AMERICA'S PHYSICIAN GROUPS

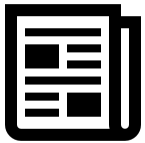
QPP, ACO, MPFS Rules: Get Ready for 2019

Valinda Rutledge
Sean Cavanaugh
Margaret Peterson

Agenda

- 5 minutes - Valinda will review the 3 proposed rules conceptually in terms of the administration's intent
- 10 minutes - Sean will discuss the MSSP proposed rule
- 10 minutes - Margaret will discuss the QPP proposed rule
- 5 min - Valinda will discuss MPFS proposed rule
- 5 min - Audience Q&A

Common Themes in Proposed Rules



Patients Over Paperwork

- Improve care coordination
- Reduce unnecessary burden for providers
- Improve patient outcomes

Listening to stakeholders

Supporting faster acceleration to risk-based APMs

Sean Cavanaugh, Chief Administrative Officer, Aledade

MSSP Proposed Rule

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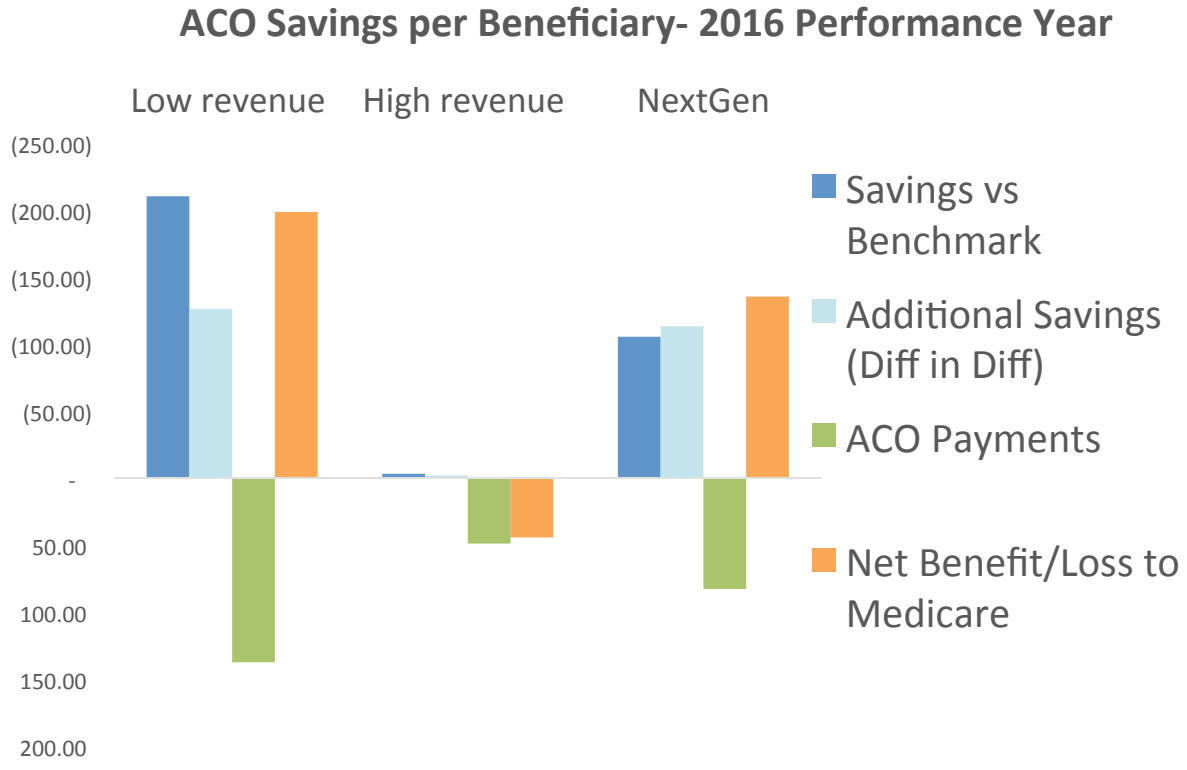
The MSSP Proposed Rule is Good for Physician-Led, "Low Revenue," ACOs

The Key Takeaways

- Strengthens the program by recognizing the unique value of physician-led ACOs
- Illustrates CMS' commitment to helping more independent physicians move to value based care
- Boosts likelihood of shared savings earlier for physician-led ACOs and motivates ACOs by introducing shared losses earlier in the program

