



# Critical Policy Updates for ACOs



NAACOS 2022 Spring Conference  
April 28

# Agenda





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1. Welcome
2. Presentation:
  - Congressional Update
  - Regulatory Update
    - COVID-19 Public Health Emergency
    - CMS Innovation Center Updates
    - MSSP Updates
    - The APM Performance Pathway (APP)
  - ACO Perspectives
3. Audience Q&A

# Speakers



	<p><b>David Pittman</b> Senior Policy Advisor NAACOS</p>
	<p><b>Maria Alexander</b> Senior Director Mount Sinai Health System</p>
	<p><b>Robert Daley</b> Senior Policy Advisor NAACOS</p>
	<p><b>Alyssa Neumann</b> Health Policy Analyst NAACOS</p>

# Congressional Update



# Issues to Watch in Congress



- Congress faces a compressed work schedule with **midterm elections in November**
- Congress **completed FY 2022 funding** in March with discussions on FY 2023 funding already underway
  - Performance year 2022 is **the last year** that providers can qualify for **MACRA's 5% Advanced APM (AAPM) bonus**
- **Build Back Better** negotiations remain stalled as lawmakers look to discuss smaller health care issues like drug prices and mental health
- Congress must complete an **FDA reauthorization** this summer
- **COVID-19** continues to have an impact on the health care system
  - How long will the Public Health Emergency (PHE) last?
  - HHS promises to give states 60 days' notice before letting the PHE expire

# FY 2022 Budget Recap



- **On March 16, President Biden signed the FY 2022 omnibus spending bill into law**
  - Includes a 151-day blanket extension of pandemic telehealth waivers after the PHE ends
  - Maintains ban on a national patient identifier, which would greatly help data aggregation for digital quality reporting purposes
- Congress is also working to negotiate another \$10 billion COVID-19 funding package that would provide additional funding for vaccines and therapeutics
  - Provides additional funding for Biomedical Advanced Research and Development Authority (BARDA) for vaccines and therapeutics

# President's FY 2023 Budget Request



- **Advanced APMs** - Proposes beginning the respective conversion factor updates for ACPM participants (0.75%) and nonparticipants (0.25%) in payment year 2025, one year earlier than under current law
- **ACO REACH** - Promotes the new ACO model and highlights it as a central component of the CMS Innovation Center's health equity portfolio
- **Telehealth** - Supports temporary extension of broader telehealth coverage under Medicare beyond the COVID-19 PHE to allow additional time to study a permanent expansion
- **ACO Program Funding** - Requests increased funds for Health Quality Initiatives and cloud based ACO Management systems



# Congressional Priorities



- For 2022, NAACOS has several legislative priorities:
  - **Deadline Dec. 31, 2022** - The extension of the 5 % AAPM bonus and prevent sharp increases of the qualifying APM participant (QP) threshold (from 2-year pause enacted in 2020)

Annual Medicare Payment Adjustments for Advanced APMs									
Performance year*	2017	2018	2019	2020	2021	2022	2023	2024	
Payment year	2019	2020	2021	2022	2023	2024	2025	2026	
Annual Payment Update	+0.5%	0.0%					AAPMs: +0.75% Others: +0.25%		
Advanced APM Bonus	+5.0%					UNABLE TO EARN BONUS PAYMENTS			

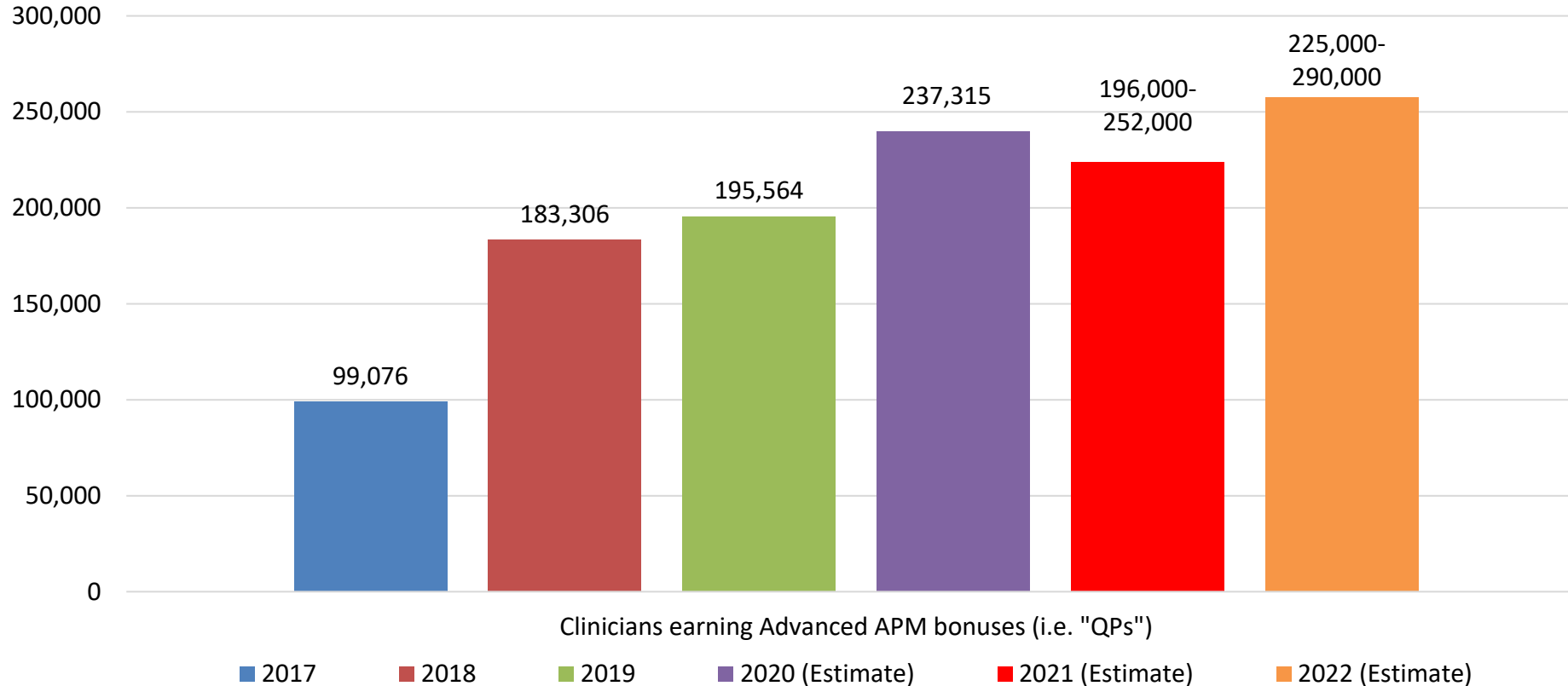
\*Performance year refers to the year in which the bonus was earned, which corresponds with payment for said bonus two years later

