

## All About APMs: What Will It Take for Physicians to Earn the APM Bonus Under MACRA?

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On May 9, 2016, the Centers for Medicare & Medicaid Services (“CMS”) published a proposed rule<sup>1</sup> addressing the implementation of physician payment reforms included in the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”).<sup>2</sup> This proposed rule defines how CMS intends to shift traditional fee-for-service payments that reward physicians for the volume of services delivered to Medicare payments that reward value and patient outcomes under the new “Quality Performance Program” (the name that CMS has given to its framework for implementing the MACRA-mandated physician payment reforms). Comments on the proposed rule are due no later than 5 p.m. (EDT) on **June 27, 2016**.

CMS has set a high bar for clinicians participating in Advanced Alternative Payment Models (“Advanced APMs”) to qualify for a 5 percent bonus payment starting in 2019 and to be exempt from Merit-Based Incentive Payment System (“MIPS”) payment adjustments. CMS expects that only about 10 percent of physicians and other clinicians will be eligible for bonus payments for participation in an Advanced APM in the first years of the Quality Performance Program.

This Client Alert provides more details about how CMS defines “Advanced APMs,” including the financial risks that clinicians are required to take on through participation in an Advanced APM to be eligible for the bonus payment.

An important takeaway from the proposed rule is that clinicians ought not to feel that participating in Advanced APMs is a must in order to receive fair compensation from Medicare post-MACRA. At least in the early years, clinicians who perform well under MIPS may be paid as well or better in Medicare fee-for-service while avoiding the risk of loss that accompanies participation in APMs. However, in later years, clinicians participating in

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<sup>1</sup> 81 Fed. Reg. 28,161 (May 9, 2016), available at [www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentivepayment-system-mips-and-alternative-payment-model-apm](http://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentivepayment-system-mips-and-alternative-payment-model-apm).

<sup>2</sup> Pub. L. 114-10 (enacted Apr. 16, 2015).

Advanced APMs receive higher annual payment updates than clinicians subject to MIPS. The cumulative nature of those higher updates over time will lead to a significant difference in payment rates, meaning that clinicians will eventually want to be in Advanced APMs.

For an overview of the entire proposed rule, please see the recent Epstein Becker Green Client Alert, “MACRA Proposed Rule: CMS Provides Details on Implementing Medicare’s New Quality Payment Program.”<sup>3</sup> We have also produced a Client Alert on MIPS scoring, “MIPS Performance Scoring: Understanding How CMS Proposes to Calculate Performance is Key to Preparing for MIPS Participation.”<sup>4</sup>

## **APM Overview**

An APM is a new approach to paying for medical care through the Medicare program that incentivizes quality and value through care coordination. Accountable care organizations (“ACOs”), patient-centered medical homes, and bundled payment models are examples of APMs.

Beginning in 2019 and continuing through 2024, clinicians participating in what CMS defines as an “Advanced APM” may be eligible for an annual lump-sum bonus payment equal to 5 percent of their prior year’s payments for Part B covered professional services. This bonus payment would be in addition to any payment incentives that the clinician receives through participation in the Advanced APM itself. Additional benefits to clinicians participating in Advanced APMs include exemption from the MIPS payment adjustments and, beginning in 2026, receipt of a higher annual payment update under the Medicare Physician Fee Schedule than those clinicians who do not significantly participate in an Advanced APM (0.75 percent vs. 0.25 percent).

