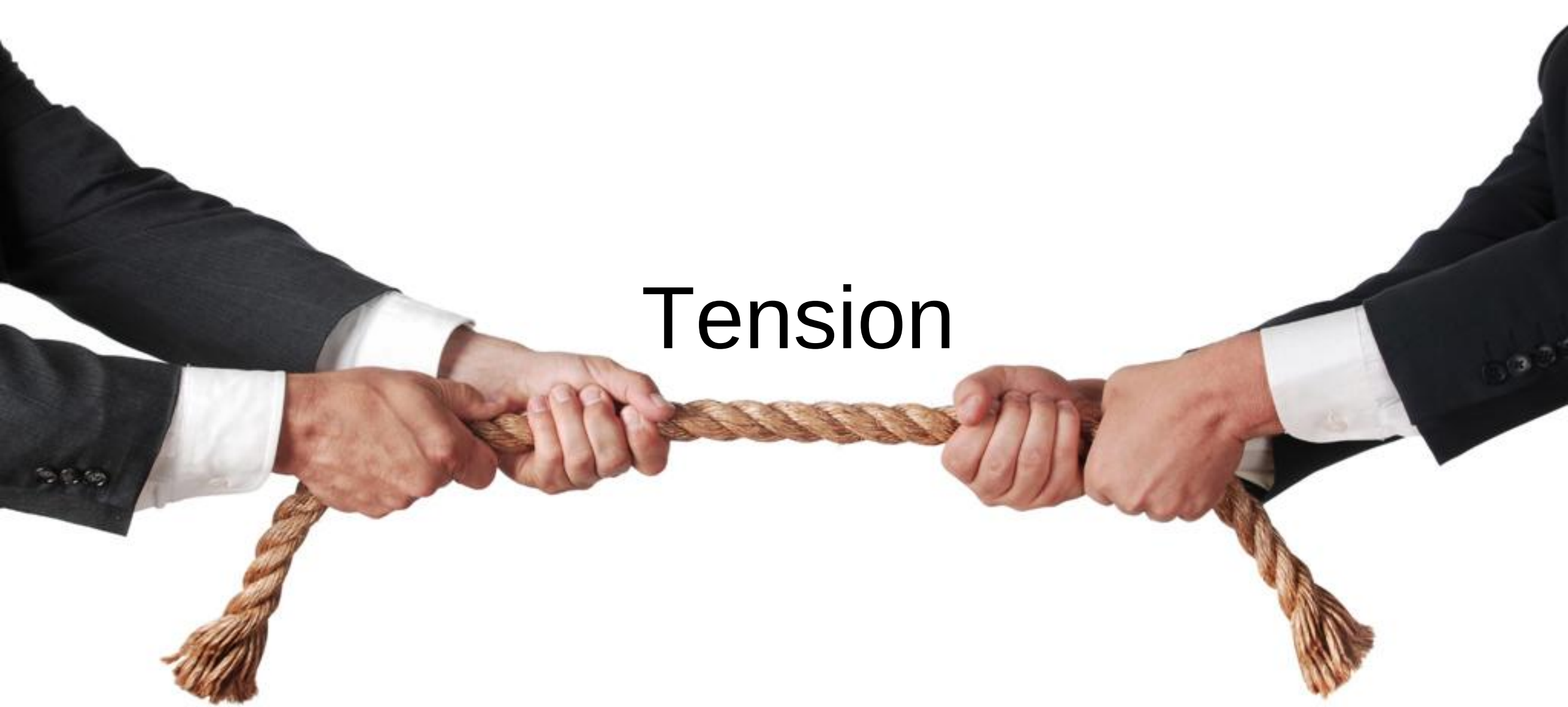
Goals for our time together

- Understand how to capitalize on the high quality care your organization is already providing
  - APMs, MACRA, MIPS, PCMH, Population Health Management
- Learn about new opportunities to positively impact revenue
- Understand new documentation and billing options
- Improve data documentation, measures, and reports to make data-driven decisions

Agenda

We're going to cover a lot today, so here's a summary:

- Introduction
- Listening to health care leaders
- Alternative Payment Models (APMs)
- Medicare's MACRA
  - MIPS
  - Advanced APMs
- How and Other Opportunities
- Key Items and Takeaway
- Q&A


Tension

Listening to Healthcare Leaders: Hospitals & Health Systems

- Expected shift from volume to value
- How to transition physician contracts
- What will the new metrics be?
- When is the time to start ‘shifting?’
- Effect of MACRA on practices & hospital performance

Listening to Healthcare Leaders: Primary Care

- Provider compensation
- Deconstructing front-end primary care
- Utilizing technology
- Patient engagement
- Malpractice exposure
- High-risk patient populations

Listening to Healthcare Leaders: Questions for the Future

- How can hospitals, EDs and primary care work together?
- What outcome measures are meaningful?
- How do we finance the new primary care team we need?
- How long will the transition take?
- What provider compensation model works?
- Provider retention, retirement, and recruitment

"Who will take care of me? And you?"