- Educate lawmakers and staff on the benefits of ACOs and increase support of the Value Act
- Fix the MSSP benchmarking known as the “rural glitch”
- The ACO Assignment Improvement Act would permit assignment through NPs, PAs, CNSs

# Advanced APM Participation



### Clinicians Earning Advanced APM Bonuses (i.e. "QPs")



CMS estimates payments for 2022 performance will be between **\$600M - \$750M**

All years refer to performance year. Payment year is two years post-performance year.

# Advanced APMs for 2022



- Medicare Shared Savings Program (Basic Level E and Enhanced)
- Global and Professional Direct Contracting Model
- Bundled Payments for Care Improvement Advanced Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Kidney Care Choices Model (Kidney Care First; Professional and Global Options)
- Maryland Total Cost of Care Model (Care Redesign Program)
- Oncology Care Model (Two-Sided Risk Arrangements)
- Primary Care First Model
- Vermont All-Payer ACO Model

# Value in Health Care Act of 2021



- NAACOS is working to pass key ACO legislation as part of its ongoing work with Congress

## Value in Health Care Act (H.R. 4587)

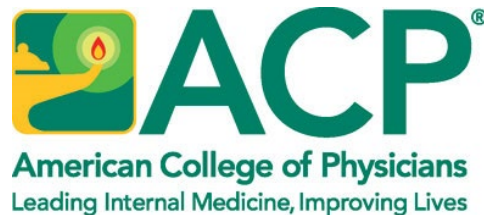
- The “Value Act” was introduced in the House of Representatives on July 20, 2021
- Bill text is available [here](#) and a summary available [here](#)
- The bill supports ACOs and the shift to value-based care and payment
- Sponsors include Reps. Peter Welch (D-Vt.), Suzan DelBene (D-Wash.), Darin LaHood (R-Ill.), and Brad Wenstrup (R-Ohio)
- Sen. Sheldon Whitehouse (D-R.I.) is the Senate champion
- An Independent [analysis](#) shows the Value Act would save \$280 million over 10 years
- 14 leading national healthcare stakeholder organizations sent a [letter](#) and issued a press [release](#) in support of the bill

# Value in Health Care Act of 2021



- Encourages participation in the Medicare Shared Savings Program by:
  - Increasing shared savings rates
  - Modifying risk adjustment
  - Eliminating high-low revenue distinction
  - Providing more time before risk is required
  - Removing ACO patients from regional population in benchmarks
- Provides advanced funding to ACOs
- Improves Advanced APM incentives and fixes “QP” thresholds
  - Extends the Advanced APM bonus for six additional years
  - Maintains the QP payment threshold at 50% through performance year 2023 (payment year 2025) with small annual increases thereafter
- Requires study on overlap in value-based care programs
- Calls for GAO study on racial health disparities for ACOs compared to FFS

# Value Act Supporters



# NAACOS Spring Congressional Advocacy



- **Value Act and AAPM Bonus**
  - Meeting with leadership and committee members to educate about the legislation and upcoming expiration of the 5% MACRA bonus and QP thresholds
  - Committee staff have not raised any policy concerns about the extension of the AAPM bonus or the QP threshold adjustment
- **ACO Value Sign on [Letter](#)**
  - On March 8<sup>th</sup>, **41 Members** of Congress sent a bipartisan letter to HHS Secretary Becerra requesting several regulatory modifications for ACOs, which tracks policies in the Value Act
  - NAACOS hopes to see some of the changes in the FY 2023 Medicare PFS
- **DCE Sign on [Letter](#)**
  - On February 24<sup>th</sup>, **23 Members** of Congress sent a bipartisan letter to Secretary Becerra and CMS Administrator Brooks-LaSure asking that the Direct Contracting model not be cancelled
- **DCE and ACO REACH Educational Meetings**
  - Meeting with Congressional offices that signed the Jayapal letter opposing direct contracting

# AAPM and QP Advocacy



## Education

- Joint ACO coalition meetings to educate on AAPM and QP issue and build support for the Value Act
- Hold Congressional briefings for staff

## Advocacy

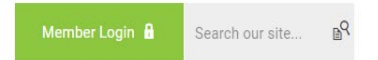
- Coordinate national stakeholder, provider, and Congressional sign on letters
- Media campaign and provider op-eds

## Grassroots

- Leverage ACO and provider grassroots engagement
- Coordinate messaging, email/phone campaigns, and fall Capitol Hill Day

# Call to Action

- **Your Voice Matters:** Congressional leaders says more lawmakers need to hear directly from providers and health professionals in their state about how important these payments have been for ACOs.
- ACOs account for the vast majority of AAPMs
  - If you haven't already, visit [NAACOS' Take Action Page](#) to contact your Representatives and Senators today to urge them to extend the Advanced APM incentive payments!!
  - Leverage relationships with your contacts in your Congressional delegations. Reach out to the NAACOS' policy team if you need help with contact information or messaging.



## Urge Congress to Prevent 5% Payment Cut for Advanced APMs

NAACOS is urging Congress to continue incentives for providers to participate in Advanced Alternative Payment Models (APMs). These bonuses have been instrumental in incentivizing providers to participate in high-risk models. ACOs reported using the bonuses to invest in ACO...

