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In anticipation of our discussion tomorrow - Mara McDermott

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I am looking forward to our visit tomorrow. The following thoughts are preparatory to our call. I have copied four slides from my presentation to HIMSS in San Antonio three weeks ago. They address: 1. A Time line for SETMA's preparation for MIPS which started in 1998; 2. The nature of an alternative payment model, two slides (APM); 3. A contrast between SETMA's four standards and the four categories of MIPS. As is explained SETMA anticipated the four categories of MIPS, ten years before CMS published MIPS.

Apparently, APM must be designed to do three things: incentivize quality and value, and require healthcare providers to assume a significant risk, upside and down. It is clear that "value" addresses the cost of care in CMS' lexicon as Value equals Quality divided by Cost.

Two elements of a practice's Quality Resource and Utilization Report (QRUR) from CMS are "cost" and "quality." A high quality, low cost QRUR will result a practice being in the right upper quadrant of CMS' scatter graph which is ideal. (I have indicated that I would love to evaluate five or six practices which are in the lower left and quadrant (high cost, low quality) as I suspect they are not bad people but just not knowledgeable about the "new" system.

Why MA Should Qualify as an APM

With these three elements being the "qualifying requirements" for a practice model to be a APM, Medicare Advantage should qualify. MA models include quality and cost standards and controls and providers and health plans assume total risk for the care of a Medicare population.

However, there is one major difference which is the 500 pound gorilla in the room; in the MA plan there are no savings for CMS. In the APM, CMS realizes a significant reduction in cost. In the MA model, the cost reductions inure to the benefit of the health plan and providers, not to CMS. However, with the 4% annual reduction over the past seven years, CMS has realized a

28% reduction in their cost. On top of that the Affordable Care Act tax charged to MA plans has added a burden which has moved many MA-plan provider groups close to insolvency.

These cost savings to CMS should be adequate to qualify MA plans as APMs but I suspect that CMS is going to continue to argue that they are not qualified.

I look forward to discussing these issues with you. I have read a good deal of your materials. Very impressive.

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2000-2017 -- SETMA's Preparation for MIPS

1. Began use of EMR (1998, voluntary)
2. Physician Consortium for Performance Improvement (PCPI, 2000, voluntary)
3. Healthcare Effectiveness Data and Information Set (HEDIS, 2002, voluntary)
4. National Quality Forum (NQF, 2004, voluntary)
5. Physician Quality Reporting Initiative (PQRI, 2006, participation voluntary, program required by *The 2006 Tax Relief and Health Care Act*)
6. Public Reporting by Provider Name on Performance on Quality metrics (2009, voluntary)
7. Data Analytics for Population Management (2009, voluntary)
8. Physician Quality Reporting System (PQRS, 2011, participation required, program required by 2010, *Affordable Care Act*)
9. Patient-Centered Medical Home (PC-MH, 2009, voluntary)
10. Meaningful Use I, II, & III (*American Recovery and Reinvestment Act* , 2011)

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APMs

Advanced Alternative Payment Models (APMs) are defined by CMS as new approaches to paying for medical care through Medicare that incentivize quality and value. MACRA doesn't create new Advanced Alternative Payment Models. Just as MACRA created MIPS, a program to change the reimbursement model, that's the exact goal of MACRA under APMs as well; additional incentives for APM participation.

Although the majority of clinicians will be subject to MIPS, those that participate in Advanced Payment Models at a certain threshold, such as Accountable Care Organizations, will be excluded from the MIPS program. To be considered as an APM, at least 50% of the participating clinicians must use a certified EHR technology. This threshold increases to 75% after year one. The group must also base payment on quality measures comparable to those in the MIPS program.

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APMs

Finally, APM entities are required to bear more than nominal financial risk. Eligible Clinicians can become Qualifying APM Participants if a certain percent of their patients or payments are through an APM. QP's are eligible for a 5% lump sum bonus in years 2019 - 2024 and even higher in subsequent years. Only QP's are excluded from MIPS.

- Accountable Care Organization (ACP)
- Comprehensive Primary Care Plus (CPC+) program
- Others

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SETMA's Strategies and MIPS Categories

SETMA's Strategy	MIPS Category
1. Methodology of healthcare must be electronic patient management	MIPS Advancing Care Information (an extension of Meaningful Use with a certified EMR)
2. The content and standards of healthcare delivery must be evidenced-based medicine	MIPS Quality (an extension of PQRI/PQRS which in 2019 will become MIPS)
3. The structure and organization of healthcare delivery must be patient-centered medical home	MIPS Clinical Practice Improvement activities (This MIPS category is met fully by Level 3 NCQA PC-MH Recognition).
4. The payment methodology of healthcare delivery must be that of capitation with additional reimbursement for proved quality performance and cost savings	MIPS Cost (measured by risk adjusted expectations of cost of care and the actual cost of care per fee-for-service Medicare and Medicaid beneficiary)

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