# Medicare Shared Savings Program in the Quality Payment Program

October 27, 2016

# Quality Payment Program

# Medicare Payment Prior to MACRA

**Fee-for-service** (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians


Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

# The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

**Advanced Alternative Payment Models (APMs)**
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

**The Merit-based Incentive Payment System (MIPS)**
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

# Who participates in MIPS?

- Medicare Part B clinicians billing more than $30,000 a year **and** providing care for more than 100 Medicare patients a year.
- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists

# Who is excluded from MIPS?

- **Newly-enrolled Medicare clinicians**
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.
- **Clinicians below the low-volume threshold**
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients
- **Clinicians significantly participating in Advanced APMs**

# Shared Savings Program

**Shared Savings Program Track 1**

- This APM is a MIPS APM.
- MIPS eligible clinicians in ACOs are subject to MIPS under the APM scoring standard.
- All MIPS eligible clinicians in the APM Entity are considered a group and will receive the same score.

**Shared Savings Program Track 2**

- This APM is an Advanced APM.
- Participating eligible clinicians who are determined to be Qualifying APM Participants are exempt from MIPS.

**Shared Savings Program Track 3**

- This model is an Advanced APM.
- Participating eligible clinicians who are determined to be Qualifying APM Participants are exempt from MIPS

# APM Scoring Standard

# What are MIPS APMs?

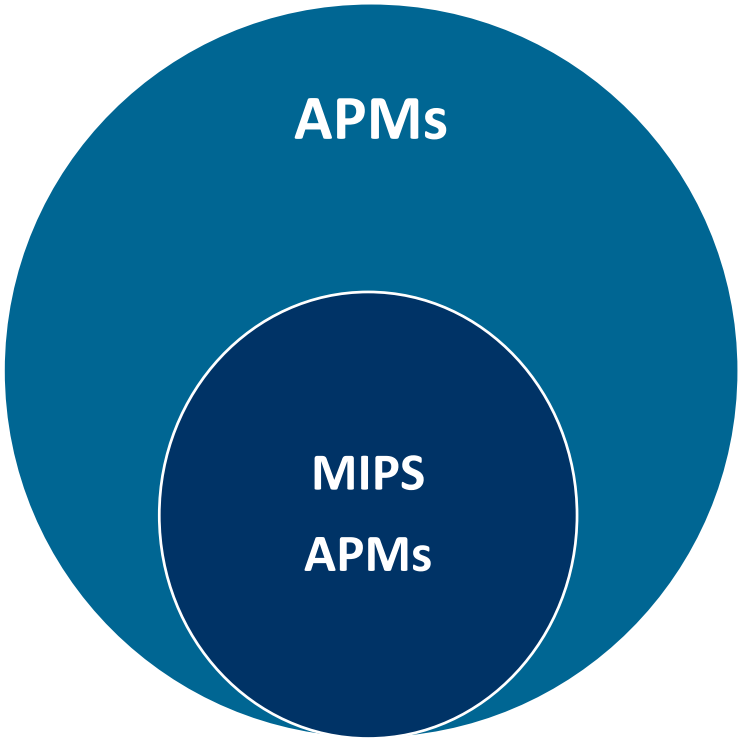
## Goals

- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

## How does it work?

- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

## MIPS APMs are a Subset of APMs



# What are the Requirements to be Considered a MIPS APM?

The APM scoring standard **applies to APMs that meet these criteria**:

- ✓ APM Entities participate in the APM under an **agreement with CMS**;
- ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
- ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization** and **quality.**

# What are key dates for the APM scoring standard?

- To be considered part of the APM Entity for the APM scoring standard, an eligible clinician **must be on an APM Participation List on at least one of the following three snapshot dates (March 31, June 30 or August 31)** of the performance period.

- Otherwise an eligible clinician must report to MIPS under the standard MIPS methods.

# To which APMs does the APM Scoring Standard apply in 2017?

For the **2017 performance year**, the following models are considered MIPS APMs:

- Comprehensive ESRD Care (CEC) Model (All Arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
- Shared Savings Program Tracks 1, 2, and 3
- Next Generation ACO Model
- Oncology Care Model (OCM) (All Arrangements)

The list of MIPS APMs is posted at QPP.CMS.GOV and will be updated on an ad hoc basis.