### Quick Links

- [REACH Model](#)
- [Value Act Reintroduced](#)
- [Contact Policymakers Today!](#)
- [Login Help & FAQs](#)

### Upcoming Events

- Mon Apr 4, 2022  
[Webinar: ACO REACH Model - Next Steps on Evaluating and Applying](#)  
Category: Events
- Wed Apr 27, 2022  
[Spring 2022 Conference](#)  
Category: Events
- Thu Apr 28, 2022  
[Spring 2022 Conference](#)  
Category: Events
- Fri Apr 29, 2022  
[Spring 2022 Conference](#)

# NAACOS Action Fund



- The National Association of ACOs established the NAACOS Action Fund, a political action committee, to support congressional candidates who understand the interests of NAACOS members and value-based care providers.
- To comply with federal election law, NAACOS members must provide the NAACOS Action Fund with written prior approval before any solicitation may be directed to eligible ACO or company executive and senior administrative personnel. Signing the approval does **not** obligate you or your organization's leadership to contribute.
- **If you are your organization's primary contact with NAACOS, and you have not already done so, we encourage you to visit our website to review and electronically sign the [NAACOS Action Fund Prior Approval Form](#).**
- The web-based form includes frequently asked questions and instructions. NAACOS staff is also available here in Baltimore to answer questions and accept signed forms.

# Regulatory Update



# COVID-19 Public Health Emergency



- The COVID-19 Public Health Emergency (PHE) is due to expire on **July 15**
  - Been in effect since January 2020
  - Extended by the HHS secretary for 90 days at a time
  - It appears unlikely to be extended any more
- The Biden administration has promised a 60-day notice before planned expiration or termination
  - The White House wants to move on from PHE
- CMS and HHS are thinking about how to unwind PHE-related policies and flexibilities

# COVID-19 PHE – E&U MSSSP Policies



- CMS will waive shared losses for MSSSP ACOs by the percentage of months in the performance year affected by the PHE
  - If the PHE ends in July, CMS will waive 7-12ths (or 58.33%) of an MSSSP ACO's losses
- During PHE effected months, CMS will remove COVID-19 treatment episodes from PY expenditures
- CMS will use the higher of the ACO's quality performance score or the mean quality performance score for all MSSSP ACOs
- There are a huge number of policies and flexibilities CMS allows in FFS Medicare
- More resources on NAACOS's [COVID-19 page](#)

# COVID-19 PHE – Telehealth



- Congress extended PHE-related telehealth flexibilities to last 151 days after the PHE expires
  - That puts expiration around mid December should the PHE end in July
- Without additional action from Congress, telehealth policies revert back to pre-PHE levels
  - Lots of interest and activity around that but \$\$ makes it difficult
  - Limited to two-sided ACOs who use prospective assignment
- **NAACOS believes all ACOs, regardless of risk level or choice of attribution, should be given the freedom to use telehealth in broader circumstance**
  - COVID-19 and ACOs [fact sheet](#)

# Innovation Center Updates



# Innovation Center Models



- CMMI continues to hold regular stakeholder calls following up its 10-year [“Strategy Refresh” paper](#) from last fall
  - NAACOS [Comments](#) on Health Equity Strategy
  - NAACOS [Comments](#) on Beneficiary Perspectives
- **What to expect:**
  - A focus on accountable care models
  - Advancing health equity
  - Fewer models that work better together
  - “Nesting” episodic or specialty models within models
  - Addressing affordability



# Innovation Center Models



## Primary Care First

- More than 3,000 practices and 24 payers participating in 2022
- The decision was made to not move forward with the Seriously Ill Population component of the model
- [NAACOS's review](#) of the model is available online

## CHART Model

- ACO track of CHART was removed as an option; Similar model expected next year

## Kidney Care Choices Model

- Started on January 1; Accepted more applications this spring to start in 2023

## Radiation Oncology Model

- Indefinitely delayed in April

## Oncology Care Model

- Anticipated to end on June 30, 2022
- Additional details on Oncology Care First haven't been released

# The Lead up to ACO REACH



- Direct Contracting drew the ire of progressive Democrats in Congress
  - On January 5<sup>th</sup>, Rep. Pramila Jayapal (D-WA) sent a [letter](#) signed by more than 50 progressive Democrats calling for CMS to end GPDC
  - On Feb. 2, Sen. Elizabeth Warren (D-MA) at a Senate Finance subcommittee [hearing](#) called for Direct Contracting's termination
- Their calls were heard by the Biden administration, who seriously considered terminating the model
  - Complaints were that Direct Contracting was a Trump-era model that would privatize Medicare and lead to stenting of care by profit-driven middlemen
- Cancelling GPDC would be devastating for ACOs and all APMs

# The Lead up to ACO REACH



- NAACOS and other ACO coalition members sent [a letter](#) on Feb. 14 with 222 signatures, urging Becerra to fix, not end, GPDC
  - This follows a Dec. 16 NAACOS [letter](#) to CMS
  - On February 24<sup>th</sup>, 23 Members of Congress sent a [bipartisan letter](#) to Becerra asking that Direct Contacting not be cancelled
- NAACOS worked behind the scenes with administration officials and Congress to get Becerra to not cancel the model
- NAACOS issued a [statement of support](#) for the new ACO REACH Model
- We continue to meet with offices on Capitol Hill to stress the importance of Medicare payment reform

# ACO REACH

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## ***Timeline***

- Implementation Period (IP3) begins August 1, 2022
- ACO REACH will continue through 2026, the original term of GPDC

## ***Application***

- Current DCEs do not need to apply; must become compliant with new policies
- Application period ended April 22

## ***Governing Body Changes***

- Increases to 75% the representation of Participant Providers on the governing body
- Requires that the beneficiary representative and consumer advocate are two separate individuals

## ***Transparency***

- More information on model participants and insight into performance outside of formal evaluations and annual performance results

## *The ACO REACH Model includes five new policies to promote Health Equity*

- **Health Equity Plan**
  - ACO initiatives and care plans that will increase access to – and quality of – care to underserved communities
- **Health Equity Data Collection Requirement**
  - ACOs must report certain beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries
  - PY2023: Upward 10 percentage point adjustment on Total Quality Score for successful reporting
- **Application Scoring for Health Equity Experience**
  - Application score includes ACO's demonstrated ability to provide high quality care to underserved communities
- **Nurse Practitioner Services Benefit Enhancement**
  - Allows Nurse Practitioners expanded authority without physician supervision

