Research

PRIMER: MACRA and Advanced Alternative Payment Models

TARA O'NEILL HAYES | MARCH 30, 2017

Background

On April 16, 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law, significantly reforming the way physicians and other health care providers will be paid for treating Medicare patients. This legislation repeals the Sustainable Growth Rate (SGR) formula, which had served as the underlying formula used to determine payment rates for providers of Medicare Part B services, and replaces it with the Quality Payment Program (QPP). This program has two separate payment tracks—the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs)—both designed to encourage physicians to improve quality and value. Under both programs, payments for services will be at least partially based on these two factors. The Centers for Medicare and Medicaid Services (CMS) released the final rule for implementing this legislation on October 14, 2016; implementation and the first performance period began January 1, 2017.

Under the AAPM payment track, Advanced APM Entities participate in an Advanced APM and eligible clinicians who are a part of that Entity and collectively meet the necessary thresholds become Qualifying APM Participants (QPs). This program does not change the structure of any APMs themselves; rather, it defines the parameters of what constitutes an Advanced APM and provides financial incentives for clinicians who participate in them.

APMs versus Advanced APMs

Various alternative payment models (APMs) have been developed over the past several years both within Medicare and in the private health care sector as stakeholders throughout the industry work to find alternative methods of reimbursement intended to incentivize different behaviors and outcomes. APMs may include episode- or condition-based payments, bundled payments for a procedure or for a team of physicians, payment incentives for high-value services, or payment incentives for meeting certain goals. While the specific objectives and means for meeting those objectives may vary, these types of payment models are universally geared toward reducing costs and/or improving quality, while simultaneously, at a minimum, maintaining performance on whichever of those two metrics is not improved.

The MACRA statute provides that an APM is any of the following: 1) a model under section 1115A (other than a health care innovation award); 2) the Shared Savings Program under section 1899; 3) a demonstration under section 1866C; or 4) a demonstration required by federal law. According to the rule, an APM that is considered a demonstration required by Federal law is one that meets the following three criteria: 1) the demonstration must be compulsory under the statute, not just a provision of statute that gives the agency authority, but one that requires the agency to undertake a demonstration; 2) there must be some "demonstration" thesis that is being evaluated; and 3) the demonstration must require that there are entities participating in the demonstration under an agreement with CMS or under a statute or regulation.

Qualifying as an Advanced APM

Under MACRA, APMs must meet certain standards in order to qualify as Advanced APMs and receive the corresponding new payment incentives. MACRA defines Advanced APMs as payment models that 1) require participants to use certified electronic health record technology (CEHRT), 2) base payment for services on quality measures comparable to those used in MIPS, and 3) require participating entities to either bear more than nominal risk for monetary losses or be a qualifying Medical Home Model (MHM). CMS will maintain the list of APMs that qualify for the "Advanced" designation, and will update that list as new ones are established in the future.

For 2017, the following APMs have been deemed "Advanced" by CMS: the Comprehensive End-Stage Renal Disease (ESRD) Care Model with two-sided risk, the Comprehensive Primary Care Plus (CPC+) Model, Tracks 2 and 3 of the Shared Savings Program, the Next Generation ACO (NextGen) Model, and the Oncology Care Model. Other APMs are considered likely to be added to the list in the near future: the Comprehensive Care for Joint Replacement Model, episode-based payment models, the Vermont Medicare ACO all-payer model, and the ACO Track 1+ that CMS is considering creating for 2018.

Certified Electronic Health Record Technology (CEHRT)

AAPMs must require participating entities to use CEHRT, just as MIPS providers are required to do, and these requirements are aligned with the EHR Incentive Program's requirements. The APM must require that at least 50 percent of eligible clinicians use CEHRT in the first performance period; CMS is considering increasing this threshold to 75 percent in the future. If a hospital is the participating entity, it is an all-or-nothing requirement—either the hospital uses CEHRT or it does not. The APM must have procedures in place to ensure that its use requirements are being met by participants. The Shared Savings Program has an alternative requirement since this program does not require use of CEHRT but rather ties degree of CEHRT use to savings earned or losses incurred; the ACOs must submit data pertaining to CEHRT use.