“Low Revenue” Physician Led ACOs Outperform All Other ACOs



- Using CMS’ data and methodology, Low Revenue Track 1 ACOs performed as well as Next Gen ACOs
- Policies that incentivize physicians to participate in low revenue ACOs will save money and lives
- Low revenue ACOs serve 5x more beneficiaries than NextGen and are easier to launch and scale
- Payments made to low revenue ACOs reflect gains, not losses, to Medicare

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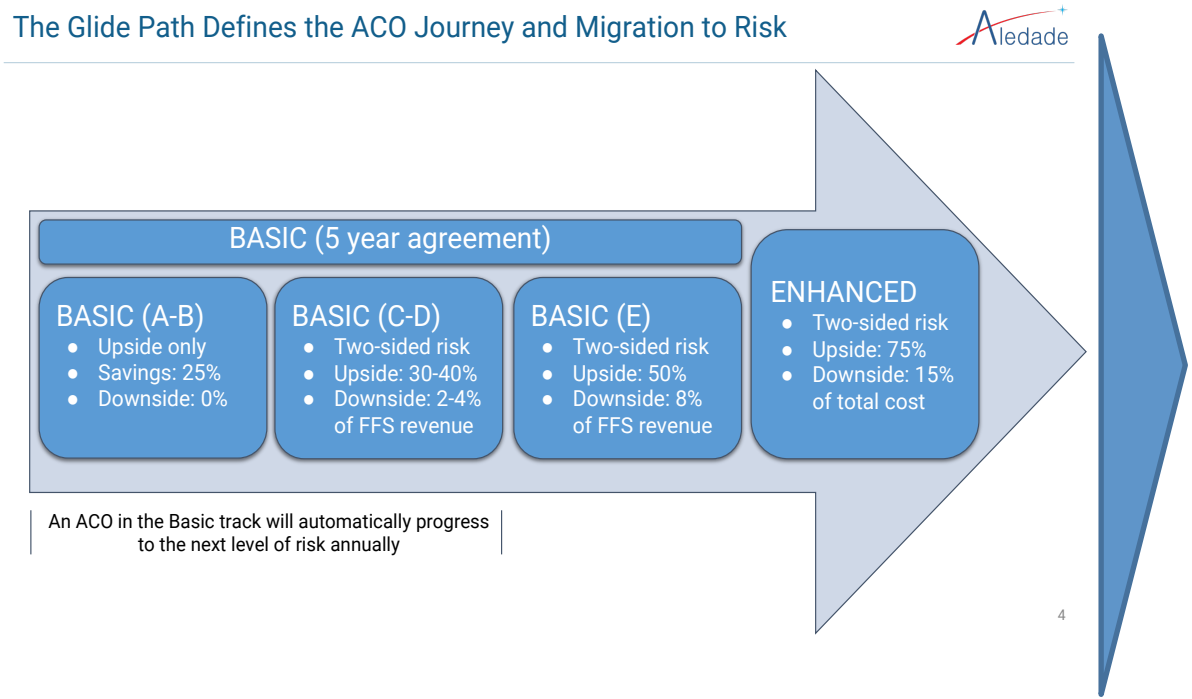
Source: CMS ACO 2018 Rule, Table 15, and NextGen Fact Sheet

There are Three Main Categories of Policy Changes

1. Glide Path to Risk
2. Enhanced Flexibility
3. Refined Benchmarking Methodology

1. Glide Path - Perspectives



What we like:

- Brings revenue-based risk to MSSP
- Downside risk weeds out ACO squatting

What worries us:

- Low gainshare in first 2 years insufficient to entice new participants, support investments
- Gaming by hospitals to qualify for "low revenue" definition

What we propose (with logical outgrowth):

- Increase gainshare and lower MSR for low revenue ACOs
- Scrutiny of participant ownership

2. Enhanced Flexibility Gives ACOs More Control and Mobility

All ACOs can:

- Choose their beneficiary attribution methodology (retrospective or prospective)
- Accelerate their path to risk as desired

ACOs in a two-sided model can:

- Choose their Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)
  - 0%
  - Symmetrical; 0.5% increment between 0.5-2.0%
  - Symmetrical; based on the number of assigned beneficiaries
- Establish a beneficiary incentive program
- Apply for Skilled Nursing Facility (SNF) 3-day waivers