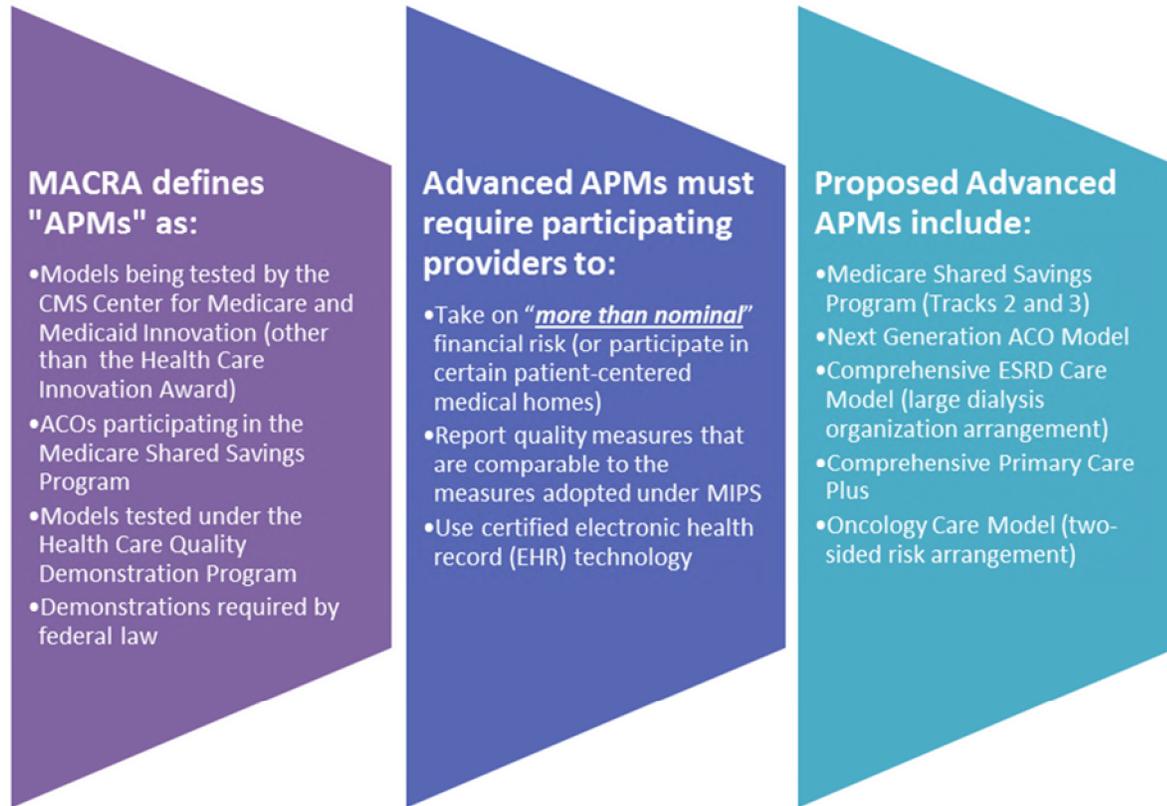
## **Identifying Advanced APMs**

In the proposed rule, CMS identifies specific criteria for determining which APMs will qualify as Advanced APMs. CMS also establishes criteria for primary care participation in Advanced APMs through Medical Home Models.

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<sup>3</sup> This Client Alert is available at <http://www.ebglaw.com/news/macra-proposed-rule-cms-provides-details-on-implementing-medicare-s-new-quality-payment-program/>.

<sup>4</sup> This Client Alert is available at <http://www.ebglaw.com/news/mips-performance-scoring-understanding-how-cms-proposes-to-calculate-performance-is-key-to-preparing-for-mips-participation/>.



For bonus payments in 2019 and 2020 (based on performance in 2017 and 2018 respectively), eligible clinicians may become qualifying APM Participants (“QPs”)<sup>5</sup> only through participation in Advanced APMs, based on the amount of Medicare Part B covered services furnished through the “Advanced APM Entity.”<sup>6</sup> Payments “through” an Advanced APM Entity means payments made by CMS for services furnished to attributed beneficiaries for whom the Advanced APM Entity is responsible for the costs and quality of their care.

For 2021 and later, eligible clinicians may become QPs through a combination of participation in Advanced APMs and APMs with other payers (“Other Payer Advanced APMs”), such as private insurers, state Medicaid programs, and Medicare Advantage plans. An Other Payer Advanced APM must meet criteria similar to those for Advanced APMs. This All-Payer Combination Option allows a clinician to become a QP based on the amount of Medicare Part B covered services furnished through a Medicare Advanced APM plus the amount of services furnished through an Other Payer Advanced APM.

