Advanced APMs and Qualifying APM Participant status

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Introduction

Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA)[1] in April 2015, which was followed by a Notice of Proposed Rulemaking released by the Centers for Medicare and Medicaid Services (CMS) in May 2016.[2] In October 2016, CMS finalized this rule.[3] In addition to repealing the Sustainable Growth Rate (SGR), MACRA made a number of changes to how physicians and other clinicians are paid under fee-for-service (FFS) Medicare. MACRA ties clinicians' payments to greater accountability of cost and quality with the introduction of two distinct pathways that adjust Part B payments using different criteria: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (Advanced APM) track. MIPS ties Medicare Part B payments to clinician performance based on the Composite Performance Score (CPS) methodology. The Advanced APM track encourages groups of clinicians to shift from FFS to delivery models in which clinicians assume more accountability and risk for the cost and quality of care. In the initial years of the program, MACRA provides incentive payments to early APM adopters.

This paper explores the definition of an Advanced APM, how providers can qualify to be paid under the provisions of the Advanced APM track instead of under MIPS, and why that might be desirable. Additionally, we highlight the need for careful evaluation regarding APM participation because there is often a complex interaction between the risk inherent in an Advanced APM and the benefits under MACRA.

Defining Alternative Payment Models (APMs)

An Alternative Payment Model (APM)[4] is defined in the statute as any of the following:

- *A model under section 1115A of the Act other than a healthcare innovation award* (a model being tested under the authority of the Center for Medicare and Medicaid Innovation (CMMI))
- *The shared savings program under section 1899 of the Act* (the Medicare Shared Savings Program)
- *A demonstration under section 1866C of the Act* (the Health Quality Demonstration Program)
- *A demonstration required by federal Law*

Under MACRA, only a subset of APMs (referred to as Advanced APMs) count for purposes of becoming a Qualifying APM Participant (QP), evaluated under the Advanced APM track. An Advanced APM must meet certain additional criteria. In particular, an Advanced APM must:

- Require participants to use certified electronic health record technology (CEHRT)
- Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS
- Require that participating entities bear more than a nominal amount of risk for monetary losses (there is an exception to the risk requirement for an APM that is a Medical Home Model expanded under section 1115A of the Social Security Act)[5]

The final rule identifies the following current APMs as Advanced APMs:

- Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model, Large Dialysis Organization (LDO) arrangement and non-LDO two-sided risk arrangement
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Shared Savings Program (MSSP), Tracks 2 and 3
- Next Generation Accountable Care Organization Model (NGACO)
- Oncology Care Model (OCM), two-sided risk arrangement only

Under the final rule, CMS will publish and update the list of APMs that qualify as Advanced APMs as they are added or modified on an annual basis. The current list is published at https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf, and it includes an indication of possible APMs and Advanced APMs that CMS has in progress to be rolled out later in 2017 and 2018.

1 MACRA: Pub. L. 114-10 (April 16, 2015).
2 81 Fed. Reg. 28162-586 (May 9, 2016).
3 81 Fed. Reg. 77008-831 (November 4, 2016).
4 MACRA: Pub. L. 114-10 Sec. 101(z)(3)(C) (April 16, 2015).
5 81 Fed. Reg. 77427-9 (November 4, 2016); MACRA: Pub. L. 114-10, Sec. 101(z)(3)(D) (April 16, 2015).

These include the following:[6]

- Advancing Care Coordination through Episode Payment Models, Tracks 1 and 2
- Cardiac Rehabilitation (CR) Incentive Payment Model
- Comprehensive Care for Joint Replacement (CJR), CEHRT Track
- Medicare ACO Track 1+
- Medicare Diabetes Prevention Program

Beginning in the 2019 performance year (2021 payment year), payments made through Advanced APMs with other payers (Other Payer Advanced APMs) will be able to count toward a clinician's Advanced APM participation. The criteria for Other Payer Advanced APMs[7] will be similar to that of the Medicare Option Advanced APMs, but will include additional requirements for information submission from both the clinician and the other payer to verify that the Advanced APM meets all relevant criteria. Of note, Medicare Advantage Organizations can count as other payers in these determinations.

MACRA provides an avenue for advancing new APMs through the Physician-Focused Payment Model Technical Advisory Committee (PTAC).[8] The PTAC will periodically review physician-focused payment models submitted by stakeholders, prepare comments and recommendations regarding whether such models meet the criteria established by the Secretary of the U.S. Department of Health and Human Services (HHS), and submit rationale for their comments and recommendations to the Secretary.[9] The PTAC provides a clear pathway for stakeholders and the public to submit APMs to be considered for adoption, including potentially as an Advanced APM. The PTAC is intended to serve as a streamlined method of accelerating such models under the CMMI.

