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NYS Webinar on Alignment of MACRA and the VBP Roadmap

OVERVIEW

The New York State (NYS) Department of Health (DOH) has posted the slides from its June 13th webinar on how providers can align their risk-sharing payment models with both federal Medicare and NYS Medicaid requirements. Under the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA), eligible clinicians serving Medicare members must join the Quality Payment Program (QPP), which has two tracks:

- The Merit-Based Incentive Payment System (MIPS); and
- Advanced Alternative Payment Models (APMs).

The Advanced APM track is designed for clinicians participating in payment models with significant shared risk. Meanwhile, NYS has established goals for its Medicaid providers to participate in risk-sharing value-based payment (VBP) arrangements through the NYS VBP Roadmap. The State is seeking to help providers who serve both Medicare and Medicaid patients reconcile these programs.

Slides from the presentation are available here, and a recording of the webinar is here. Questions and feedback may be submitted to vbp@health.ny.gov.

The Merit-Based Incentive Payment System (MIPS)

Under the MIPS track of the Medicare QPP, eligible participants earn a performance-based payment adjustment that is determined by scores on the following four performance categories:

- Quality;
- Promoting Interoperability;
- Improvement Activities; and
- Cost.

All eligible providers are subject to reporting under MIPS unless they are a low volume Medicare Part B provider or unless they qualify to participate in the Advanced APM track. If a provider is not exempt from MIPS reporting requirements, failure to meet MIPS thresholds can result in up to a 5% cut in Medicare Part B reimbursement for the 2018 performance year, increasing to a 9% maximum cut by 2022. Clinicians participating in the MIPS track can satisfy some of the MIPS reporting requirements by aligning the following NYS Medicaid Programs with corresponding performance categories:

NYS Medicaid Program	MIPS Performance Category
Advanced Primary Care (APC)/VBP Arrangement Quality Measures	Quality
SHIN-NY Participation/Usage	Promoting Interoperability
NYC Patient Centered Medical Home (PCMH) Completion	Improvement Activities

Advanced APMs vs. VBP Roadmap Arrangements

Eligible providers who participate in the Advanced APM track of the Medicare QPP are excluded from MIPS reporting requirements and receive a 5% lump sum bonus on Medicare Part B services. Medicare providers may qualify for the Advanced APM track under the "All-Payer Combination Option," which would incorporate both Medicare and Other Payer Advanced APMs. An Other Payer Advanced APM is a payment model for a non-Medicare population (e.g., Medicaid) that:

- Requires participants to use certified electronic health record (EHR) technology;
- Reimburses providers based on quality measures comparable to those used in MIPS; and
- Either is a Medical Home Model expanded under the Centers for Medicare & Medicaid Services (CMS) Innovation Center's authority, **or** requires participants to bear a more than nominal amount of financial risk.

The Patient-Centered Medical Home (PCMH) model is not the same as a CMS Medicaid Medical Home model. Being PCMH-certified is not a substitute for meeting the requirements of a Medicaid Medical Home, which is defined as a primary care provider in which each patient is empaneled to a primary clinician and which incorporates at least four of the seven Medical Home Model elements:

- Planned coordination of chronic and preventive care;
- Patient access and continuity of care;
- Risk-stratified care management;
- Coordination of care across the medical neighborhood;
- Patient and caregiver engagement;
- Shared decision-making; and
- Payment arrangements in addition to, or substituting for, fee-for-service payments.

Under the QPP, Advanced APMs must meet similar criteria to those used by the VBP Roadmap to delineate Level 2 or 3 VBP arrangements. Level 2 VBP models include both shared savings and losses for providers, while Level 3 models are prepaid capitation arrangements.

The following table compares the two sets of requirements. Providers should consider constructing the VBP models they participate in to meet both sets of requirements simultaneously.

Requirement	Advanced APMs	VBP Roadmap Level 2/3
EHRs	Requires the use of 2015 Edition Certified EHR Technology (CEHRT).	No requirement.
Performance Measures	Requires that "MIPS-comparable" quality measures must be tied to payments, including at least one outcome measure.	Requires that quality measures are tied to payments. For each on-menu VBP arrangement, the State has proposed a list of suggested quality measures. About half of the State's proposed measures are on the 2018 MIPS measure list.
Marginal Shared Losses	Requires providers to share at least 30% of marginal losses	Requires providers to share at least 20% of marginal losses
Minimum Loss Rate	Contracts may establish a minimum loss rate for providers of no more than 4%. That is, providers may establish a threshold by which	No requirement.

Requirement	Advanced APMs	VBP Roadmap Level 2/3
	actual costs may exceed the expected costs before they begin to share losses, but this threshold may be no greater than 4% of the expected budget.	
Cap on Total Shared Losses	Contracts may establish a cap on total shared losses for providers, but the cap must be either (1) at least 3% of estimated spending or (2) at least 8% of total revenue paid to the provider. For Medicaid Medical Homes, the minimum cap amount is lowered to 3% of total revenue in 2019, increasing to 4% in 2020 and 5% in 2021.	Level 2 VBP arrangements may establish a cap on total shared losses for providers, but the cap must be at least 3% of the target budget in the first year of the arrangement, and at least 5% of the target budget in the second year.

MIPS or Non-Advanced APMs

In addition to Advanced APMs, there are alternative payment models that do not qualify as "Advanced" and must still satisfy a modified version of the MIPS reporting requirements. Medicare ACOs that do not meet the Advanced APM shared loss requirements, for example, are considered MIPS APMs. These APMs may include a waiver from certain traditional Medicare regulations (such as telehealth).

The following table compares the two sets of requirements. Providers should consider constructing the VBP models they participate in to meet both sets of requirements simultaneously.

Requirement	MIPS APMs	VBP Roadmap Level 1/2
EHRs	Requires the use of 2015 Edition Certified EHR Technology (CEHRT), or 2014 CEHRT with a transition plan	No requirement.
Performance Measures	Requires that MIPS Quality, Improvement Activities and Promoting Interoperability measures are reported, and that Quality measures are tied to payments, though exemptions are possible. Standard MIPS Quality and Improvement Activities measures may be replaced by APM-specific measures.	Requires that quality measures are tied to payments. For each on-menu VBP arrangement, the State has proposed a list of suggested quality measures. About half of the State's proposed measures are on the 2018 MIPS measure list.
Shared Losses	No requirement.	No requirement for Level 1. Level 2 requires providers to share at least 20% of marginal losses and any cap on total shared losses for providers, must be at least 3% of the target budget in the first year of the arrangement, and at least 5% of the target budget in the second year.