# ACO REACH



## Health Equity Benchmark Adjustment

- Higher Benchmarks for serving the most underserved beneficiaries
- All DCE-aligned patients stratified based on Area Deprivation Index
- 25-point adjustment for full or partial dual Medicaid eligibility status
- Essentially ranked from highest to lowest
- Adjustments are aggregated at the ACO level
- The adjustment in budget neutral
- The full adjustment for ACOs won't be known until the end of the year, but CMS said they expect most ACOs will have a fairly minimal impact

Percentile	Adjustment
91st – 100th Percentile <i>(Top Decile)</i>	<b>+\$30 PBPM</b> Adjustment
51st – 90th Percentile <i>(Middle 4 Deciles)</i>	No Adjustment
1st – 50th Percentile <i>(Bottom 5 Deciles)</i>	<b>-\$6 PBPM</b> Adjustment

# ACO REACH

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## ***Discount/Withholds***

- Reduced discount for Global ACOs
  - 2023-2024: 3%
  - 2025-2026: 3.5%
- Reduced quality withhold to 2%

## ***Quality Measures and Reporting***

- Same four measures; All measures will be pay for performance
- For current DCEs, Continuous Improvement/Sustaining Exceptional Performance (CI/SEP) criteria and High Performer Pool will start in 2023

## ***Stop-Loss***

- Discontinuing use of a fixed attachment point
- Innovation Center will risk-adjust attachment points to reflect beneficiary risk scores and benchmarks

## ***Risk Adjustment Changes***

- Changes to cap on risk score growth begins in 2024
- Two changes to the cap:
  - (1) adoption of a static reference year population, and
  - (2) capping ACO risk score growth relative to ACO demographic risk score growth in determining the ACO-specific 3% risk score cap thresholds

## ***Audits/Monitoring***

- Assess annually whether beneficiaries are being shifted into or out of MA
- Examine ACO's risk score growth to identify inappropriate coding practices
- Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data
- Monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care

# ACO REACH – Advocacy ‘Wins’



Several changes are included in ACO REACH that NAACOS asked for

- Keeps CMMI’s premier ACO model with a new name to better reflect how it is part of the evolution of accountable care
- Expresses a commitment to provider-led organizations and value-based care
- Allows a 2023 cohort
- Permanently cancels Geographic Direct Contracting
- Reduces the discount in the global risk option
- Places more emphasis on equity, which NAACOS has devoted [attention](#) to and provided [recommendations](#) on how to address in ACOs
- Increases provider and patient participation on governing boards

# NAACOS ACO REACH Coalition



***Dedicated to promoting shared learning and advocating on behalf of Medicare's newest value-based payment model***

- Stand-alone [webpage](#) with CMS and NAACOS resources
  - [April 4 webinar](#) -- ACO REACH Model - Next Steps for Evaluating and Applying
  - [March 10 webinar](#) -- Understanding Medicare's Latest Accountable Care Model
  - NAACOS [MSSP vs. REACH ACO Comparison Chart](#)
  - NAACOS [Summary of ACO REACH Model](#)
- Current NAACOS members will enjoy all of the benefits of the new coalition
- NAACOS continues to meet with Democrats, including Jayapal and Warren, advocating for them to back down from their demands to permanently end GPDC 33

# Health Equity Update.....



- NAACOS continues to advocate for policies that enable ACOs to better track and address health inequities
- Recent health equity activity by NAACOS:
  - Published [series of case studies](#) highlighting ACOs' health equity efforts
  - Sent [comments to CMMI](#) on health equity strategy
  - Submitted a [Statement for the Record](#) on a House W&M Committee hearing on improving health equity for individuals with chronic conditions
  - Hosted a [webinar highlighting examples](#) of ACOs working to reduce health inequities

