Advanced Topics
managed care training manual

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Balancing Risk and Rewards: Advanced Alternative Payment Model Participation in 2018 and Beyond

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As we approach the third anniversary of the signing of the Medicare Access and CHIP Reauthorization Act of 2015, providers and health systems continue to evaluate the best ways to align and take advantage of positive payment adjustments and incentives available under the Act. Physicians have voiced concern that MACRA's value-based payment options put too much financial risk and administrative burden on their practices. As physician payment programs created by MACRA continue to be reformed and refined, health industry leaders should continue to weigh the challenges and opportunities presented by MACRA, and particularly the benefits of participating in one sided- or two sided-risk Alternative Payment Models.

As providers evaluate their options, APM participation presents itself as an attractive option to achieve scale and enhance care coordination along the continuum of patient care. Participating in APMs with downside risk – known as Advanced APMs – also prepares providers for additional risk sharing in the future.

MACRA Background

MACRA is bipartisan legislation that fundamentally transforms the way Medicare pays physicians and hospitals for professional services. While Medicare traditionally paid physicians on a fee-for-service basis, MACRA marks a shift to paying physicians for successful treatment outcomes and rewarding value over volume.

MACRA ended the Sustainable Growth Rate formula and required the Centers for Medicare and Medicaid Services to implement the Quality Payment Program. The QPP provides two pathways for physician payment:

- *The Merit-Based Incentive Payment System program*. Payments to physicians who elect the MIPS option are adjusted (positively or negatively) based on how the physicians score on a number of performance metrics relative to their peers. MIPS streamlines multiple legacy CMS quality and incentive programs, such as PQRS and the Meaningful Use incentive program.
- *Advanced APMs.* Physicians who elect to participate in an Advanced APM instead of MIPS can be exempt from MIPS's reporting requirements and may be eligible to receive a 5% annual payment bonus, if a sufficient portion of their revenue comes through Advanced APMs. Starting in 2026, they are also eligible for higher annual Medicare Physician Fee Schedule adjustments.

When MACRA was enacted, 2017 and 2018 were slated to be the only transition years before providers' payments were affected in 2019. Recent changes to the MIPS program have altered the MIPS implementation timeline and the amount of positive payment adjustments that may be earned by providers participating in that model. When deciding whether to participate in MIPS or an Advanced APM, providers should evaluate each model to determine the best fit based on its care strategy, incentives and risk structure.

Considerations for Participating in MIPS, Advanced APMs or MIPS APMs

[1] MIPS

"The MIPS program has been controversial since its implementation due to its complexity and onerous reporting requirements."

MIPS requires providers to report to CMS across four separate categories: quality, cost, clinical practice improvement activities and electronic health record meaningful use (known now as "advancing care information"). Providers may receive sliding scale bonuses or cuts to their Medicare payments based on their reporting and performance in the categories. Providers have the ability to choose which metrics to be measured against and report on, depending on the size of their practice and its strengths.

Providers can be exempt from MIPS reporting if they meet Advanced APM participation criteria, if they are new to Medicare or if they care for a low volume of Medicare patients.

The MIPS program has been controversial since its implementation due to its complexity and onerous reporting requirements. Congress recently approved the Bipartisan Budget Act of 2018, which makes key reforms to the MIPS program.

- Rather than require adjustments to providers' Medicare reimbursement starting in 2019, the BBA gives CMS three additional years (through performance period 2021) to start lowering payments to physicians in connection with their performance. This decreases the number of physician practices that face potential Medicare payment reductions under MIPS in the near term.
- The BBA further limits MIPS payment adjustments by prohibiting CMS from applying any adjustments to separately billed items like drugs and biologics. This is a significant carve-out from the program and has a large impact on oncologists and other physicians whose charges for separately billed drugs represent a significant portion of their in-office services.
- Finally, the "low-volume threshold" exemption now excludes the cost of such drugs and services from the amount of Medicare charges needed to be able to participate in MIPS, excluding even more physicians from MIPS.

Taken together, the recent changes to MIPS in the BBA signal a slow-down by CMS in implementation of the MIPS program. Assuming CMS continues to set relatively low performance thresholds during this extended transition period, physicians will continue to enjoy only moderate upward adjustments and fewer physicians will receive downward adjustments.