Quality Measures

AAPMs must base payments, at least partially, on performance on some quality measures. All quality measures considered, just as in MIPS, must be evidence-based, reliable, and valid. An APM may use any of the MIPS measures; any measures endorsed by a consensus-based entity (such as the National Quality Forum (NQF)); measures developed under the Measure Development Plan established by MACRA; submitted in response to the MIPS Call for Quality Measures; or any other quality measures that CMS determines meet these criteria. A quality measure review process will be established in the Center for Medicare and Medicaid Innovation (CMMI). AAPMs must require entities to report at least one outcome measure, if available on the MIPS list. Not all, but at least some payments must be tied to "comparable" MIPS measures.

Financial Risk for Monetary Losses

While most providers are now using Electronic Medical Records and participate in some sort of quality measurement program, a much smaller percentage participate in payment arrangements which put some portion of their revenue at risk based on their performance and their costs. CMS will use a general standard for most AAPMs, but some will be subject a slightly different standard as appropriate.

Under the "generally applicable" standard defining what constitutes risk, an AAPM must provide that CMS can

either withhold or reduce payments for services to any APM Entity and/or the Entity's eligible clinicians participating in the APM that has expenditures in excess of the target or expected expenditures, or require the Entity to owe payment to CMS. Case management fees and otherwise guaranteed payments that vary based on quality performance would not be subject to these payment reductions.

In considering whether a payments arrangement's provisions constitute a "nominal" amount of risk, CMS will (eventually) consider three aspects: marginal risk, the minimal loss rate (MLR), and total risk. Marginal risk refers to the percentage of excess expenditures—in which actual expenditures exceed expected expenditures—for which an Entity would be liable. The MLR is the percentage by which actual expenditures may exceed expected expenditures without triggering the incurrence of losses. The total risk faced by an Entity is the maximum potential payment for which an Entity could be liable.

In considering the thresholds that should be used, CMS looked to the existing APMs, as well as the MIPS payment adjustment percentages. CMS proposed requiring an Entity's marginal risk to be at least 30 percent of losses in excess of the target or expected expenditures; the MLR to be no greater than 4 percent of expected expenditures; and the total risk to be at least 4 percent of expected expenditures. The agency decided not to finalize these requirements for the first performance period for APMs being considered under the Medicare Option, but these standards will apply to Other Advanced APMs being considered beginning with performance period 2019 (except the total risk threshold will be reduced to 3 percent).

CMS instead finalized the following two options for Medicare AAPMs, expected to make it easier for APMs to qualify as "Advanced:" the "revenue-based standard" and the "benchmark-based standard." Under the revenue-based standard, the total amount of expenditures potentially owed or foregone must be, in 2017 and 2018, at least 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities. In 2019 and beyond, CMS is considering increasing the standard up to 15 percent of revenue, or 10 percent so long as total risk is at least equal to 1.5 percent of expected expenditures for which an Entity is responsible. Under the benchmark-based standard, the total amount of expenditures potentially owed or foregone must be at least 3 percent of the expected expenditures (or target price for episode-based models) for which an Entity is responsible under the APM. This standard is so-called because an Entity's "benchmark" is the amount of expenditures (or target price) above which an Entity owes losses and below which it earns savings.

Medical Homes, which to date have not been required to bear financial risk by either CMS or commercial insurers, would be held to a different standard. According to CMS, MHMs tend to be smaller and have lower Medicare revenues relative to total Medicare spending than other APM entities which makes it more difficult for them to bear substantial risk. Qualifying Medical Homes must have a primary care focus and assign each patient to a primary care clinician. Additionally, qualifying Medical Homes must provide four of the following 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 instead of FFS payment. Medical Homes will also be limited in size to 50 or fewer eligible clinicians in order to qualify under the MHM financial criteria; otherwise, they will be held to the generally applicable standard.

The financial risk standard for MHMs would require the inclusion of either one of the same provisions as the "generally applicable" risk standard in the payment arrangement contract, or a fourth option: the Entity would lose the right to all or part of otherwise guaranteed payments if either actual expenditures for which the Entity is responsible under the APM exceed expected expenditures during a specified performance period or the Entity performance on specified measures does not meet expected performance on such measures for a specified performance period. For a MHM's risk amount to be considered "nominal", the following percentage of the

Entity's Medicare Parts A and B revenue must be at risk: 2017- 2.5 percent, 2018- 3 percent, 2019- 4 percent and 2020 and beyond- 5 percent.

Full capitation risk arrangements will automatically meet the Advanced APM financial risk criterion. Under these payment arrangements, per capita or predetermined payments are made to the Entity for all items and services furnished to a population of beneficiaries, and no settlement is performed for the reconciliation or sharing of losses incurred or savings earned. Medicare Advantage plans are not considered full capitation risk arrangements. Partial capitation arrangements would be required to meet the criteria under the generally applicable standards to be considered an AAPM.