What we like:

- Shifts decision-making from CMS to ACOs

What worries us:

- Any progression to opt-in requirement creates massive paperwork and administrative burden

What we propose:

- Allow ACOs to choose to go to ENHANCED at any time
- Opt-in required only when beneficiaries lose a benefit- eg narrow network design

3. Refined Benchmarking Methodology (“more similar to MA”)

- Improved benchmarking methodology incorporates regional trend and efficiency starting in the first agreement to more accurately reflect changes in cost and quality for patients attributed to ACOs (see table)
- Updated cap to risk score adjustment of +/- 3% more accurately reflects the changing profile of beneficiaries attributed to ACOs within a contract

	1st Agreement (1 - 5 years)	2nd Agreement (Soon as Yr 2 Late as Yr 6)	3rd Agreement
Regionally Efficient ACO	35% Regional Costs 65% ACO’s Historical Costs	50% Regional Costs 50% ACO’s Historical Costs	50% Regional Costs 50% ACO’s Historical Costs
Regionally Inefficient ACO	25% Regional Costs 75% ACO’s Historical Costs	35% Regional Costs 65% ACO’s Historical Costs	50% Regional Costs 50% ACO’s Historical Costs

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What we like:

- Greater predictability through risk adjustment, regional trend, and regional efficiency

What worries us:

- Caps on risk adjustment inadequately controls for rising risk, and introduces gaming potential on falling risk
- Cap on regional efficiency blunts further improvement (“100% tax bracket”)

What we propose: (“more like MA”):

- Renormalization, not a risk adjustment cap
- Raise regional efficiency cap

Rural ACOs are still Disadvantaged with the Proposed Rule

Market Share	Savings Lost
0%	0%
5%	5%
10%	10%
20%	20%
40%	40%

Including an ACO's population in their regional benchmark reduces their savings opportunity in direct proportion to their market share.

What we like:

- Taking seriously the predicament of rural ACOs

What we are worried about:

- Proposed solution does not address this systematic problem- hurts as many as it helps

What we propose:

- Do not include the ACO's population in the regional benchmark
- Expand geographic area to deal with low population situations- as done by MA

Summary Policy Recommendations to Further Improve the Rule

It does come down to the Benchmark

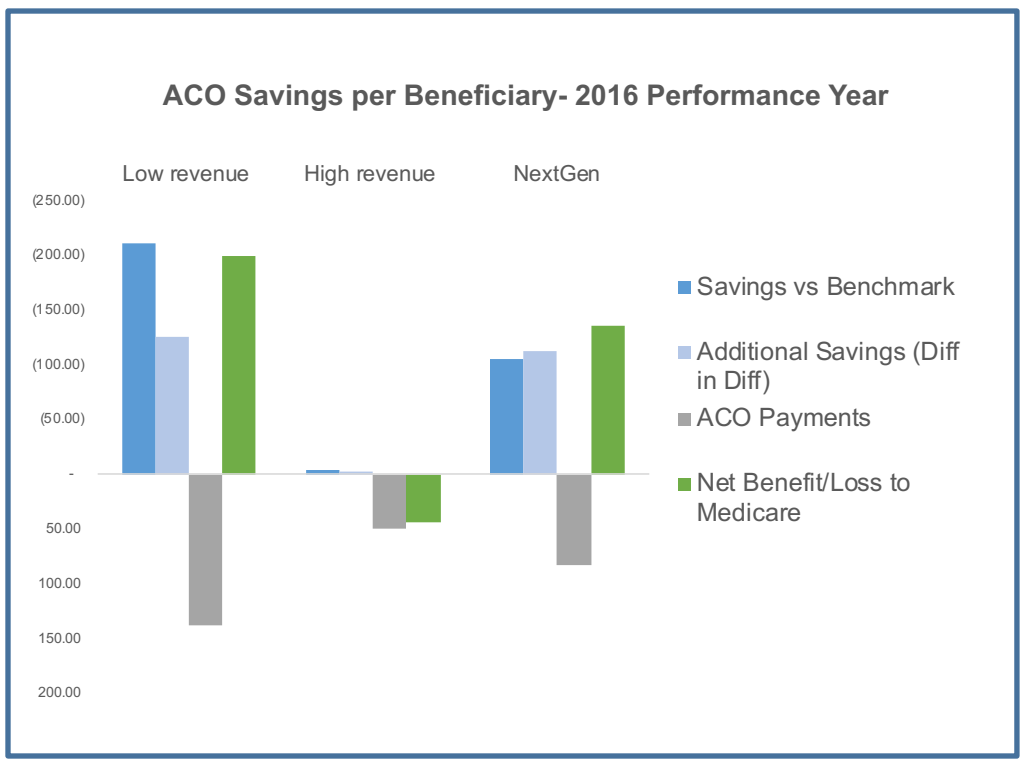
Benchmark- Further increase predictability and fairness