Achieving QP status through Advanced APMs

There is specific language in the MACRA statute that quantifies the level of a clinician's participation in an Advanced APM. Only clinicians who annually meet certain thresholds will attain QP status under the Advanced APM track (instead of the MIPS track). Importantly, whether the applicable thresholds for participation are met for an Advanced APM is determined at the entity level rather than at the individual clinician level. That is, for an Advanced APM Entity, CMS will evaluate the aggregate experience of all eligible clinicians in that entity and determine whether that aggregate experience meets the threshold. If the threshold is met, then all eligible clinicians associated with that entity are considered QPs.[10] If the threshold is not met, it is still possible for individual eligible clinicians to be considered QPs if they are participating in another Advanced APM, either if that other Advanced APM achieves the threshold or if the individual eligible clinician's combined participation in both Advanced APMs achieves the threshold.[11]

According to the final rule, CMS will evaluate whether Advanced APM entities meet the thresholds using a combination of two methods, the Payment Amount Method and the Patient Count Method, which are described below.[12]

- **Payment Amount Method.** For Medicare FFS beneficiaries, the Payment Amount Method considers the percentage of Medicare Part B payments made to all clinicians in the Advanced APM Entity that were for beneficiaries attributed to the Advanced APM Entity. It is calculated as the aggregate of all payments for Medicare Part B covered professional services that the Advanced APM Entity clinicians provided to attributed beneficiaries during the QP performance period, divided by the total payments for Medicare Part B covered professional services furnished by the Advanced APM Entity clinicians to all "attribution-eligible" beneficiaries during the QP Performance Period.
- **Patient Count Method.** For Medicare FFS beneficiaries, the Patient Count Method considers the percentage of attribution-eligible beneficiaries who are attributed to the Advanced APM Entity. It is calculated as the number of unique beneficiaries attributed to the Advanced APM Entity for whom the Advanced APM Entity clinicians provided professional services covered by Medicare Part B during the QP performance period, divided by the total number of attribution-eligible beneficiaries for whom the Advanced APM Entity clinicians provided professional services covered by Medicare Part B during the QP performance period.

Attribution under both the Payment Amount Method and Patient Count Method during the QP performance period is based on each Advanced APM's respective attribution rules.[13]

For the first two years of MACRA, Advanced APM entities can only meet these targets based on Medicare FFS Advanced APM participation (the Medicare Option). Beginning in the 2021 payment year, Other Payer Advanced APMs may also count toward these thresholds (the All-Payer Combination Option).[14] This means that organizations that wish to meet the QP threshold through an Other Payer Advanced APM will need to be engaged in those models prior to the end of the 2019 performance year. The thresholds for the All-Payer Combination Option are calculated in the same way as the Medicare Option, with the numerator and denominator

6 https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.
7 81 Fed. Reg. 77463 (November 4, 2016).
8 MACRA: Pub. L. 114-10, Sec. 101(y) (April 16, 2015).
9 81 Fed. Reg. 77491 (November 4, 2016).
10 81 Fed. Reg. 77433 (November 4, 2016).
11 81 Fed. Reg. 77433, ibid.
12 81 Fed. Reg. 77434, (November 4, 2016).
13 CMS notes that specialty-focused or disease-specific APMs may not have attribution methodologies based on evaluation and management services, such that there may need to be targeted exceptions to ensure that each attributed beneficiary population is truly a subset of the attribution-eligible population.
14 81 Fed. Reg. 77434, ibid.

adjusted to reflect the appropriate all-payer categories. Under the All-Payer Combination Option, Advanced APM entities must meet both the Medicare FFS and All Patients thresholds. Note that under the final rule, certain exclusions apply under the All-Payer Combination Option (e.g., Department of Defense healthcare programs).[15]

15 81 Fed. Reg. 77434, ibid.

The thresholds for being a QP increase over time and are shown in the table in Figure 1. Appendix A provides more detail on the specifics of the Payment Amount Method and Patient Count Method.