Alternative Payment Models (APMs)

What are Alternative Payment Models (in general)?

"Methods of payment used by payers to reimburse providers that are not solely based on a fee-for-service basis in which some of the financial risks associated with both the occurrence of medical conditions as well as the management of those candidates is shifted from payers to providers to incentivize efficiency and quality of healthcare delivery." - Center for Health Information & Analysis

Quick(er) definition:

A payment method that aims to incentivize efficiency and quality, and reimburses for it. There are shared risks, but also shared rewards. - Clarify

http://www.chiamass.gov/assets/docs/r/pubs/15/apm-methodology-paper.pdf

A Few Examples of APMs

- Global Payment
- Limited Budget
- Bundled Payments
- Other payment models that aren't just fee-for-service
  - PCMH
  - Per member per month (PMPM)
  - Accountable Care Organization (ACO)

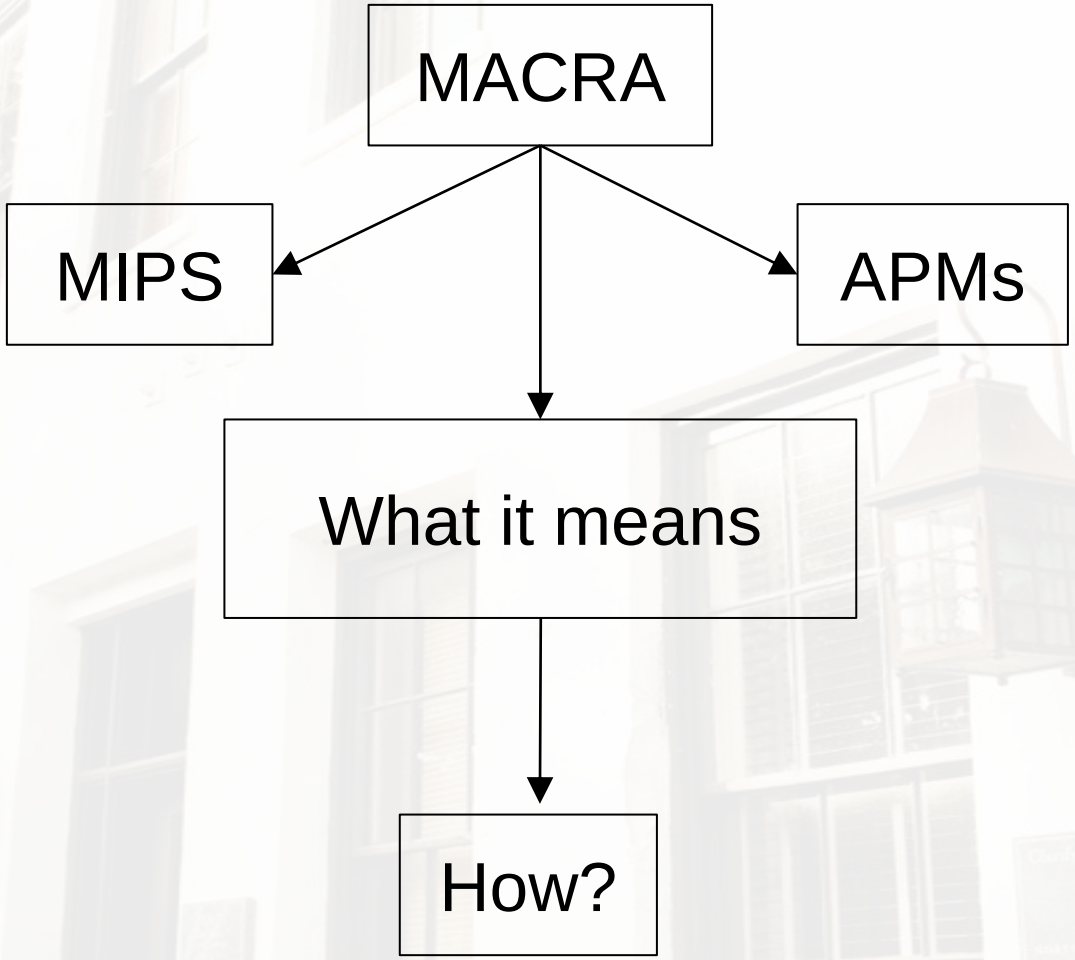
Medicare and CHIP Reauthorization Act of 2015 (MACRA)

What does MACRA do?