- Increase regional efficiency to maintain motivation, and recognize the multiple years of work that go into hitting those caps
- Replace risk coding caps with renormalization
- Improve benchmarking calculation methodology for rural ACOs

Glidepath- Create incentives for physicians to continue to move towards robust risk-taking ACOs

- Increase gainshare and lower MSR for low revenue ACOs in first 2 years
- Ensure integrity of “low revenue” designation through scrutiny of participant ownership
- Allow ACOs to choose to go to ENHANCED at any time

Issue to Consider: Finding the Optimal Balance Between Protecting Trust Fund from Saving Payments versus Healthcare Cost Growth?



- Current impact assessment emphasizes reducing ACO net earnings versus increasing shared savings:
  - 169 fewer ACOs through 2024
    - -$330 million in "net federal impact"
    - $390 million in reduced ACO earnings
    - $60 million in INCREASED claims costs (and lost benefit to beneficiaries)
- Creating greater incentives for ACO participation and motivation will spur private sector investment and progress towards value-based care, quality gains.
- Payments made to low revenue ACOs reflect gains, not losses, to Medicare
- Does *not* include positive spillover effects to community costs, and Medicare Advantage premiums

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Margaret Peterson, Director of Federal Affairs, APG

QPP Proposed Rule

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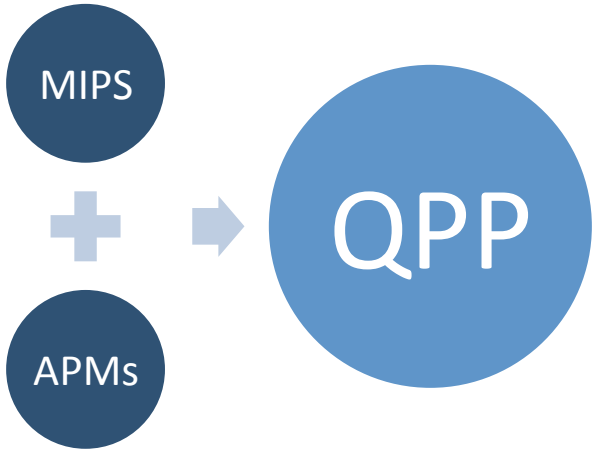
Level Setting

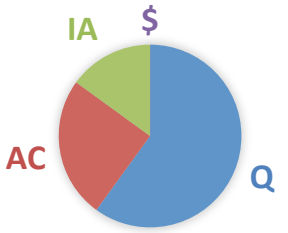
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment, and established the Quality Payment Program (QPP)

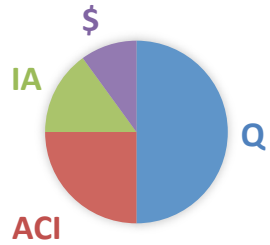
- MIPS
  - Quality (formerly PQRS program)
  - Advancing Care Information (formerly Meaningful Use program)
  - Improvement Activities
  - Cost (formerly the Value-Based Modifier program)

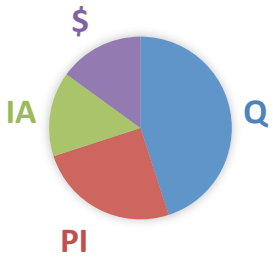
- Advanced APMs
  - Use quality measures comparable to MIPS
  - Use Certified Electronic Health Records Technology (CEHRT)
  - Bear more than nominal financial risk, or are a qualifying medical home
  - Threshold: 25% of Medicare Part B revenue OR 20% of Medicare patients



Proposed MIPS Highlights for Year 3 (2019)