# Shared Savings Program (All Tracks) under the APM Scoring Standard

| | REPORTING REQUIREMENT | PERFORMANCE SCORE | WEIGHT |
|---|---|---|---|
|  Quality | ✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians. | ✓ The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level. | 50% |
|  Cost | ✓ MIPS eligible clinicians will not be assessed on cost. | ✓ N/A | 0% |
|  Improvement Activities | ✓ No additional reporting necessary. | ✓ CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program. | 20% |
|  Advancing Care | ✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements. | ✓ All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score. | 30% |

# Alternative Payment Models (APMs)

# What is an Alternative Payment Model (APM)?

Alternative Payment Models (APMs) are new approaches to paying for medical care through Medicare that incentivize quality and value. The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined – both through the Affordable Care Act and other legislation – a number of demonstrations that CMS conducts.

As defined by MACRA, **APMs include:**

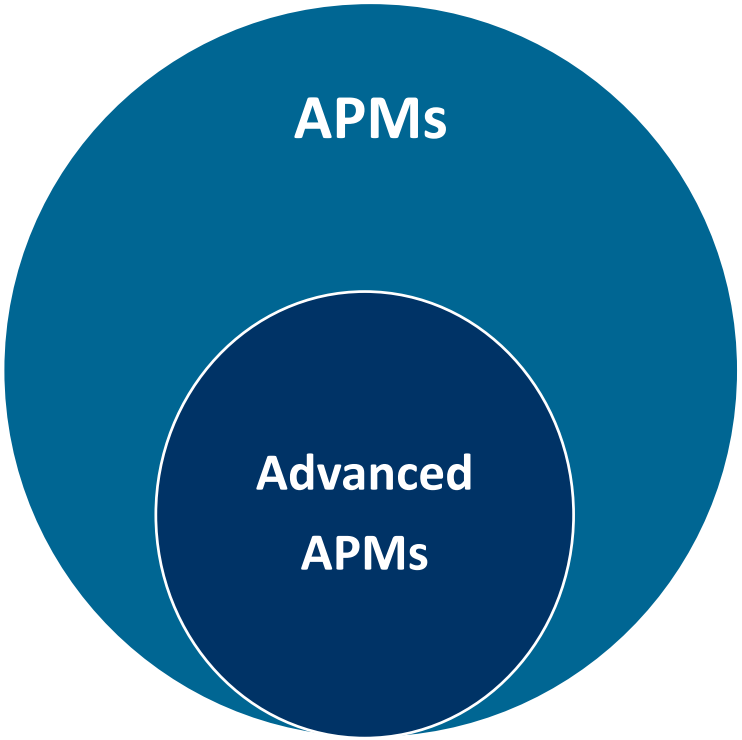
- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

# Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



# Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes.
- It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

| Advanced APMs |
| --- |
| Advanced APM-specific rewards<br>+<br>5% lump sum incentive |

# What are the Benefits of Participating in an Advanced APM as a Qualifying APM Participant (QP)?

QPs:

- Are excluded from MIPS
- Receive a 5% lump sum bonus
- Receive a higher Physician Fee Schedule update starting in 2026

# The Quality Payment Program provides **additional** rewards for participating in APMs.

Potential financial rewards 

| Not in APM | In APM | In Advanced APM |
|---|---|---|
| MIPS adjustments | MIPS adjustments | |
| | + | |
| | APM-specific rewards | APM-specific rewards |
| | | + |
| | If you are a **Qualifying APM Participant (QP)** = | 5% lump sum bonus |

# Advanced APM Criteria

# Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

# Advanced APM Criterion 1: Requires use of Certified EHR Technology

## 1. Requires participants to use certified EHR technology

- Requires that at least 50% of the clinicians in each APM Entity use certified EHR technology to document and communicate clinical care information with patients and other health care professionals.
- For APM Entity groups in the Shared Savings Program, each ACO participant TIN submits data on the advancing care information performance category as specified in §414.1375(b)

# Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

**2. Bases payments on quality measures that are comparable to those used in the MIPS quality performance category.**

- Ties payment to quality measures that are evidence-based, reliable, and valid.
- At least one of these measures must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.

# Advanced APM Criterion 3: Bear a More than Nominal Amount of Financial Risk

**3.** Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority, OR **(2) requires participants to bear a more than nominal amount of financial risk**.

**Financial Risk**

Bearing financial risk means that the Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to CMS.

**Total Amount of Risk**

The total amount of that risk must be equal to at least either:

- 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities; OR
- 3% of the expected expenditures for which an APM Entity is responsible under the APM.