This is a stark departure from the originally proposed 9% adjustment in payments under the original MIPS program. Importantly, the BBA also reduces the general MPFS annual update for 2019 from 0.5% to 0.25%. This will reduce total Medicare payments to physicians by more than $100 million next year. In light of these changes and the overall reduction in Medicare reimbursement, providers should consider participating in Advanced APMs to take advantage of potential upward payment adjustments and incentives that are available.

[2] Advanced APMs

An APM is a payment model that differs from the traditional fee-for-service model; physicians are reimbursed through it with a fee set according to the MPFS. Healthcare providers in an APM seek to align themselves with the goal of taking better care of a certain population of patients, usually within a targeted geographic area. If an organization adopts one of CMS' APMs, all participants agree to be paid according to the payment model's rules.

A common example of an APM is the Medicare Shared Savings Program. In that program, an Accountable Care Organization applies to participate in the MSSP APM option. Under the MSSP, if the ACO can realize savings by providing high-quality and low-cost care to the Medicare beneficiaries who are assigned to the ACO, Medicare will share the savings with the ACO. Physicians in the ACO may be eligible to share in the ACO's savings. Only the APMs that CMS deems Advanced allow participating physicians to achieve qualifying participant status and thus be eligible for the annual 5% payment bonus.

Advanced APMs must meet the following three requirements:

- Providers in the APM must accept financial risk which is "more than nominal" (e.g., either withhold payments, reduce rates or require the APM entity to pay CMS back if the APM entity's actual expenditures exceed expected expenditures).
- Payments must be tied to MIPS or comparable quality measures. No minimum number of measures is required, but at least one must be an outcomes-based measure.
- At least 50% of the Advanced APM participants must use certified EHR technology in the first performance year. This requirement increases to 75% in the second performance year.

Physicians who participate in Advanced APMs and meet the patient or revenue threshold requirements to be recognized as QPs are exempt from the complex MIPS scoring system, and they receive 5% bonuses between 2019 and 2024, and a 0.75% increase in the MPFS in 2026 and beyond. The Advanced APM bonuses and incentives are in addition to any APM-specific benefits that participating providers may receive through their participation in an APM (e.g., shared savings from an ACO).

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Whether or not a provider will be recognized as a QP is a determination made at the APM entity level for all providers participating in the Advanced APM. CMS calculates the total Advanced APM Medicare Part B payments made to the Advanced APM entity providers, and also determines the number of Advanced APM entity-attributed lives. CMS then compares the total Advanced APM entity Medicare Part B payments and the total number of Advanced APM entity-attributed lives to thresholds. If either threshold is met, all providers in the advanced APM entity are deemed QPs for that performance year, and receive the 5% payment bonus. A provider can choose to participate in several different APMs, however, CMS may make adjustments in certain of its calculations to prevent providers from "double dipping" in program incentives that otherwise cover the same set of Medicare beneficiaries.

For example, CMS requires providers who participate in both an MSSP ACO and a Comprehensive Primary Care Plus program primary care practice to forfeit the quality incentive bonus otherwise payable under the CPC+ program. Providers should therefore weigh the likely amount of any anticipated shared savings they might earn from participating in the MSSP against the amount of the quality incentive payment they would be forfeiting under the CPC+ program were they to participate in both programs.

For the 2019 performance year, clinicians may earn a 5% annual incentive payment on their total Medicare reimbursements through sufficient participation in any of the following Advanced APMs:

- CPC+
- MSSP Tracks 1+, 2 and 3
- Comprehensive ESRD Care Model (Large Dialysis Organization [LDO] arrangement and non-LDO two-sided risk arrangement)
- Next-Generation ACO Model
- Oncology Care Model (two-sided risk arrangement
- Comprehensive Care for Joint Replacement Payment Model CEHRT track
- Bundled Payments for Care Improvement-Advanced Model

That list is anticipated to grow as CMS introduces more value-based payment models and programs.