- Repeals the Sustainable Growth Rate (SGR) Formula
- Changes how Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit-Based Incentive Payments System (MIPS)
- Provides bonus payments for participation in eligible alternative payment models (APMs)

Source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

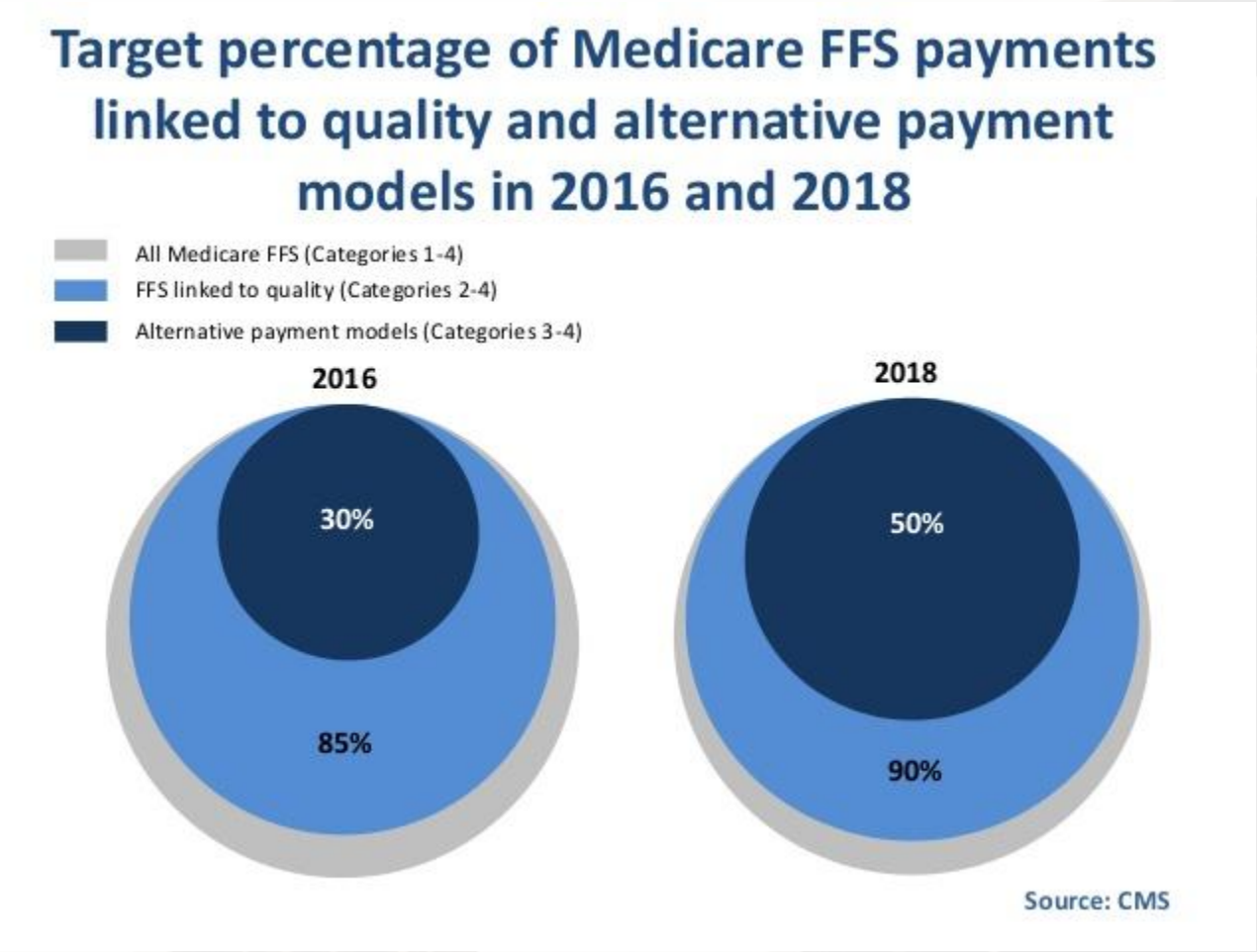
For Us Visual Learners



MACRA

MACRA changes how Medicare pays health care providers:

- Repeals the Sustainable Growth Rate (SGR)
- New framework to reward giving better care, not volume of care provided
- Combines existing quality reporting programs into one new system
- Shifts to quality focused reimbursement



MACRA's Two Paths

Participate in Medicare quality programs in one of two ways:

MIPS and APMs will go into effect over a timeline from 2017 through 2026+

Payments begin in 2019

Source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

Medicare's Merit-Based Incentive Program (MIPS)

MIPS

Combines these existing Medicare programs into one:

- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier
- Medicare Electronic Health Record (EHR) incentive program