# Advanced APMs in 2017

For the **2017 performance year**, the following models are Advanced APMs:

| | |
|---|---|
| Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements) | Comprehensive Primary Care Plus (CPC+) |
| Shared Savings Program Track 2 | Shared Savings Program Track 3 |
| Next Generation ACO Model | Oncology Care Model (Two-Sided Risk Arrangement) |

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.

# Qualifying APM Participants (QPs)

# What is a Qualifying APM Participant (QP)?

- Qualifying APM Participants (QPs) are clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.
- Beginning in 2021, this threshold % may be reached through a **combination** of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

# How do Eligible Clinicians become Qualifying APM Participants? – Step 1

1

- ✓ Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - ✓ individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - ✓ eligible clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model will be assessed individually.

# How do Eligible Clinicians become Qualifying APM Participants? – Step 2

2

- ✓ CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).
- ✓ Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM
- ✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

These definitions are used for calculating Threshold Scores under both methods.

**Attributed** (beneficiaries for whose cost and quality of care the APM Entity is responsible)

**Attribution-eligible** (all beneficiaries who could potentially be attributed)

# How do Eligible Clinicians become Qualifying APM Participants? – Step 2

2

✓ The two methods for calculation are Payment Amount Method and Patient Count Method.

**Payment Amount Method**

$$\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$

**Patient Count Method**

$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score \%}$$

# How do Eligible Clinicians become Qualifying APM Participants? – Step 3

3

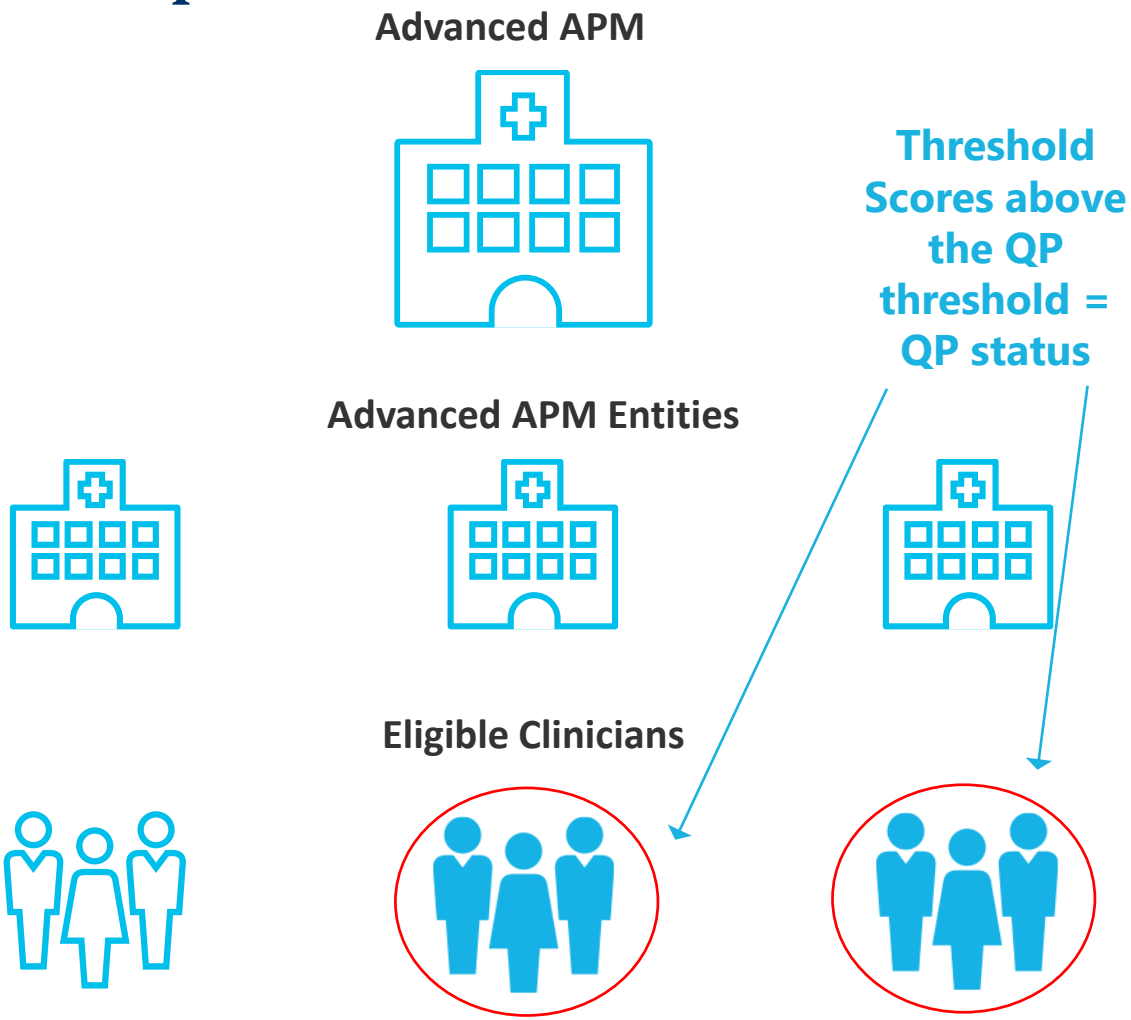
✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

| Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements) | | | | | | |
|---|---|---|---|---|---|---|
| **Performance Year** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022 and later** |
| **Percentage of Payments through an Advanced APM** | 25% | 25% | 50% | 50% | 75% | 75% |
| **Percentage of Patients through an Advanced APM** | 20% | 20% | 35% | 35% | 50% | 50% |

# How do Eligible Clinicians become Qualifying APM Participants? – Step 4

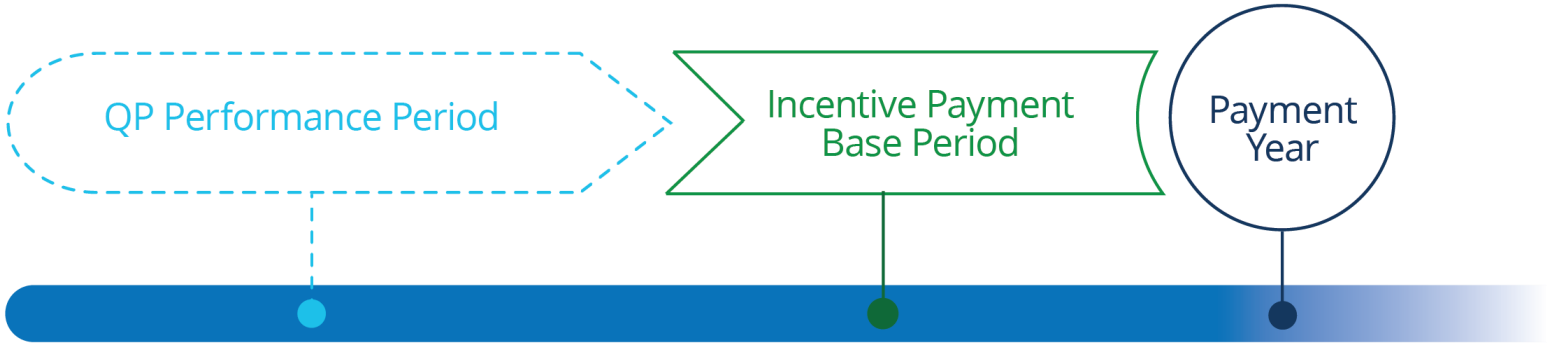
4

- ✓ All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.



# What is the Performance Period for QPs?

- The QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for the payment year.
- The QP Performance Period for each payment year will be from **January 1 – August 31st** of the calendar year that is **two years prior** to the **payment year**.




**Performance Period:**
QP status based on Advanced APM participation

**Incentive Determination:**
Add up payments for Part B professional services furnished by QP

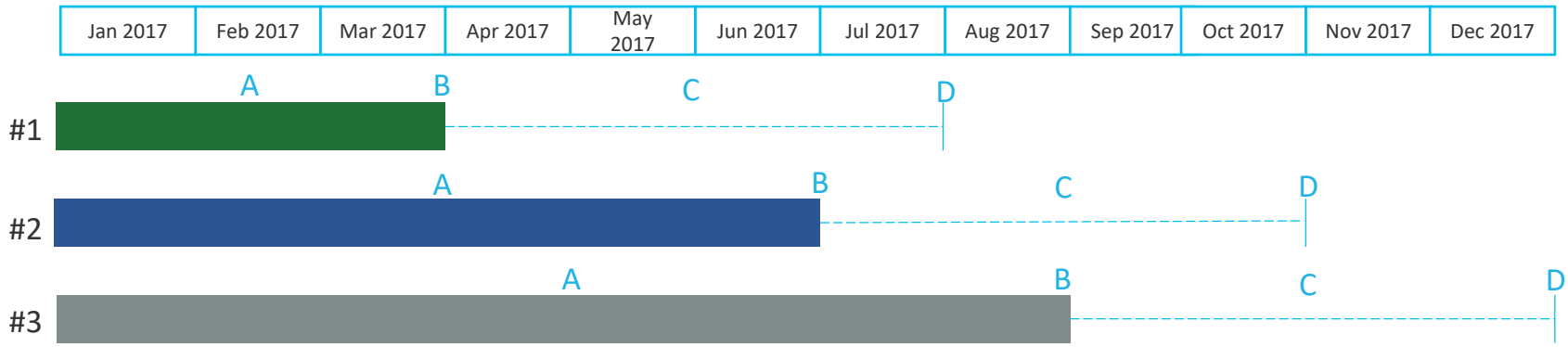
**Payment:**
+5% lump sum payment made (excluded from MIPS adjustment)