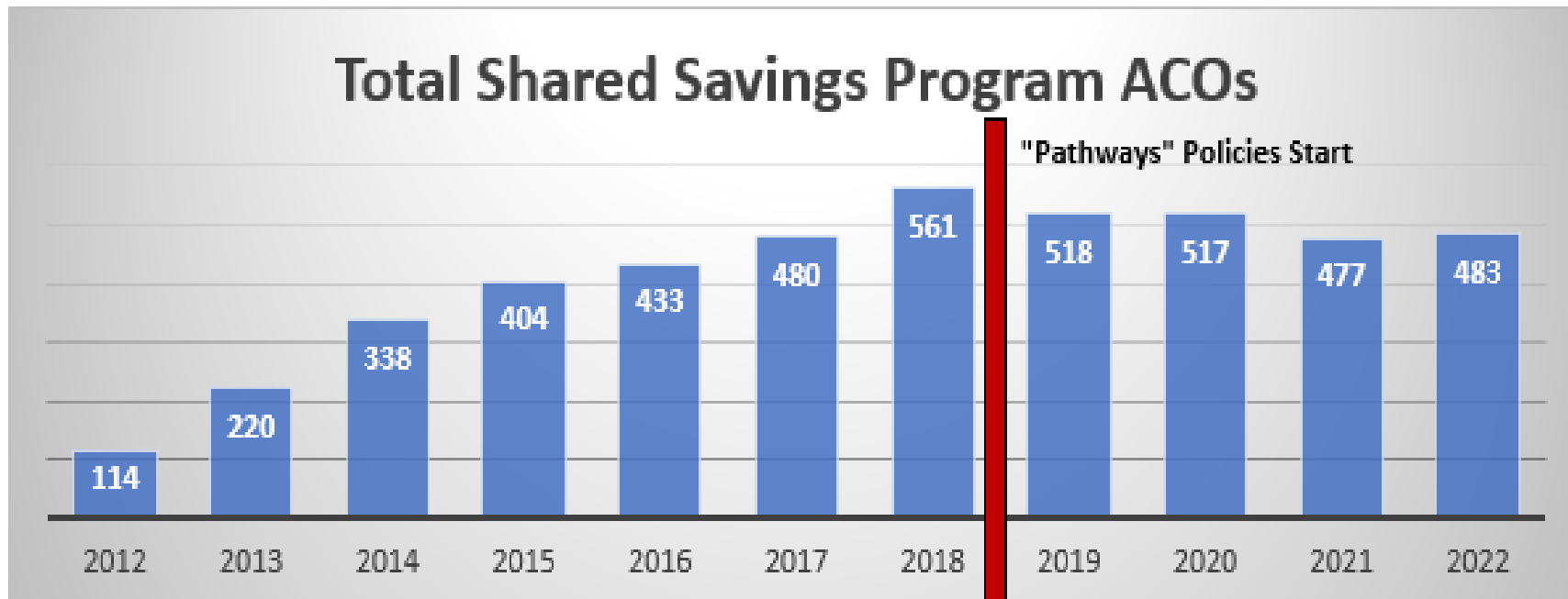
# MSSP Updates



# 2022 MSSP Participation



- Very modest growth in overall ACOs and beneficiary lives (approx. 11 million)
- 529,000 physicians and NPPs are participating in 2022
- We hope the flat growth spurs policies to better attract and support ACOs
- NAACOS has provided recommendations to both the [administration](#) and [Congress](#) on strategies to bolster ACO participation



## RESOURCES

CMS Fast Facts  
[Summary](#)

Full participation [data](#)

NAACOS press [release](#)

# Key Application Deadlines



- CMS has published [MSSP application cycle dates](#) for a January 1, 2023 start date:

Application stage	Submission window	Notes
Notice of Intent to Apply (NOIA)	June 1, 2022 – June 7, 2022, at 12:00PM (noon) ET	<ul style="list-style-type: none"> <li>• You must submit a NOIA in order to be eligible to apply</li> <li>• NOIA is non-binding</li> </ul>
Phase 1 application	June 8, 2022 – June 29, 2022, at 12:00PM (noon) ET	<ul style="list-style-type: none"> <li>• ACO Participant List</li> <li>• SNF 3-Day Rule Waiver application and SNF Affiliate List</li> <li>• Repayment mechanism documentation</li> </ul>
Respond to Phase 1 RFI-1	July 22, 2022 – August 4, 2022, at 12:00PM (noon) ET	<ul style="list-style-type: none"> <li>• Last opportunity to add ACO participants/SNF affiliates</li> </ul>
Respond to Phase 1 RFI-2	August 26, 2022 – September 9, 2022, at 12:00PM (noon) ET	<ul style="list-style-type: none"> <li>• Last opportunity to remove ACO participants/SNF affiliates</li> <li>• Final repayment mechanism documentation due (final amount will be provided to ACOs on 08/26/22)</li> </ul>

- CMS has published an [application toolkit](#) to guide ACOs through the application process
- As a result of NAACOS advocacy, CMS has confirmed that deadlines to add/remove ACO participants is aligned with ACO REACH Model application deadlines
- Application dates are subject change, NAACOS will continue to monitor and update our members of any changes

# The APM Performance Pathway (APP) for ACOs



# Background.....



- In the 2021 and 2022 Medicare Physician Fee Schedule (MPFS) Rules, CMS made significant changes to the way MSSP ACOs are evaluated on quality, which will impact whether ACOs are eligible to share in any savings generated
- Changes to both reporting requirements and scoring methods
- The new APM Performance Pathway (APP) structure is intended to align quality measurements in MSSP with the Merit-Based Incentive Payment System (MIPS)
- Consequences for MSSP ACOs:
  - Minimum quality performance requirements are altered significantly
  - CMS will require moving away from the sampling method using the Web Interface (WI) reporting to electronic clinical quality measures (eCQMs) by 2025, which includes a requirement to report and be assessed on **all patients, regardless of payer**

- **NAACOS advocacy resulted in 3-year delay for the eCQM requirement for ACOs**
  - Option to report either via Web Interface or eCQM/MIPS CQM (or both) through 2024
  - Beginning in **2025**, CMS will require all ACOs to report via eCQM/MIPS CQM
  - The quality performance standard threshold (30<sup>th</sup> percentile of MIPS quality performance category scores) will remain through 2023 and increase to the 40<sup>th</sup> percentile in 2024
- **Work remains**
  - CMS continues to rely on the MIPS structure to assess ACOs and compares ACO quality scores to MIPS quality scores for purposes of determining shared savings/losses
  - These continue to be key advocacy issues for NAACOS
  - While the move to more digital quality measurement is positive, there are many operational issues to be resolved before ACOs can be successful in this approach
  - New NAACOS Digital Quality Task Force launched in March
- Access our [new resource](#) reviewing the APP for ACOs!

# Timeline for Implementation



## 2021-2024:

ACOs can report either WI or eCQMs, or both. If you report both, you will receive the higher of the scores

## 2022-2023:

ACOs can report WI or eCQMs w/ incentives for those who report eCQMs

## 2024:

Quality Performance Standard Increases from 30<sup>th</sup> percentile to the 40<sup>th</sup> percentile of MIPS quality performance category scores

## 2025:

All ACOs must report eCQMs

# APP Reporting Options



- **Web Interface:**
  - Scored on 10 WI quality measures, 2 administrative claims measures and the CAHPS for MIPS survey = 13 total measures
  - Report on a sample of ACO assigned patients included in the WI tool
- **APP Measures:**
  - Scored on 3 clinical quality measures, 2 administrative claims measures and the CAHPS for MIPS survey = 6 total measures
  - Must report via eCQM/MIPS CQM- this requires reporting on all patients meeting the measure's denominator criteria- regardless of payer!
    - eCQMs require ACOs to send one aggregate QRDA III file to CMS
    - eCQM specifications are presented differently- see our [guide](#) to accessing specs!
    - 70% data completeness requirement
  - NAACOS' has raised concerns about unintended negative consequences of the all-patient/all-payer requirement for eCQM reporting
- **2021 – 2024:** ACOs can report both WI and APP measures and receive the higher of their two scores

# Measure Updates 2022



- For 2022, three of the CMS WI measures (Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Tobacco Cessation: Screening and Cessation Intervention (Quality ID# 236)) do not have benchmarks for PY 2022, and, therefore, will not be scored
  - **NOTE: Beginning in 2021, measures with no BM are suppressed (not pay for reporting)**
  - These measures are required to be reported in order to complete the CMS WI dataset
  - [NAACOS' website](#) has more details about 2022 quality measure information
- See Table 35: Measures included in the APM Performance Pathway Measure Set, found on page 65266 in the 2022 final MPFS [rule](#) for list of measures available in the APP
  - 3 APP eCQM/MIPS CQMs, OR
  - 10 WI measures
  - BMs vary based on reporting method chosen!