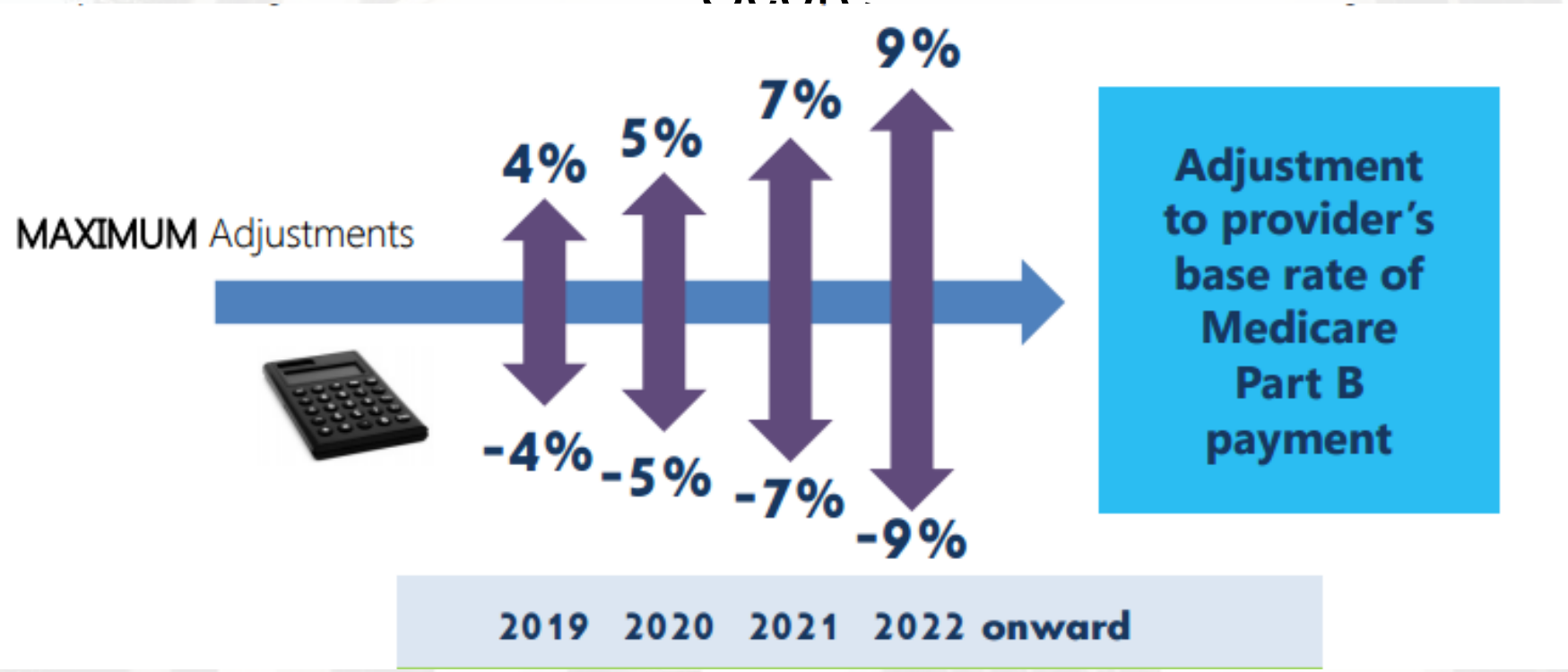
Table 1: Summary of MIPS Performance Categories

Performance Category	Points Need to Get a Full Score per Performance Category[1]	Maximum Possible Points per Performance Category
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource measures that can be attributed.	10 percent

source:www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

MIPS Payment Adjustments

Providers receive positive, negative, or neutral adjustments to Medicare Part B payments based on Composite Performance Score



Source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

Can you opt-out of MIPS?

You can opt-out of MIPS if:

- It's Your First Year of Medicare Participation
- Below Low Volume Threshold
- Currently enrolled in an Eligible APM and qualify for Bonus Payment

source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

Medicare's Alternative Payment Models (APMs)

Medicare's APM

"APMs are new approaches to paying for medical care through Medicare that incentivize quality and value." -CMS