<sup>5</sup> If an eligible clinician is determined by CMS to be a QP, that clinician will be eligible for the 5 percent bonus payment.

<sup>6</sup> An “Advanced APM Entity” is an entity participating in an Advanced APM. An example of an Advanced APM is the Medicare Shared Savings Program, Track 2. An Advanced APM Entity would be an ACO that is participating in the Medicare Shared Savings Program, Track 2. Further, an eligible clinician would be the individual or group that is participating in the ACO.

## Financial Risk Requirements

A key metric for determining if an APM qualifies as an Advanced APM is whether clinicians participating in the APM are required to assume “more than nominal” financial risk.

In general, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce payment rates, or require an Advanced APM Entity to make payments to CMS if its actual expenditures exceed expected expenditures during a specified performance period.

Note that CMS considered, but rejected, the concept that the required assumption of financial risk by Advanced APMs can arise from an APM’s “business risks” associated with the size of the financial investments made by an APM, in terms of time and money, to meet the conditions to be an Advanced APM. CMS felt these business risks would vary too widely and might be difficult to quantify, leaving it uncertain whether a particular APM has, or has not, assumed more than a “nominal” amount of financial risk. CMS seeks comments on how to craft objective financial risk criteria that would define financial risk for monetary losses differently than its proposal. We do anticipate that the final rule will differ from the proposed rule on this topic.

Further, CMS proposes that the amount of risk that clinicians assume must meet the following three standards:

- Total Risk: The maximum amount of losses possible under an Advanced APM must be at least 4 percent of the APM spending target.
- Marginal Risk: The percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM Entity is responsible (i.e., sharing rate) must be at least 30 percent.
- Minimum Loss Rate: The amount by which a clinician’s spending can exceed the APM benchmark (or target price for bundles) before the Advanced APM Entity bears responsibility for financial losses cannot exceed 4 percent.

CMS proposes that a full capitation risk arrangement will always meet the Advanced APM financial risk criteria. For this purpose, full capitation risk exists where the APM Entity receives a per capita or an otherwise predetermined fixed payment for all items and services delivered to a population of beneficiaries, with no settlements done to reconcile or share losses incurred or savings earned by the APM Entity. The APM Entity bears the full risk, both downside and upside; therefore, capitation risk arrangements always require the APM Entity to bear the risk of more than nominal financial losses. Cash flow adjustments to later reconcile or adjust predetermined amounts based on actual experience may not be full risk arrangements. CMS seeks comments on this proposal and whether other types of arrangements may be suitable for such treatment under the Advanced APM financial risk criteria.

The following table shows examples of shared savings risk arrangements and assesses whether these arrangements would meet the financial risk conditions established in the proposed rule.

Benchmark	Actual Spend	Marginal Risk	Stop Loss	Amount Owed	Financial Risk Condition Met?
\$1,000,000	\$1,100,000	50%	15%	\$50,000	Yes
\$1,000,000	\$1,100,000	60%	10%	\$60,000	Yes
\$1,000,000	\$1,100,000	40%	3%	\$30,000	No, total risk less than 4%
\$1,000,000	\$1,100,000	100%	5%	\$50,000	Yes
\$1,000,000	\$1,100,000	25%	10%	\$25,000	No, marginal risk less than 30%

In addition, the following table shows examples of non-shared-savings risk and assesses whether these arrangements would meet the financial risk conditions established in the proposed rule.