# APP Measures 2022



- See Table 35: Measures included in the APM Performance Pathway Measure Set
  - P. 65266 in the 2022 final MPFS [rule](#) for the detailed list of measures available in the APP

Measure Title	Collection Type	Meaningful Measure Area
CAHPS for MIPS	CAHPS for MIPS Survey	Patient's Experience
Hospital-wide, 30-d, all-cause unplanned readmission rate	Administrative claims	Admissions & readmissions
Risk standardized, all-cause unplanned admissions for MCC	Administrative claims	Admissions & readmissions
Diabetes A1c poor control	eCQM/MIPS CQM or WI	Mgt. of chronic conditions
Screening for depression & follow-up	eCQM/MIPS CQM or WI	Treatment of mental health
Controlling high blood pressure	eCQM/MIPS CQM or WI	Mgt. of chronic conditions
Screening for future fall risk	Web Interface	Preventable healthcare harm
Influenza immunization	Web Interface	Preventive care
Tobacco use screening & cessation intervention	Web Interface	Prevention & treatment of SUD
Colorectal cancer screening	Web Interface	Preventive care
Breast cancer screening	Web Interface	Preventive care
Statin therapy for prevention & treatment of CVD	Web Interface	Mgt. of chronic conditions
Depression remission at 12 months	Web Interface	Treatment of mental health

# APP Scoring Rules



- APP quality scoring uses a different approach than the previous MSSP quality scoring (domain-based scoring approach) and is effective for all ACOs starting in 2021
  - 10 points earned per measure – comparing your score to the benchmark for that individual measure (BM varies based on reporting method selected)
  - Add any bonus points and improvement points earned
  - Sum all points and this gives you your final ACO quality score
    - For MIPS, BMs are presented in terms of deciles, with the BM file displaying Deciles 3-10 and identifying the range of points available for each measure based on the decile your performance rate falls in
- This final quality score must meet or exceed the established quality performance standard threshold for a given year in order to be eligible for shared savings
  - While we know individual measure BMs prior to the performance period, **we will not know the quality performance standard threshold amount prior to the start of a performance period-** this is established by looking at the distribution of all MIPS quality performance category scores

# Quality Performance Standard



- The MSSP quality performance standard is the minimum performance threshold required to earn shared savings in the MSSP
- **2021:** ACOs' final quality score must be equal to or higher than the 30<sup>th</sup> percentile across all MIPS Quality performance category scores. If met, ACOs are eligible to share in savings earned at the maximum sharing rate available in their particular track
- **2022-2023:** An ACO will meet the quality performance standard used to determine shared savings and losses if the ACO:
  - Achieves a final quality score equivalent to or higher than the 30th percentile across all MIPS quality performance category scores; **or**
  - Reports the 3 eCQMs/MIPS CQMs (meeting data completeness and case minimum requirements) and achieves a quality score  $\geq$  the 10th percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP measure set and achieves a quality score  $\geq$  the 30th percentile of the performance benchmark on at least 1 of the remaining 5 measures in the APP measure set
- This will exclude entities/providers eligible for facility-based scoring in MIPS\*

# Quality Performance Standard



- **2024:** ACOs final quality score must be  $\geq$  the 40<sup>th</sup> percentile across all MIPS Quality performance category scores
- CMS provided historic MIPS Quality performance category scores at the 30<sup>th</sup> and 40<sup>th</sup> percentiles to help ACOs estimate what this threshold could look like in future years:

MIPS Quality performance category scores	30 <sup>th</sup> percentile	40 <sup>th</sup> percentile
<b>PY 2018</b>	<b>83.9</b>	<b>93.3</b>
<b>PY 2019</b>	<b>87.9</b>	<b>95.7</b>

- Previously, MSSP ACOs were only compared to other WI reporters, which was mostly MSSP. This new policy compares an ACO's final quality score to all MIPS quality performance category scores across all MIPS eligible clinicians
  - MIPS reporters have the options to select measures to report that they know they will do well on, which is why the 30<sup>th</sup> & 40<sup>th</sup> percentile scores are so high
- This is an unfair and inappropriate comparison and NAACOS continues to call on CMS to fix this flawed, and overly punitive approach