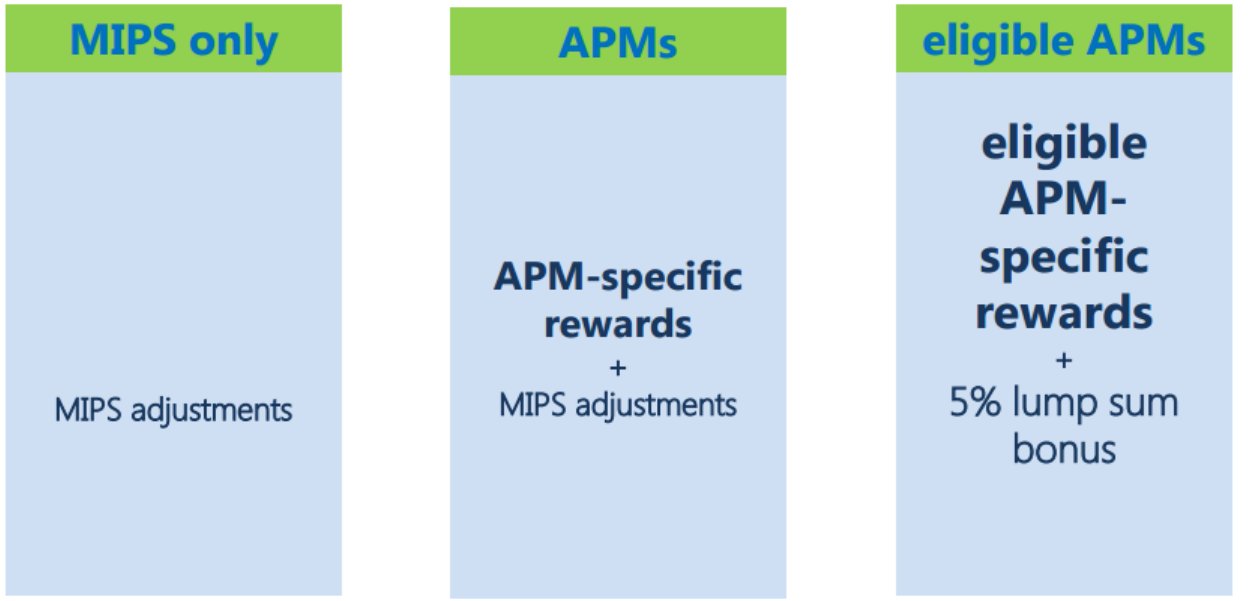
APMs include:

- CMS Innovation Center model
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by Federal Law

Source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

How Practices are Rewarded for APM Participation

- Those who select the APM path can receive APM-specific rewards + MIPS adjustments
- Scored using MIPS clinical practice improvement activities performance category
- For Advanced APMs, providers may be recognized as qualified or eligible APM participants



source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

There will also be Advanced APMs

"Under the new law, Advanced APMs are the
CMS Innovation Center models,
Shared Savings Program tracks, or
statutorily-required demonstrations
where clinicians accept both risk and reward for providing
coordinated, high quality, and efficient care."
-CMS

source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

Advanced APM aka Eligible APM

Meet the following criteria:

- Base payment on quality measures comparable to those in MIPS
- Require use of certified EHR technology
- Bear more than nominal financial risk for monetary losses

Qualifying for APM Track No Easy Feat

Providers Must Meet Two Conditions

1 Participate in an *Eligible* Alternative Payment Model

Alternative Payment Models

New approaches for paying for care that incentivize quality, value

***Eligible* Alternative Payment Models**

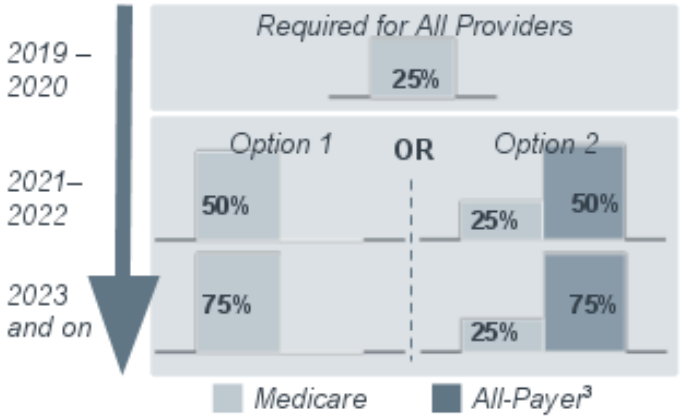
Eligibility Criteria

- ☑ Incentivize providers to meet quality measures comparable to those in MIPS
- ☑ Require use of certified EHR[1] technology
- ☑ Bear *more than nominal financial risk for monetary losses* OR are medical home model expanded under CMMI[2] authority

Thought to mean two-sided risk, but CMS is not yet definitive on whether that model will include one-sided risk models like MSSP Track One as well

2 Meet Revenue at Risk Requirement

Revenue at Risk Requirements



1) Electronic Health Record.
2) Center for Medicare and Medicaid Innovation.
3) Includes risk-based contracts with Medicare Advantage plans.

Source: CMS, "The Medicare Access and CHIP Re-Authorization Act of 2015 Path to Value", available at www.cms.gov; H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board Company interviews and analysis.