Certain clinicians will participate in an Advanced APM but will not meet the QP thresholds shown in the table in Figure 2. CMS has established lower thresholds for Partial Qualifying APM Participant (Partial QP) status. This status allows these

FIGURE 1: THRESHOLDS FOR QUALIFYING APM PARTICIPANT STATUS

PATIENT COUNT METHOD			
PAYMENT YEAR	MEDICARE OPTION	ALL-PAYER COMBINATION OPTION (MUST MEET BOTH CRITERIA BELOW)	
	MEDICARE FFS	MEDICARE FFS	ALL PAYERS
2019-20	20%	MEDICARE OPTION ONLY IN THESE YEARS	
2021-22	35%	20%	35%
2023 AND SUBSEQUENT YEARS	50%	20%	50%
PAYMENT AMOUNT METHOD			
PAYMENT YEAR	MEDICARE OPTION	ALL-PAYER COMBINATION OPTION (MUST MEET BOTH CRITERIA BELOW)	
	MEDICARE FFS	MEDICARE FFS	ALL PAYERS
2019-20	25%	MEDICARE OPTION ONLY IN THESE YEARS	
2021-22	50%	25%	50%
2023 AND SUBSEQUENT YEARS	75%	25%	75%

FIGURE 2: THRESHOLDS FOR PARTIAL QUALIFYING APM PARTICIPANT STATUS

PATIENT COUNT METHOD			
PAYMENT YEAR	MEDICARE OPTION	ALL-PAYER COMBINATION OPTION (MUST MEET BOTH CRITERIA BELOW)	
	MEDICARE FFS	MEDICARE FFS	ALL PAYERS
2019-20	10%	MEDICARE OPTION ONLY IN THESE YEARS	
2021-22	25%	10%	25%
2023 AND SUBSEQUENT YEARS	35%	10%	35%
PAYMENT AMOUNT METHOD			
PAYMENT YEAR	MEDICARE OPTION	ALL-PAYER COMBINATION OPTION (MUST MEET BOTH CRITERIA BELOW)	
	MEDICARE FFS	MEDICARE FFS	ALL PAYERS
2019-20	20%	MEDICARE OPTION ONLY IN THESE YEARS	
2021-22	40%	20%	40%
2023 AND SUBSEQUENT YEARS	50%	20%	50%

clinicians to opt out of the MIPS program but does not confer all of the benefits of QP status, as described in the next section. Any clinician that falls between the partial qualification thresholds (below) and the full qualification thresholds (above) would be considered a Partial QP. The thresholds for being a Partial QP increase over time and are shown in Figure 2.

Benefits of Advanced APM participation

Those clinicians who achieve either QP or Partial QP status have differences in the way they are evaluated under MACRA than other MIPS-eligible clinicians.

QPs are excluded from MIPS. However, these clinicians are required to submit certain MIPS-comparable reporting measures through their Advanced APM Entity. The performance on these measures will affect the shared savings that each entity receives. QPs receive an APM incentive payment (5% lump sum) for the payment years 2019 to 2024 in addition to the payment impact (e.g., shared savings or shared losses) from the APM directly.[16] Beginning in 2026, QPs will receive a 0.75% payment rate increase (compared with the 0.25% increase for other eligible clinicians).

Clinicians who attain Partial QP status do not receive the APM incentive payment that QPs receive. However, Partial QPs can opt in or out of MIPS.[17] The Advanced APM Entity must make an election on behalf of all participating clinicians by the end of the MIPS reporting period regarding whether Partial QPs will opt in or out of MIPS. The "opt-out" decision means that CMS will not score the information submitted by the APM Entity.[18] Because the election must be made before the scores are calculated, an election to participate in MIPS means that Partial QPs could be subject to either positive or negative payment adjustments.

Some clinicians participating in Advanced APMs will not satisfy either of the QP or the Partial QP thresholds, so will be subject to MIPS. CMS has designated certain APMs to be MIPS APMs. Participants in these MIPS APMs will be subject to the APM scoring standard. The APM scoring standard is intended to reduce the burden on participating clinicians given that most current APMs already assess participants on the cost and quality of care and require engagement in certain improvement activities. APMs subject to the APM scoring standard include all Advanced APMs, as well as the MSSP Track 1, the one-sided track of the OCM, and the one-sided risk arrangement in the CEC Model. Eligible clinicians participating in one of these MIPS APMs will receive favorable weighting in their CPS scores. In the calculation, more weight is placed on the Clinical Practice Improvement Activities and Advancing Care Information categories, where the MIPS APM potentially has the most direct control over its score. The table in Figure 3 shows the composite performance score weights for providers in MIPS APMs versus those not participating in MIPS APMs.

In some situations, the differences in weightings could provide an advantage to MIPS-eligible clinicians who do not meet the QP or Partial QP thresholds.

Important considerations

While participating in Advanced APMs contracts may have advantages in terms of helping an organization meet the requirements for QP status, it is also critical to understand the potential risks inherent in each APM.