# Extreme & Uncontrollable Circumstances Policy



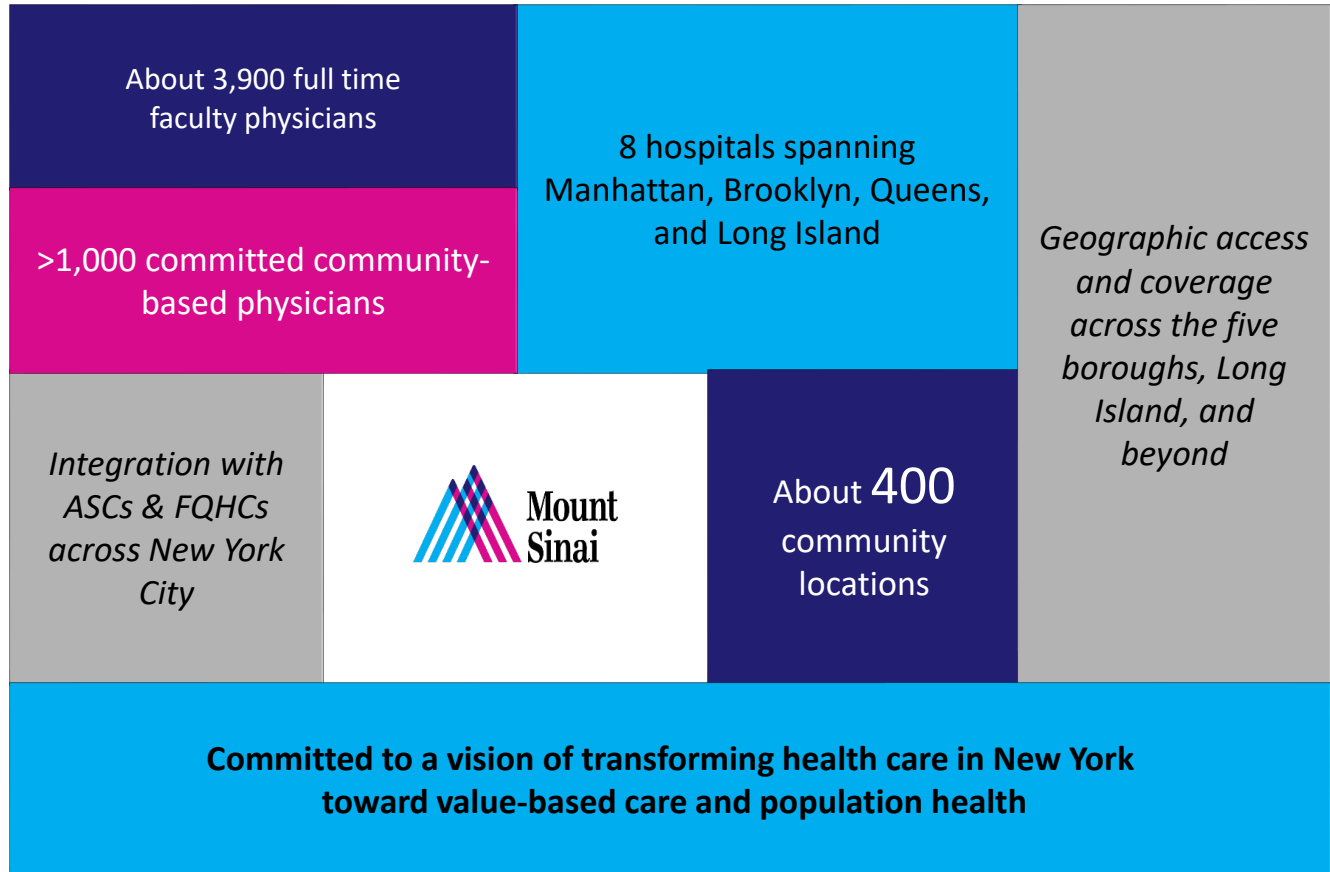
- **The Extreme and Uncontrollable Circumstances policy was in effect for all ACOs in 2021 and will apply for performance year 2022 as well**
  - This means no ACO will fall below the established performance standard threshold (30<sup>th</sup> percentile) for 2021 or 2022 quality assessments
  - CMS has confirmed that the E&U policy will apply for the entire PY 2022, even if the PHE ends prior to the end of the year
  - ACOs do not need to apply in order to be covered by this policy, all MSSP ACOs are automatically covered
  - More information on the MSSP Extreme and Uncontrollable circumstances policy is available in our [quality resource](#)
  - This MSSP E&U policy is separate from the MIPS hardship exceptions and exemptions offered due to the COVID-19 PHE

# ACO Perspectives



# Mount Sinai Health System – Population Health

## Mount Sinai Health Partners Clinically Integrated Network



### ▶ Mount Sinai Health Partners:

- ▶ Multiple value-based contracts with commercial, Medicare Advantage, Medicaid payers
- ▶ ~375k attributed lives in value-based contracts

### ▶ Medicare Shared Savings Program ACO – New York Medical Partners ACO

- ▶ ~45,000 attributed lives
- ▶ Currently participating in the BASIC Track, Level E
- ▶ ~35 TINs, mixture of employed practices and independent practices
- ▶ >15 EMRs
  - ▶ Majority of employed providers on Epic (but across multiple TINs)
  - ▶ Several groups on Athena
  - ▶ Independent practices on a variety of other EMRs
- ▶ Generated \$28 million in total savings in PY2020

# eCQM Reporting Decision Making

## Reasons to consider reporting eCQMs before PY2025:

- Easier to meet the Quality Performance Standard in 2022\* and 2023
- If ACO reports WI and eCQM, receive the higher score\*\*
- Experience with processes (internal and CMS)

\*Likely not relevant for 2022 due to E&U Circumstances policy

\*\*May not matter in 2022 if your providers are QPs and not subject to MIPS

## Reasons to *not* report eCQMs yet:

- More cost to report two ways
- May be putting resources into a process/requirements that could change
- Most vendors do not seem ready to implement

## Other Considerations:

- How many EMRs in your ACO?
- How many TINs in your ACO?
- Are any of your TINs or EMRs much larger than the rest? Could you meet data completeness without having to combine data from all EMRs/TINs?
- Internal resources vs. vendor support
- Would eCQM data help with our value-based contracts?

# Data Completeness

## What is it?

- Data completeness requirement for eCQM reporting is 70% for PY2022
- This means you must report performance or exclusion/exception data for at least 70% of patients or encounters that are eligible for the measure's denominator
- Data completeness  $\neq$  Performance Rate