Advanced APM Participants

"Those who participate in the most advanced APMs may be determined to be qualifying APM participants or 'QP's'"

QP = Advanced APM participant

QPs:

-do not participate in MIPS payment adjustments

-receive a 5% bonus payment for the years 2019-2024

-receive a higher fee schedule for year 2026 and on

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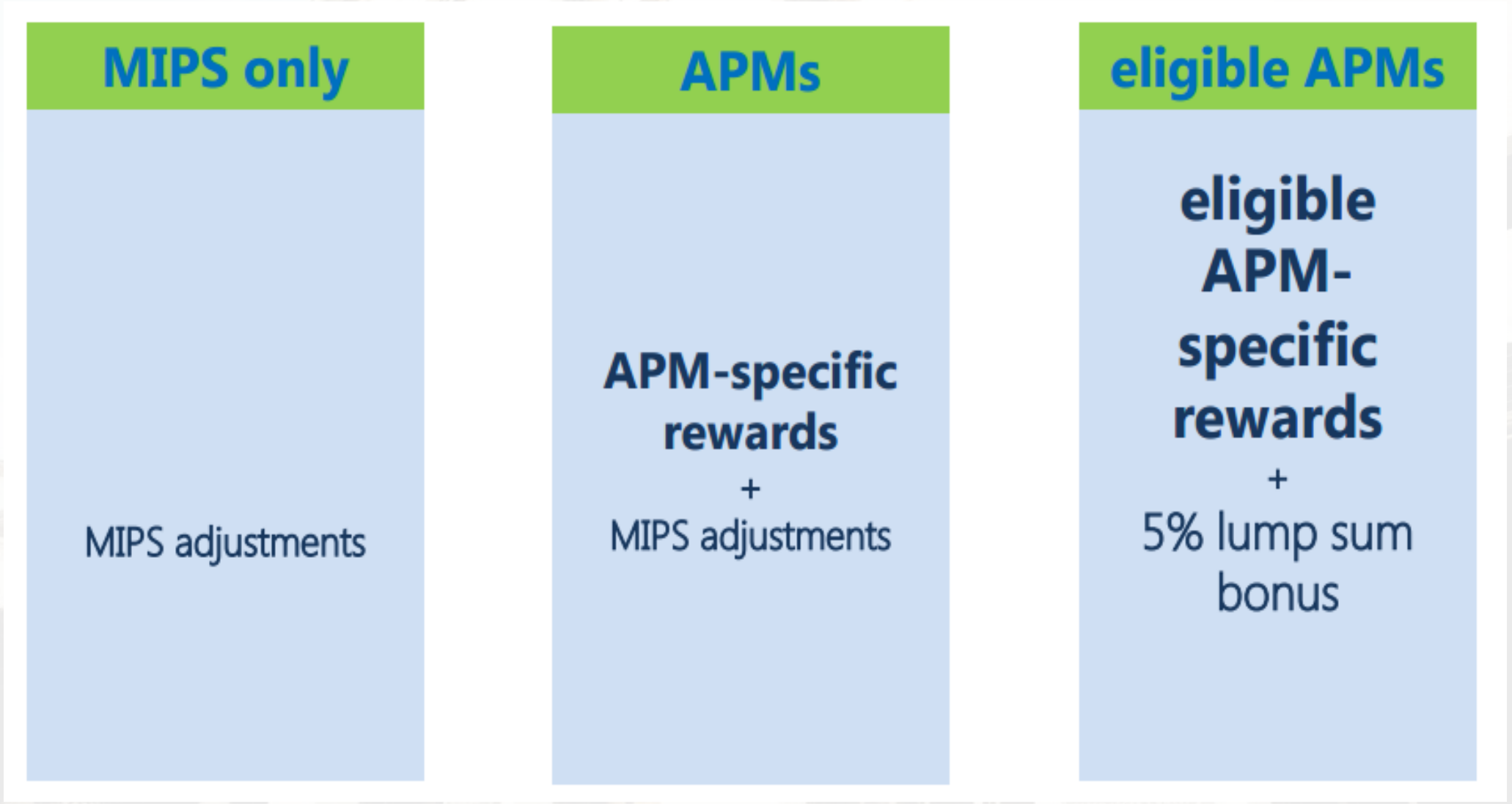

