MedPAC Presents on APMs and MIPS Provisions in MACRA

Recently, MedPAC staff presented on alternative payment models (APMs) and Merit-Based Incentive Payment Systems (MIPS) and outlined draft principles for performance and administration. While APMs are still being developed by the Centers for Medicare and Medicaid Services, a proposed rule is expected to be released this Spring, with APMs becoming active beginning in 2019.

MedPAC stated that the only certainty is a 5 percent incentive payment, that risk and reward is greater under APM provisions than MIPS, but will depend on the level of “risk” and for what the eligible APM entity is responsible. Draft principles include:

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; and
- 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; and
- 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; and
  - 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; and
  - Simplifies administration for CMS

For the MedPAC presentation, click here.

**HCPLAN Releases APM Framework White Paper**

The Health Care Payment Learning & Action Network’s Alternative Payment Models Framework and Progress Tracking Work Group recently released a white paper that categorizes alternative payment models (APMs) and establishes a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. healthcare system.

Among the provisions included in the APM Framework include:
- Changing providers’ financial incentives is not sufficient to achieve person centered care, so it will be essential to empower patients to be partners in health care transformation.
- The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
- Value based incentives should ideally reach the providers that deliver care.
- Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
- Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
- APMs will be classified according to the dominant form of payment when more than one type of payment is used.
Centers of excellence, accountable care organizations, and patient centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

For the full white paper, click here.

House Passes Reconciliation Bill Repealing ACA

On January 6, the U.S. House of Representatives passed the Senate Amendment to the Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015 (H.R. 3762) with a vote of 240-181. It marked the first ACA repeal bill to reach the president’s desk, where it was vetoed.

The bill authorizes $750 million for FY 2016 and FY 2017 for the U.S. Department of Health and Human Services (HHS) to provide grants to the states to address substance abuse and mental health needs.

The ACA-related provisions in the bill include:

- Medicaid expansion and reduction in Medicaid DHS payment
- Premium tax credits and cost-sharing reductions
- Individual and employer mandates
- Auto-enrollment mandate
- HHS authority to collect risk reinsurance fees or make payments
- Prevention and Public Health Fund
- Tanning Tax
- Health insurance tax
- Annual fee on manufacturers and imports of branded-Rx
- Medical device tax (2 year delay became law in December)
- Cadillac tax (2 year delay became law in December)

Although the original bill included a provision to repeal the Independent Payment Advisory Board (IPAB), the Senate parliamentarian ruled that including it would violate the Byrd Rule.

The bill is expected to reduce the deficit $516 billion from FY 2016 to FY 2015, according to the Congressional Budget Office and the Joint Committee on Taxes.

For a table showing the differences between the initial bill and Senate amendments, click here.
President Obama Delivers Last State of the Union

On January 12, President Obama delivered his final State of the Union speech. Some of the health-related highlights included the President mentioning that 18 million people have gained coverage under the Affordable Care Act, stressing the importance of preserving and strengthening Medicare, announcing a new initiative – to be lead by Vice President Biden – to find a cure for cancer, and the global partnership that helped stop the spread of Ebola.

For the full speech, click here.

Senate Health Panel Floats Draft HIT Reform Bill

The Senate health committee is floating draft health information technology (HIT) improvement legislation aiming to reduce documentation burdens on providers, gives the U.S. Department of Health and Human Services Office of Inspector General authority to go after vendors that block information sharing, facilitates interoperability, and directs the Government Accountability Office (GAO) to look into matching patients to their records, among other provisions.

The draft legislation is part of a package of bipartisan bills the committee plans to start taking up in February as a companion to the 21st Century Cures bill. The draft would attempt to reduce documentation burdens by gathering public and private stakeholders to develop goals, a strategy and recommendations to minimize those burdens while also maintaining quality. It also allows non-physician members of a care team, like nurses, to document care in an electronic health record on doctors’ behalf. The draft looks to encourage certification of health IT for specific specialties, like pediatricians, as well.

“The committee has been working for months on legislation to help improve electronic health records, and it involves especially technical work to get this right, which is why our committee looks forward to feedback on today’s draft from doctors, hospitals, health IT developers, and other experts in this area of health care,” Chairman Alexander said in a statement Wednesday.

The committee requests feedback on the draft by January 29.

To view a summary of the draft legislation, click here.
Hospitals and Health Care Providers Join ACO Models

Recently the Centers for Medicare and Medicaid Services (CMS) announced 121 new participants in Accountable Care Organization (ACO) initiatives, which now represent 49 states and the District of Columbia.

CMS also announced that providers and hospitals have signed up to join new types of ACOs. With these new participants in the Shared Savings Program (SSP), the Next Generation ACO Model, Pioneer ACO Model, and the Comprehensive ESRD Care Model, there will now be:

- 8.9 million beneficiaries served;
- 477 ACOs across SSP, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive ESRD Care Model; and
- 64 ACOs are in a risk-bearing track including SSP, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive ESRD Care Model

The U.S. Department of Health and Human Services also announced enrollment data for the Medicare Shared Savings Program (MSSP) ACOs. For the 2016 performance year, 100 new ACOs and 147 renewing ACOs are joining or continuing their participation in the MSSP. Updated enrollment figures also show that about one third of the original 220 MSSP ACOs have decided to exit. In 2016, nearly 15,000 more physicians will be participating in ACOs under the program. With the new group of ACOs, CMS will have 434 ACOs participating in the SSP, serving approximately 7.7 million beneficiaries.

Thirty-nine SSP ACOs will also participate in the ACO investment Model (AIM), which has a total of 41 participants and provides pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current SSP ACOs to transition to performance-based risk arrangement.

For the press release, click here.

HHS Announces Accountable Health Communities Model

The U.S. Department of Health and Human Services (HHS) recently announced a new funding opportunity of up to $157 million to test whether screening beneficiaries for health-related social needs and associated referrals to and navigation of community-based services will improve quality and affordability in Medicare and Medicaid.

The program is called the Accountable Health Communities (AHC) Model is expected to last for five years and focus on the health-related social needs of beneficiaries, which includes building alignment between clinical and community-based services locally.
AHC will support 44 bridge organizations through cooperative agreements and will test three scalable approaches to addressing health-related social needs and linking clinical community services, including community referrals, community service navigation, and community service alignment.

The program is based on emerging evidence that addressing health-related social needs through enhance clinical-community linkages can improve health outcome sand reduce costs.

For the press release, click here.

For a fact sheet on the program, click here.