Risk Arrangement	Performance Standard	Maximum Potential Loss	Financial Risk Criteria Met?
Percent of fee-for-service payments withheld and paid in lump sum if performance standard is met	Quality measures	6% withheld	No, expenses that count toward the nominal risk standard do not include payments to CMS by the APM if actual expenses matched expected expenses
Percent of fee-for-service payments in subsequent year if performance standard is not met	Expenditures more than 2% above expected expenditures	5% reduction	Yes
Percentage discount of fee-for-service payments with lump-sum payment of the difference to APM	None	10% reduction in fee-for-service payments paid in a lump sum	No, not tied to actual expenditure performance

## ***Special Rules for Medical Home Models***

Medical Home Models that have been expanded under the Center for Medicare and Medicaid Innovation's ("CMMI's") demonstration expansion authority<sup>7</sup> qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While Medical Home Models have not yet been expanded through CMMI, the proposed rule lays out criteria for Medical Home Models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

Specifically, a Medical Home Model must have the following two elements at a minimum:

- Model participants are composed of primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services
- Empanelment of each patient to a primary clinician

In addition to these elements, a Medical Home Model must have at least 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
- Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g., shared savings, population-based payments).

Further, to determine that the Medical Home Model has a primary care focus, it would have to involve specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice, 08 Family Medicine, 11 Internal Medicine, 37 Pediatric Medicine, 38 Geriatric Medicine, 50 Nurse Practitioner, 89 Clinical Nurse Specialist, and 97 Physician Assistant.

Because medical homes tend to have both less experience with financial risk than larger organizations and limited capacity to sustain substantial losses, CMS proposes unique Advanced APM financial risk standards to accommodate medical homes that are part of

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<sup>7</sup> See section 1115A(c) of the Social Security Act.

organizations with 50 or fewer clinicians. Namely, the required assumption of financial risk can arise from CMS withholding payment, reducing payment rates, requiring the Medical Home Model Advanced APM Entity to make payments to CMS, or reducing an otherwise guaranteed payment or payments if its actual expenditures exceed expected expenditures or if specific performance measures are not met for a specified performance period. In addition, the amount of risk under the Medical Home Model must be at least the following amounts: 2.5 percent of Medicare Parts A and B revenue (2017), increasing to 3 percent (2018), 4 percent (2019), and 5 percent (2020 and later). CMS seeks comments about whether 50 clinicians is the appropriate threshold for the application of these modified financial risk standards.

The following table provides examples of Medical Home Model non-shared risk arrangements and assesses whether these arrangements would meet the financial risk conditions established in the proposed rule.

Medical Revenue	Maximum Potential Loss	Risk as a Percent of Revenue	Criteria Met?
\$1,000,000	Reduction of per beneficiary per month care management fees equal to \$30,000 annually	3%	Yes
\$1,000,000	Repayment of \$50,000 quality performance bonus	5%	Yes
\$1,000,000	Failure to achieve \$25,000 quality bonus	2%	No, 2.5% minimum risk standard for 2017 not met

**Medicare Advantage Plan Participation**

CMS proposes to exclude clinician participation in Medicare Advantage plans from designation as an Advanced APM. CMS’s position is that the governing statute<sup>8</sup> requires that the Advanced APM bonus payment must be based on payments for Medicare Part B services and do not, therefore, include payments for services delivered to Medicare Advantage enrollees. By July 1, 2016, the U.S. Department of Health and Human Services (“HHS”) is required to report to Congress on the feasibility of integrating the APM concept

<sup>8</sup> See section 1833(z)(1)(A) of the Social Security Act.

in the Medicare Advantage payment system, which could lead to changes in how clinicians participating in Medicare Advantage plans are treated in the future.<sup>9</sup>

However, for Advanced APM bonus payments made in 2021 and beyond (based on performance in 2019 and beyond), eligible clinicians may meet the QP threshold based in part on payment amounts or patient counts associated with Medicare Advantage plans and other payers, as long as such arrangements meet the criteria to be considered an Other Payer Advanced APM, including a financial risk component. Accordingly, CMS will not consider an arrangement where a Medicare Advantage plan meets the certified EHR technology and quality measure requirements but which pays the APM Entity on a fee-for-service basis, to be an Other Payer Advanced APM. The reason is that there is no provider risk connected to the actual cost of care exceeding projections.