Other Payer Advanced APMs

Beginning with Performance Period 3 (calendar year 2019), clinicians participating in both Medicare Advanced APMs and APMs established by other payers—such as Medicaid, Medicare Advantage, and commercial insurers—will also be able to count patients treated and payments made under those APMs to earn QP status under the All-Payer Combination Option.

The Other Payer Advanced APM criteria largely align with those required for CMS-established Advanced APMs. Payment arrangements must require 50 percent of participating eligible clinicians in each Entity to use CEHRT to document and communicate clinical care; this may increase to 75 percent, proposed, in future years. Payment to Entities must be based on quality measures that are evidence-based, reliable, and valid; and there must be at least one outcome measure required unless there is not an applicable one. The financial risk criteria will match what was originally proposed for Medicare APMs: marginal risk must be at least 30 percent of losses in excess of expected expenditures; the maximum allowable MLR must be no greater than 4 percent; and the total risk must at least 3 percent of expected expenditures.

Exceptions to these criteria may be made if the MLR percentage is not met but the size of the attributed patient population is small; the relative magnitude of expenditures assessed under the APM is particularly small; and the difference between actual expenditures and expected expenditures would not be statistically significant even when actual expenditures are 4 percent above expected expenditures. APMs would have to demonstrate that a significant number of Entity participants are likely to incur losses in excess of the higher MLR; in other words, the risk must still be meaningful. An exception may also be made if the marginal risk percentage would result in a payment/loss that would exceed the total risk percentage.

The following are potential "Other Payer Advanced APMs."

Medicaid Medical Home Model

Medicaid Medical Home Models (MMHMs) are established in a state under the Medicaid program and must include primary care physicians to whom each beneficiary must be assigned and at least four of the following features: 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/or payment arrangements in addition to, or substituting for fee-for-service payments. In 2019, at least 4 percent of the Entity's total revenue must be at risk, and in 2020 and later, at least 5 percent must be at risk.

Medicare Advantage

Medicare Advantage (MA) plans will only be considered for AAPM status under the Other Payer standard, not the Medicare standard. Assessments will be based upon the payment arrangement between the MA plan and its providers, the participating Entity. If providers are paid on a fee-for-service basis, it will not count.

Qualifying as a QP

As listed in the statute, the following types of providers will be considered eligible clinicians: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists; and a group that includes these professionals. In order to be deemed a Qualifying APM Participant (QP), these eligible clinicians must be participating in an AAPM Entity and have a certain percentage of either total Medicare Part B payments made or patients treated through the Entity, signifying sufficient Advanced APM participation.

Medicare Option

Under the Medicare Option payment amount method, CMS will consider only those payments made for covered Part B professional services; payment for drugs or devices covered under Part B are not considered because they are not professional services. The threshold score will be calculated as the percentage of payments for Part B services to an attributed beneficiary in relation to the total amount of Part B services payments provided for all attribution-eligible beneficiaries. In 2017, the threshold will be 25 percent; this threshold is set by statute, and will gradually increase to 75 percent by 2023. Under the patient count method, CMS will consider the number of unique attributed beneficiaries the clinician treats relative to the number of attribution-eligible beneficiaries he or she treats during the performance period. The patient count threshold will be 20 percent in the first two years, gradually increasing to 50 percent by 2023. Whichever method gives clinicians the most favorable ability to be considered a QP will be used.

All-Payer Combination Option

As discussed above, beginning with the third performance period in 2019, clinicians may alternatively become QPs under the All-Payer Combination Option. Under this option, CMS will consider whether the provider has participated in both Medicare and Other Payer Advanced APMs and met the relevant QP thresholds through the combination of AAPMs in which he or she participates to determine whether they qualify as a QP. CMS will allow both the payment amount method and the patient count method under this option, as well, and will again use whichever provides the more favorable score. The thresholds under this option will begin in performance year 2019 at 25 percent of Medicare payments and 50 percent of all payments under the payment amount method, and 20 percent of Medicare patients and 35 percent of all patients under the patient count method. Because this option, by definition, will require consideration of payment and patient data from payers other than Medicare, providers will be required to submit all necessary and sufficient information in order for their QP determination to be made under this option.