Year 1, 2017

- Must achieve score of **3** to avoid penalty (submit one measure with information for one day)
- Score composite – 60% quality, 25% advancing care, 15% improvement activities, 0% cost.
- Exceptional Performer – 70 points
- Payment adjustment -4% / +4% (in reality, a score of 100 this year only yielded a 1.8% increase)

Year 2, 2018

- Must achieve a score of **15** to avoid penalty
- Score composite – 50% quality, 25% advancing care information, 15% improvement activities, 10% cost
- Exceptional Performer – 70 points
- Payment adjustment -5% / +5%

Year 3, 2019

- Must achieve a score of **30** to avoid penalty
- Score composite – 45% quality, 25% promoting interoperability, 15% improvement activities, 15% cost
- Exceptional Performer – 80 points
- Payment adjustment -7% / +7%

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Other Proposed MIPS changes for Year 3 (2019)

Promoting Interoperability performance category replaces ACI, and score is on a single, smaller set of measures, no longer divided into Base, Performance, and Bonus

Expansion of MIPS eligible clinicians

- Physical Therapists
- Occupational Therapists
- Clinical Social Workers
- Clinical Psychologists

Eligible clinicians and groups will now be able to submit Quality data through multiple submission types (i.e. submit some measures through an EHR and some through a QCDR, and the measures will be scored together as part of one set)

Small practice bonus will be applied at the Quality Category level, rather than being applied to the overall CPS, slightly decreases the benefit of this bonus to small practices (3pts to quality category vs. five points to the MIPS final score)

CEHRT 2015 certification required (could use 2014 or 2015 previously)

Proposed Advanced APM Highlights for Year 3 (2019)

8%

Nominal risk threshold **maintained** at 8% of the average estimated total Medicare Parts A and B revenue (however, CMS requested comments on whether they should consider raising the revenue based nominal amount standard to 10 percent)

Advanced APM CEHRT threshold **increased** to 75% (from 50%)

At least one Advanced APM quality measure must: be on the MIPS final list of measures, endorsed by a consensus-based entity, or determined by CMS to be “evidenced-based, reliable, and valid”

All-Payer Combination

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

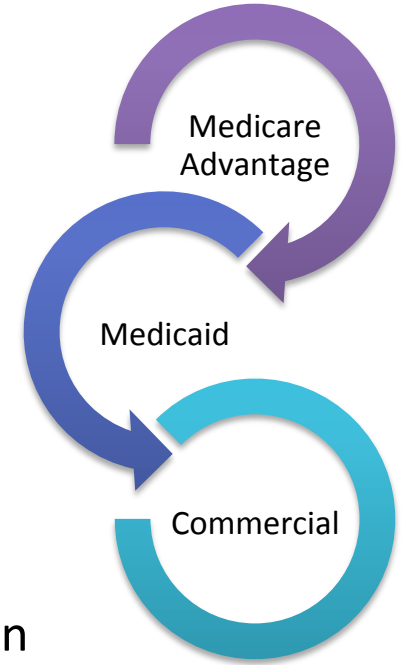
All Payer Combination

Allow eligible clinicians to become QPs by utilizing the All-Payer Combination of Medicare Advanced APMs + Other Payers

Other Payers = MA, Medicaid, commercial

Other payers must meet nominal risk threshold and report on quality, but have flexibility on CEHRT (50% through 2019, 75% 2020 and beyond)

QP determinations to be requested at the tax ID number (TIN) level in addition to the APM Entity and individual eligible clinician (NPI) levels



Valinda Rutledge, VP Federal Affairs, APG

MPFS Proposed Rule

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Proposed MPFS Highlights for 2019

Collapse of E/M codes

Advancing Virtual Health with new codes

MA

MAQI model

Proposed Changes to Evaluation and Management (E/M) Codes

Proposed Payment for Office/Outpatient Based E/M Visits

Level	Current Payment* (established patient)	Proposed Payment**
1	$22	$24
2	$45	$93
3	$74	
4	$109	
5	$148	

Level	Current Payment* (new patient)	Proposed Payment**
1	$45	$44
2	$76	$135
3	$110	
4	$167	
5	$211	

- Reducing Documentation Standards
- Allowing choice in time or medical decision making

Advancing Virtual Health with New Codes

Allowing clinicians to bill under a new term- “communication technology codes”

Must be patient initiated

A good start!

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Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

8% Has to meet nominal risk based definition in a MA contract

Only allows Opt-out of MIPS

Little Value!

Questions?