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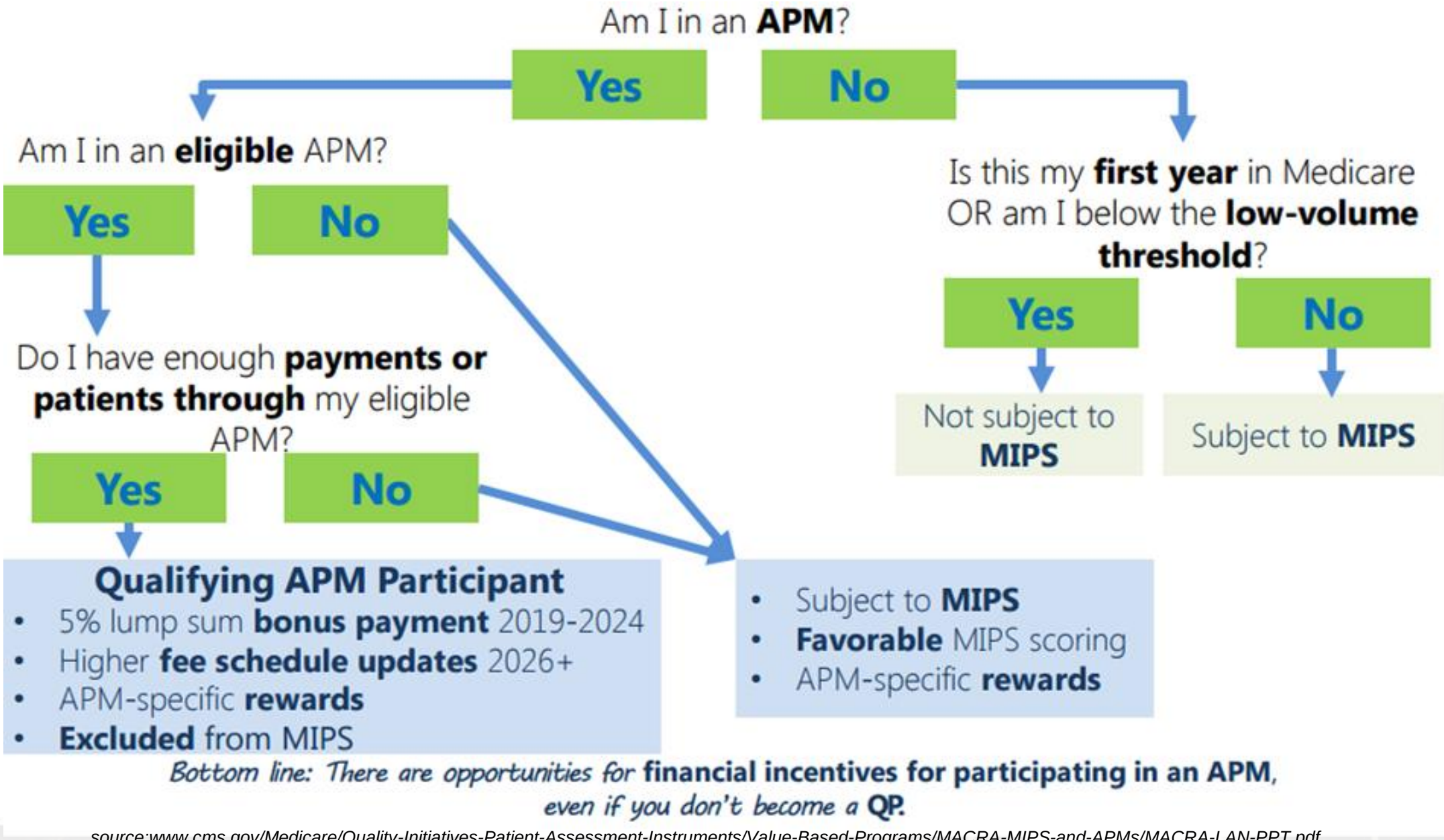