Beneficiary Attribution

To determine which payments and patients may be counted to meet the threshold, CMS will consider the

number of beneficiaries attributed to the clinician. In order to be considered attribution-eligible, a beneficiary must be enrolled in both Parts A and B, but not enrolled in MA or a Medicare cost plan; Medicare must be the patient's primary insurer; the individual must be at least 18 years old and a citizen of the US; and must have at least one claim for evaluation and management (E&M) services by an eligible clinician during the performance period.

CMS uses medical claims to identify and attribute beneficiaries for whom the Entities are responsible in a published patient list, and will match the list of attributed beneficiaries of the APMs themselves, using the most recent list available at the time of determination. Primarily, CMS attributes a beneficiary to the Entity where the patient receives the plurality of their (E&M) visits, and typically does not allow a beneficiary to be assigned to more than one APM. On average, only about 30-50 percent of all an Entity's beneficiaries ultimately get attributed to that Entity for a given performance period since beneficiaries often are unaware that their providers may be participating in an APM and cannot be required to only see clinicians within that organization.

All of the eligible clinicians in the AAPM Entity listed on the Participation List will be considered for QP determination at the group level each year. As CMS explains, "[Entities] face the risks and rewards of participation in an Advanced APM as a single unit, and [are] responsible for performance metrics that are aggregated to the level of that entity." For AAPM Entities that do not have a Participation List but have an Affiliated Practitioner List, those clinicians on the APL will be assessed individually (this is likely to apply only to clinicians participating in episode-based payment models). An exception will also be made for individuals participating in multiple AAPMs, none of which meet the threshold as a group.

In recognition that clinicians may join or leave a practice at any point in a year, CMS has backed away from its proposal to take only a year-end snapshot of the participation list and will instead evaluate participation of clinicians in each Entity at multiple points throughout the year (March 31, June 30, and August 31 (the last day of the performance period)). Clinicians must be listed as Entity participants for a minimum amount of time. If an Entity participates in a MIPS APM, rather than an AAPM, and is not excluded from MIPS, the final APM Entity group identified in the third snapshot will be the group used for purposes of MIPS group reporting and scoring under the MIPS APM scoring standard.

Partial QP Election to Report to MIPS

Following a determination that clinicians in an AAPM only qualify as partial QPs because they do not meet the necessary QP thresholds, the Entity must decide whether or not to report under MIPS; all clinicians participating in the Entity will be treated equally as a group. Clinicians being considered individually, as discussed above, must decide for themselves. If no election is made, the default position will be to not consider the clinicians for MIPS scoring and payment adjustments, meaning the clinicians will not receive any payment adjustments.

Payment as a QP

If a clinician is deemed a QP, he or she will earn additional financial payments. Between payment years 2019 and 2024, QPs will receive a lump sum payment equal to five percent of their prior year's Part B services payments. In 2026 and beyond, QPs' payments will be based on a higher physician fee schedule, which will increase at 0.75 percent per year, compared to an update of only 0.25 percent under MIPS.

Calculating a QP's Part B services payments will not be straight-forward, since, as required, these individuals are participating in payment arrangements that differ from simple fee-for-service payment arrangements, and

include various types of payments and structures. Payments made to the Entity rather than the individual QP that will be considered for the lump sum bonus payment fall into three categories: financial risk payments, supplemental service payments, and cash flow mechanisms. CMS classifies financial risk payments as "non-claims-based payments based on performance in an APM". These will be excluded from the calculation of total covered services payment amounts for purposes of determining the incentive payment because they are not payments specifically for Part B covered services. Supplemental services payments will be included if the payment meets the following four criteria: 1) it is for physicians' services; it is for only Part B services; it is directly attributable to an eligible clinician; and it is directly attributable to services provided to an eligible, individual beneficiary. Cash flow mechanisms do not change the overall amount of payments received, but provide a different method of payment for services. For these types of payments, CMS will use the payment amount that would have been made for Part B covered services if the cash flow mechanism had not been in place. Payments made to the Entity rather than an individual clinician will be considered to have been divided up equally among the eligible clinicians in the Entity. Other incentive payments will not be included in the 5 percent lump sum incentive payment calculation.

The incentive payments will be made to the taxpayer (billing TIN) associated with the Entity, and not the individual clinicians; the Entity will then be responsible for distributing the payments to the QPs, except where the QP is being considered individually. In these cases, the incentive payment will be split proportionally across the TINs associated with the various Entities in which the QP participates.