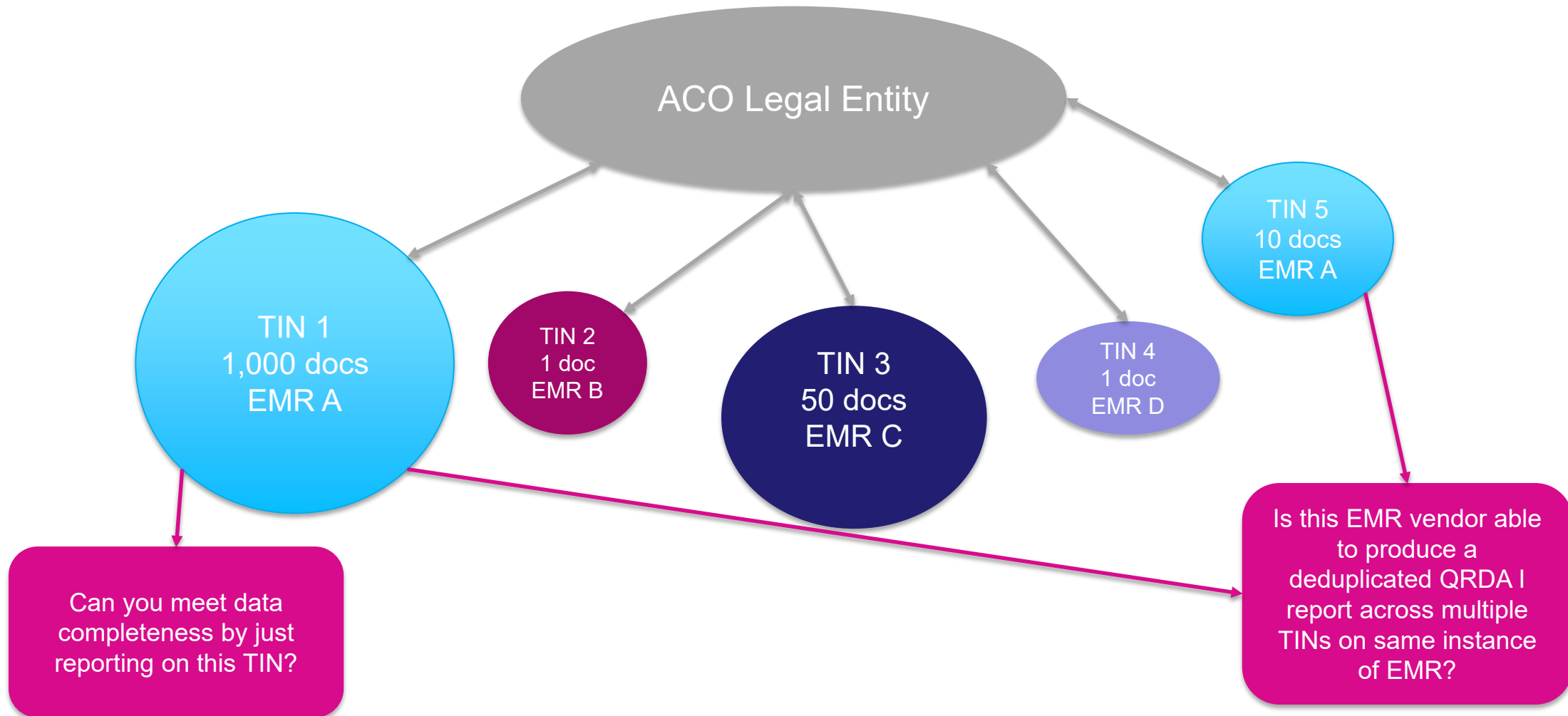
### Cherry-Picking Warning:

CMS states that “selectively reporting data that misrepresents your performance in a disingenuous manner results in data that aren't complete and may subject you to audit.

## Considerations for ACOs with multiple EMRs

- What will your method be for determining if you've met the data completeness requirement?
- If a practice doesn't provide eCQM data, how do you know how many eligible patients or encounters they would have had? Is there a proxy you can use to determine this without eCQM data?
- How would CMS audit this and how would you be prepared to respond to an audit?

## Example ACO – Data Completeness Questions



## Where to Start and Other Tips

- **Assess number of EMRs in your ACO and readiness to produce QRDA I files**
- **Business Associate Agreements (BAAs)** – are your current BAAs between ACO and Participants limited to attributed patient or Medicare patient information? If so, they likely need to be updated.
- **Data aggregation – do you have in-house capabilities to do this or do you need a vendor?**
  - Beware: there are vendors that have done eCQM reporting but likely not many that have aggregating data from multiple EMRs for an ACO. Make sure you are asking for details on how they will de-duplicate and help you ensure data completeness
- **Start assessing performance to see how you are doing!**
  - TIP: if you have a primary EMR or two, you may want to start there. Eventually you may need to aggregate across others but you may not want to wait to start understanding your performance if you haven't looked at all-payer eCQM data before.
- **Start now but stay flexible**
  - eCQM/MIPS CQM reporting is not required until 2025 but highly recommend starting to prepare well in advance of that.
  - CMS policies may continue to evolve so you may want to avoid long-term vendor contracts or huge capital investments solely for the purpose of MSSP quality reporting.

## QP Thresholds, APM Incentive Payments

- ▶ Uncertainty around possible extension of APM incentive payments, increase in QP thresholds makes it difficult for ACOs to plan
  - Do we want our providers to be QPs after 2022?
  - Should we consider possibility of APM incentive payments in our budgets?
  - Which TINs do we want in/out of the ACO from a QP perspective?
  
- ▶ For example: PY2022, we removed a handful of TINs from our ACO that we believe decreased our chances of meeting QP threshold and enhanced our patient outreach efforts to get MSSP patients in during Q1
  - Without congressional action, we would prefer to be scored under MIPS for PY2023 than to have our providers be QPs and receive no APM incentive payment and no MIPS adjustment
  
  - After 2023, not clear that it will be more advantageous to be a QP. MIPS adjustment plus .25 FFS adjustment may be better than a .75 FFS payment adjustment

## Key Public Health Emergency (PHE) Implications

- ▶ MSSP downside risk mitigation
  
- ▶ Telehealth
  - Implications of end of PHE may not be well-understood by providers
    - Confusion around PHE waivers, recent changes to Medicare coverage for behavioral health telehealth visits
    - Challenge of how to educate/prepare for possible end while recognizing that Congress may take further action
  - 151 day extension helpful in providing additional time but does not address issues long term
  - MSSP telehealth waiver unlikely to be very useful because it only applies to attributed patients
  
- ▶ Hospital at Home
  
- ▶ Medicaid enrollment – potential impact on Medicaid value-based arrangements and increase in uninsured patients

# Q & A