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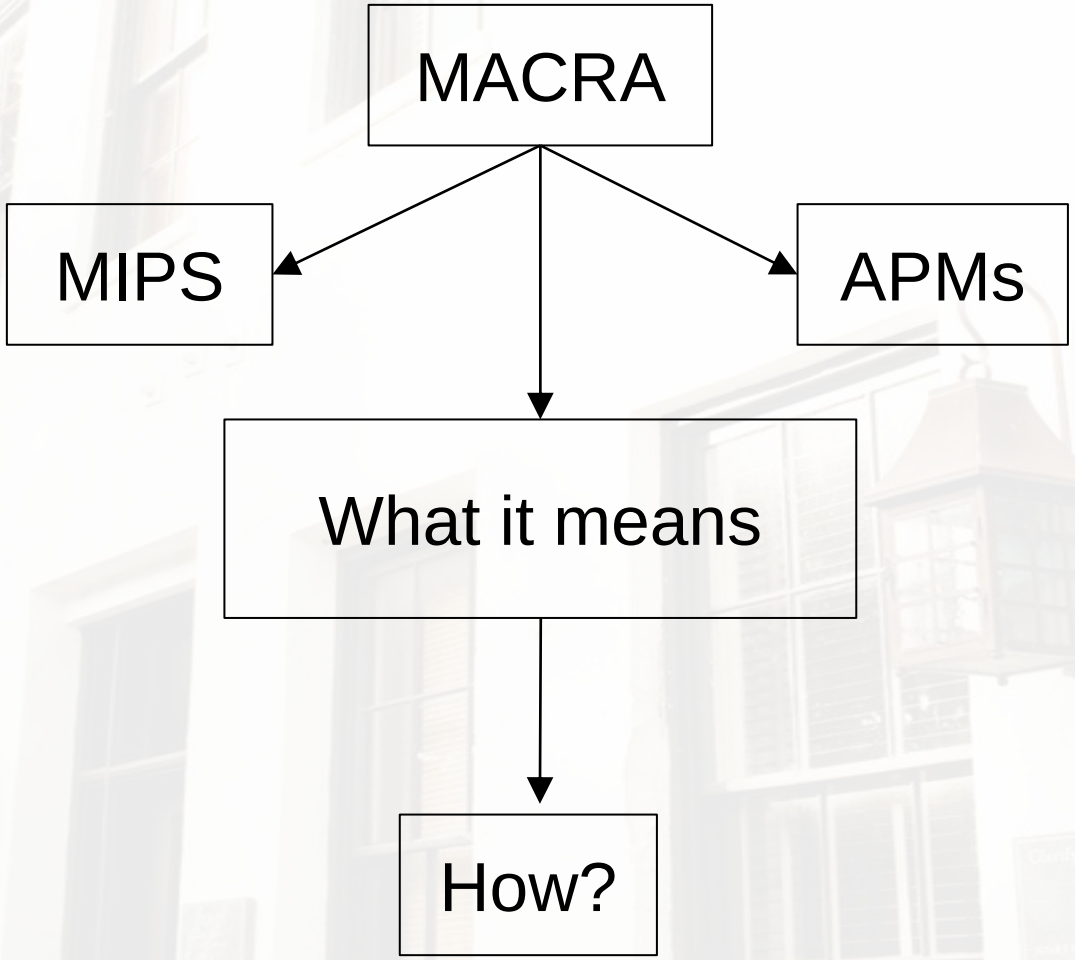
Timeline

2017	Clinicians will report through MIPS for the first performance year
2019	First payment year for MIPS- payment based off performance from 2017
2019-2020	Participation requirements for Advanced APMs are *only* for Medicare payments or patients
2021	Participation requirements for Advanced APMs may include non-Medicare payers & patients
2026+	Clinicians who meet Advanced APM standards are *excluded* from MIPS adjustments and receive a higher fee schedule update

**2019-2024: Clinicians who meet Advanced APM standards are excluded from MIPS adjustments and receive a 5% Medicare Part B incentive payment.*

source: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf


MACRA
MIPS
APMs
What it means
How?

We know this is coming, so…

How do we do this?

How can we be proactive?

How do we make sure we can do this well?

How do we prepare?

Where do we begin?

Read and understand MACRA and the implications for your organization, providers, and bottom-line.

Begin to educate leaders, providers and care team members. This helps people feel informed and understand ‘why’ the organization needs to make changes in the coming months and years.

Optimize your current quality and reporting programs like PQRS, Meaningful Use, PCMH, etc.

Patient-Centered Medical Home (PCMH)

The medical home's a model/philosophy of care that's patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. Patients are treated with respect, dignity, and compassion, and enable strong trusting relationships with providers and staff.

- Patient-Centered Primary Care Collaborative (PCPCC)

Patient-Centered Medical Home (PCMH)

- Helps practices build a strong foundation for:
  - data-driven decision making
  - focus on process
  - population health
  - prepares them to be paid for value
- Improves:
  - documentation
  - quality and usefulness of reports
  - appropriateness and timeliness of care
- Recognition types: PCMH, PCSP & PCCC

Population Health Management (PHM)

- Population Health: “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”
- PHM: “the technical field of endeavor which utilizes individual, organizational, and cultural interventions to help improve the morbidity patterns (i.e., the illness and injury burden) and the healthcare use behavior of defined populations”
- Define populations, processes, reports, timelines, follow-up

Sources: Kindig D, Stoddart G. What is population health? American Journal of Public Health 2003 Mar;93(3):380–3. Hillman, Michael. Testimony before the Subcommittee on Health of the House Committee on Ways and Means, hearing on promoting disease management in Medicare. 2002-04-16.

http://bhmpc.com/wp-content/uploads/2015/03/Population-Managment.jpg

Other Opportunities

- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Annual Wellness Visits (AWV)
- Condition-specific education
- Group visits
- Smoking & tobacco use counseling and cessation
- Evidence-based guidelines
- Process ‘scrubbing’

Discussion & Sharing

Questions? Comments?

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