[3] MIPS APMs

Even if providers in an Advanced APM do not qualify as QPs, or if providers participate in an APM that is not an Advanced APM but meets certain criteria to be a MIPS APM, favorable MIPS scoring and APM-specific rewards are still available to participating physicians. Non-Advanced APMs that meet the following criteria are deemed by CMS to be MIPS APMs:

- The APM entity has an agreement with CMS (e.g., MSSP-CMS Participation Agreement)
- The APM entity has at least one MIPS-eligible clinician on its roster who is on a CMS participation list (e.g., MSSP ACO participant)
- Payment incentives under the AMP (either at the AMP entity level or the provider level) are based on cost/utilization and quality measures (e.g., MSSP benchmarks and quality metrics)

As an example, participation in an ACO in Track 1 of the MSSP offers physicians the opportunity to earn a portion of the ACO's shared savings payment from CMS without any downside risk, and prepares the physician for the shift to value-based care.

- In a MIPS APM, physicians are scored under the same four performance categories as regular MIPS, except cost (referred to as "resource use" by CMS). Providers in ACOs are not scored on cost factors because CMS is already evaluating this metric as part of their participation in the MSSP.
- In addition, providers in ACOs that qualify as MIPS APMs receive credit in other performance categories required in MIPS because they are already making efforts in value-based payment models – such as population health and care coordination.
- Another advantage of participating in a MIPS APM like the MSSP is that the ACO does the quality reporting on the provider's behalf.

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Physicians may ultimately find participation in an ACO attractive because the ACO handles the majority of the MIPS reporting requirements. Furthermore, once a provider has gained experience through participation in a Track 1 ACO, the provider might find participation in a newer Advanced APM model, such as MSSP Track 1+, attractive as a next step in the evolution toward risk and value-based payment. The MSSP Track 1+ is an Advanced APM and a two-sided risk model with less downside risk than Tracks 2 and 3.

Choosing a Path Forward

CMS is not alone in rolling out innovative risk-based payment models. Many commercial payers are following suit, finding that the quality of care can greatly increase while simultaneously decreasing costs when providers are invested in outcomes.

Advanced Topics: Provider Issues

So, how do you know whether your organization and providers are ready to participate in an Advanced APM? Implementing an APM strategy that will ultimately generate savings can be a years-long endeavor that should be approached in a stepwise fashion. At the outset, providers that desire to leverage MACRA's payment incentives need to complete an assessment of their readiness and willingness to potentially take on risk – and their likelihood of success. Key APM strategy considerations include the following:

[1] Understand the timing and deadlines for applying for APM programs and models. For example, the deadline for 2019 Medicare Shared Savings Program participation is May 2018, whereas the deadline for submitting 2017 MIPS performance data was March 31.

[2] Review the organization's historical PQRS, Hospital Value-Based Purchasing Program and Meaningful Use performance to help forecast potential APM bonuses and MIPS payment adjustments.

[3] Perform an APM versus MIPS participation cost/benefit analysis.

[4] Assess organizational readiness to accept risk-based reimbursement under Advanced APMs.

[5] Evaluate APM and commercial contracting strategies to project risk-based revenue sufficient to qualify providers in the organization as QPs who are thus eligible for the 5% Advanced APM bonuses and the long-term 0.75% increase in the MPFS starting in 2026. Assess which commercial payer agreements will need to be renegotiated to contain clear metrics and goals, and ensure that data can be shared across involved parties.

[6] If considering participation in multiple APMs, consider the potential financial tradeoffs. For example, providers who participate in both MSSP and CPC+ must forgo the CPC+ quality incentive payment and instead are only entitled to share in any MSSP ACO savings.

[7] Assess data management capabilities to support integration and sharing of clinical and claims data.

[8] Develop plans for clinical integration across providers and ways to appropriately share information to track care for patients that is accessed out-of-network, i.e., outside the ACO.

[9] Plan to include specialists and ancillary providers such as behavioral health, rehabilitative services, post-acute and hospice care.

Conducting a readiness assessment and adopting a stepwise approach to Advanced APM participation can help providers ease their way into value- and risk-based payment models under MACRA, while simultaneously helping them develop and implement care redesign strategies that will help them succeed in the ever-expanding value-based reimbursement environment.

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