Some Advanced APMs affecting Medicare FFS have significant downside risk that encompasses both Part A and Part B services, so an organization's downside risk is potentially greater than the maximum negative MIPS adjustment (which is applied only to the Part B services). A potential outcome is that an organization participating in an Advanced APM could owe CMS a large payment, which would be due to actual costs exceeding the benchmark or target for a two-sided risk model. At the same time, the organization could meet the threshold for QP status, so it would receive the 5% incentive payment for Part B services. In some cases, the relative magnitude of the Part A/Part B payment to CMS and the Part B incentive payment may be roughly offsetting; however, in other cases, it is possible that the payment to CMS could significantly exceed the 5% QP incentive payment. Similarly, an organization may be assuming considerable financial risk under two-sided commercial risk-sharing agreements.

16 81 Fed. Reg. 77433, ibid.

17 MACRA: Pub. L. 114-10, Sec. 101(q)(C)(vii)(II) (April 16, 2015); 81 Fed. Reg. 77448 (November 4, 2016).

18 81 Fed. Reg 77448 (November 4, 2016).

FIGURE 3: COMPOSITE PERFORMANCE SCORE WEIGHTS FOR PAYMENT YEAR 2019

MIPS PERFORMANCE CATEGORY	MIPS ELIGIBLE CLINICIANS NOT IN A MIPS APM	MIPS ELIGIBLE CLINICIANS PARTICIPATING IN MSSP OR NGACO	MIPS ELIGIBLE CLINICIANS PARTICIPATING IN ANY OTHER MIPS APM (EXCLUSIVE OF MSSP AND NGACO)
QUALITY	60%	50%	0%
RESOURCE USE	0%	0%	0%
ADVANCING CARE INFORMATION	25%	30%	75%
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES	15%	20%	25%

For any organization, an understanding of the specific financial terms of each Advanced APM contract, the potential combined outcomes under the Advanced APM and MIPS, the organization's appetite for risk, and other considerations should factor into the decision regarding entering an Advanced APM. Because each organization's risk tolerance, strategic objectives, and financial considerations will differ, detailed financial modeling specific to each organization is critical.

Conclusion

The Advanced APM track and the QP status may be desirable for many MIPS-eligible clinicians. Because of the inherent financial risks involved in any Advanced APM, however, an organization should evaluate these programs with care and consideration. Milliman has the expertise and tools to assist clinicians in determining which paths may be most financially beneficial given their own unique circumstances. We strongly recommend that organizations considering participating in Advanced APMs and pursuing the QP status work with a qualified actuary. Working with a qualified actuary will help to ensure that the organization fully understands the potential risks and opportunities. Milliman consultants are available and excited to assist providers with the changing needs, requirements, and opportunities that MACRA and MIPS present.

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APPENDIX A: ADVANCED APM CALCULATION THRESHOLDS

ADVANCED APM CALCULATION THRESHOLDS, MEDICARE ONLY		
PAYMENT AMOUNT METHOD*		
	ADVANCED APMS (NOT EPISODE-BASED)	EPISODE PAYMENT MODELS
NUMERATOR	All Medicare Part B payments for covered professional services furnished by eligible clinicians in the Advanced APM Entity to attributed beneficiaries.	All Medicare Part B payments for covered professional services furnished by eligible clinicians in the Advanced APM Entity to an attributed beneficiary during the course of an episode.
DENOMINATOR	All Medicare Part B payments for covered professional services furnished by the eligible clinicians in the Advanced APM Entity to attribution-eligible beneficiaries.	All Medicare Part B payments for covered professional services furnished by the eligible clinician in the Advanced APM to any attribution-eligible beneficiary. This includes all such services to all attribution-eligible beneficiaries, whether or not such services occur during the course of an episode under the Advanced APM.
PATIENT COUNT METHOD**		
	STANDARD APMS	EPISODE PAYMENT MODELS
NUMERATOR	Unique attributed beneficiaries for whom eligible clinicians in the Advanced APM Entity furnish professional services covered by Medicare Part B during the QP Performance Period.	Unique attributed beneficiaries for whom eligible clinicians in the Advanced APM Entity furnish Medicare Part-B-covered professional services during the course of an episode.
DENOMINATOR	Attribution-eligible beneficiaries for whom eligible clinicians in the Advanced APM Entity furnish professional services covered by Medicare Part B during the QP Performance Period.	Attribution-eligible beneficiaries for whom eligible clinicians in the Advanced APM Entity furnish professional services covered by Medicare Part B at any point during the QP Performance Period, irrespective of whether such services occur during the course of an episode.

* 81 Fed. Reg. 77452-3 (November 4, 2016).

** 81 Fed. Reg. 77455 (November 4, 2016).