### **Intermediate Options: What If a Clinician’s Participation in an APM Does Not Qualify for a Bonus Payment?**

Not all clinicians who participate in an APM will meet the criteria for the Advanced APM bonus payment. CMS proposes to reward clinicians participating in APMs with certain advantages under MIPS that could help the clinicians achieve positive MIPS payment adjustments. CMS also proposes to align standards when possible between the two components of the Quality Payment Program (MIPS and Advanced APMs) to make it easier for clinicians to move between them, thereby making the path to Advanced APM status a gradual slope rather than a steep cliff.

To determine whether a clinician meets the requirements for the Advanced APM bonus payment, all clinicians will report through MIPS in the first year. Eligible clinicians who are participating in an Advanced APM but fall short of the requirements for the Advanced APM bonus payment will be able to choose whether they would like to receive a payment adjustment through MIPS.<sup>10</sup>

Further, clinicians who participate in any APMs will receive favorable scoring and other benefits under MIPS,<sup>11</sup> including the following:

- APM Entities may submit their quality measures for MIPS using the CMS Web Interface, which may be the same process that they already use to report under the APM, thereby reducing the burden on individual clinicians (i.e., because reporting is

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<sup>9</sup> Section 101(e)(6) of MACRA.

<sup>10</sup> To qualify for the Advanced APM bonus payment, clinicians must reach a certain threshold of Medicare payments or Medicare patients through the Advanced APM Entity. For the first performance period, those thresholds are 25 percent of Medicare Part B payments or 20 percent of Medicare patients are seen through the Advanced APM Entity. An Advanced APM Entity that receives at least 20 percent of Medicare Part B payments or 10 percent of Medicare beneficiaries will qualify as a “Partial QP” and can choose whether to opt out of the MIPS payment adjustments.

<sup>11</sup> Performance under MIPS is calculated based on measures and activities reported under four performance categories: Quality, Resource Use, Clinical Practice Improvement Activities, and Advancing Care Information.

done through the APM Entity, using a process that the APM Entity is already familiar with).

- Quality performance data that is not submitted to the CMS Web Interface, for example, the Consumer Assessment of Healthcare Providers and Systems (“CAHPS”) survey and other claims measures would not be included in the Quality performance category score.
- APM Entities will automatically receive at least half of the possible points in the Clinical Practice Improvement Activities (“CPIA”) performance category and will have the opportunity to earn additional points based on other activities reported. If the APM is a patient-centered medical home or comparable specialty practice, then clinicians will automatically receive the highest potential score for the CPIA performance category.
- APM Entities will not be assessed under the Resource Use performance category; instead, higher weights will be assigned to the CPIA and Advancing Care Information performance categories.<sup>12</sup> Accordingly, APM participants could have higher-than-average MIPS performance scores to the extent that their CPIA and Advancing Care Information scores are higher than the scores they would have received under Resource Use.

The following table summarizes the various positive payment adjustments in 2019 that are possible based on a clinician’s participation in an APM in 2017.

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<sup>12</sup> For the first performance period, the Resource Use performance category has a weight of 10 percent. For APM participants, the Resource Use performance category will have zero weight, and the 10 percent will be redistributed to the CPIA and Advancing Care Information performance categories as follows: for CPIA, the weight will increase from 15 percent to 20 percent; for Advancing Care Information, the weight will increase from 25 percent to 30 percent.