# What are the three "Snapshots" for QPs during the Performance Period?

- During the QP Performance Period (January – August), CMS will take three "snapshots" (March 31, June 30, August 31) to determine which eligible clinicians are participating in an Advanced APM and whether they meet the thresholds to become Qualifying APM Participants.

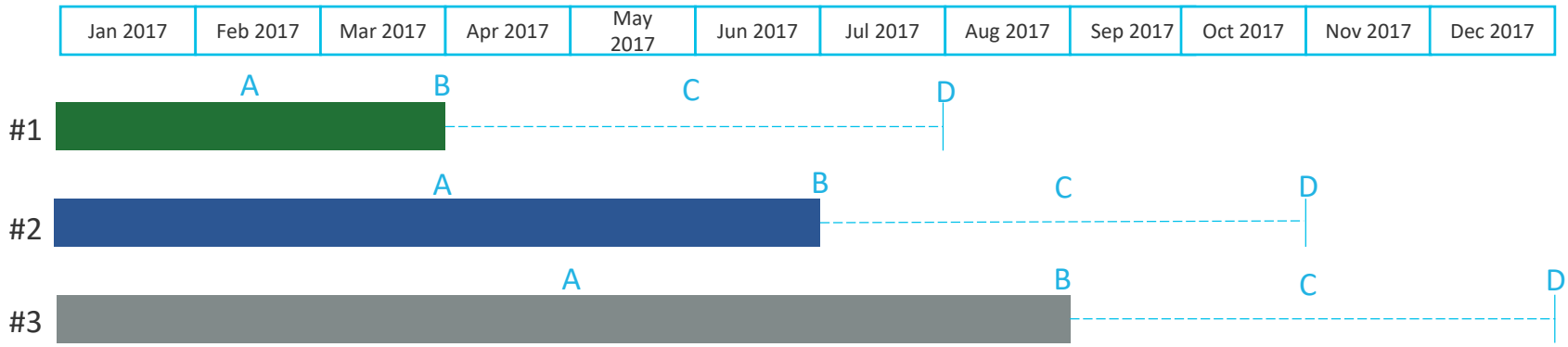
# How are QPs determined during the Performance Period?

- For each of the three QP determinations, CMS will use claims data from period "A" for the APM Entity participants captured in the snapshot at point "B." CMS then allows for claims run-out during period "C" and finalizes QP determinations at point "D."
- If an APM Entity meets the QP threshold, subsequent eligible clinician additions to the Participation List do not automatically confer QP status to those eligible clinicians. If the group meets the QP threshold for a subsequent QP determination, then the new additions become QPs.



# When Will Clinicians Learn their QP Status?

- Reaching the QP threshold at any one of the three QP determinations will result in QP status for the eligible clinicians in the Advanced APM Entity
- Eligible clinicians will be notified of their QP status after each QP determination is complete (point D).



# What if Clinicians do not Meet the QP Payment or Patient Thresholds?

- Clinicians who participate in Advanced APMs, but do not meet the QP threshold, may become "Partial" Qualifying APM Participants (Partial QPs).
- Partial QPs choose whether to participate in MIPS.

**Medicare-Only Partial QP Thresholds in Advanced APMs**

| Payment Year | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 and later |
|---|---|---|---|---|---|---|
| Percentage of Payments | 20% | 20% | 40% | 40% | 50% | 50% |
| Percentage of Patients | 10% | 10% | 25% | 25% | 35% | 35% |

# Where can I go to learn more?

**The Quality Payment Program Service Center is also available to help:**

# qpp.cms.gov

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:


**Transforming Clinical Practice Initiative (TCPI):** TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.


**Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):** The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.


**If you're in an APM:** The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.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