APM Entity Participating in MIPS	Advanced APM Entity Participating in MIPS	Advanced APM Entity Is Partial QP	Advanced APM Entity Is QP
<p><u>MIPS-related</u> If eligible clinicians perform well/receive a high composite performance score, they could receive up to a 4 percent adjustment to the base rate of Medicare Part B payments during 2019</p> <p>If the full scaling factor is applied, the payment adjustment could be up to 12 percent</p> <p>If performance is “exceptional,” an eligible clinician could qualify for an additional adjustment, up to 10 percent</p> <p><u>APM-related</u> APM participants could receive a financial reward for participation in an APM</p>	<p><u>MIPS-related</u> If eligible clinicians perform well/receive a high composite performance score, they could receive up to a 4 percent adjustment to the base rate of Medicare Part B payments during 2019</p> <p>If the full scaling factor is applied, the payment adjustment could be up to 12 percent</p> <p>If performance is “exceptional,” an eligible clinician could qualify for an additional adjustment, up to 10 percent</p> <p><u>APM-related</u> APM participants could receive a financial reward for participation in an APM</p>	<p><u>MIPS-related</u> If the partial qualifying Advanced APM chooses to be subject to MIPS, then possible positive payment adjustments could be:</p> <p>If eligible clinicians receive a high composite performance score, they could earn up to a 4 percent adjustment to the base rate of Medicare Part B payments during 2019</p> <p>If the full scaling factor is applied, the payment adjustment could be up to 12 percent</p> <p>If performance is “exceptional,” an eligible clinician could qualify for an additional adjustment, up to 10 percent</p> <p><u>APM-related</u> APM participants could receive a financial reward for participation in an APM</p>	<p><u>Advanced APM-related</u> If an Advanced APM Entity is a QP, it will qualify for the 5 percent lump-sum bonus in 2019, based on estimated aggregate payments received in 2018</p> <p><u>APM-related</u> APM participants could receive a financial reward for participation in an APM</p>

In addition, the following table summarizes the negative payment adjustments in 2019 that are possible based on a clinician’s participation in an APM in 2017.

APM Entity Participating in MIPS	Advanced APM Entity Participating in MIPS	Advanced APM Entity Is Partial QP	Advanced APM Entity Is QP
<p><u>MIPS-related</u> Eligible clinicians could have their Medicare Part B payments reduced by up to 4 percent in 2019</p>	<p><u>MIPS-related</u> Eligible clinicians could have their Medicare Part B payments reduced by up to 4 percent in 2019</p> <p><u>APM-related</u> APM participants could be subject to financial penalties, based on the amount of financial risk assumed</p>	<p><u>MIPS-related</u> Partial QPs likely would <i>not choose</i> to be subject to MIPS if performance would cause payments to be reduced</p> <p><u>APM-related</u> APM participants could be subject to financial penalties, based on the amount of financial risk assumed</p>	<p><u>APM-related</u> APM participants could be subject to financial penalties, based on the amount of financial risk assumed</p>

### Physician-Focused APMs

A physician-focused APM is an APM that (1) is designed to be tested as an APM with Medicare as a payer, although the proposed model may also include other payers in addition to Medicare, such as Medicaid, Medicare Advantage, Children’s Health Insurance Program (“CHIP”), and private payers; (2) contains either individual physicians or physician group practices as APM Entities, although other facilities or practitioner types may be included; (3) targets the quality and costs of physician services; and (4) may address such elements as physician behavior or clinical decision-making.

CMS seeks to test physician-focused APMs that pay for higher-value care, promote better care coordination, protect patient safety, encourage patient engagement, and improve the availability of information to guide decision-making.

The proposed rule establishes the Physician-Focused Payment Technical Advisory Committee (“PTAC”) to review and assess additional physician-focused payment models suggested by stakeholders. The PTAC includes 11 members who were appointed in October 2015 by the U.S. Comptroller General based on their expertise in physician-focused payment models and related delivery of care.<sup>13</sup> The PTAC will meet quarterly, or more frequently, if necessary, and make comments and recommendations on the inclusion

<sup>13</sup> See HHS, Office of The Assistant Secretary for Planning and Evaluation, PTAC: Physician-Focused Payment Model Technical Advisory Committee (Feb. 1, 2016), available at <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>.

of proposed physician-focused payment models in the Quality Performance Program. This process should allow stakeholders a unique opportunity to play a role in developing new models and to determine priorities for the physician community.

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In analyzing the proposed rule and preparing for participation in the Quality Performance Program, stakeholders should consider how CMS has defined “Advanced APMs” and weigh the financial benefits associated with Advanced APM participation versus the costs and financial risks associated with such participation.

All stakeholders are encouraged to provide CMS with feedback on the proposed rule to help shape how Advanced APMs are defined and how the attainment of financial incentives associated with Advanced APM participation evolves over time.

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