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Challenges and opportunities with obtaining Qualifying APM Participant status

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Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA)[1] in April 2015.

In addition to repealing Medicare's Sustainable Growth Rate legislation,[2] MACRA ties clinicians' payments to greater accountability of cost and quality with the introduction of two distinct tracks that adjust Medicare Part B payments using different criteria: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) track. MIPS ties Medicare Part B payments to clinician performance based on the Composite Performance Score (CPS) methodology, further explained in the MIPS adjustment overview.[3] The Advanced APM track encourages groups of clinicians to shift away from fee-for-service (FFS) payment models to new delivery models that require them to assume more accountability and financial risk for the cost and quality of care. MACRA provides financial incentives for APM participants, and those clinicians who become Qualifying APM Participants (QPs) receive a lump-sum incentive payment equal to 5% of the prior year's payments for their professional services covered by Part B. They are also exempt from the upward and downward payment adjustments associated with MIPS. For more information on what Advanced APMs are available and how eligible clinicians can become QPs, please see Advanced APMs and Qualifying APM Participant status.[4]

1 MACRA: Pub. L. 114-10 (April 16, 2015).

2 The sustainable growth rate (SGR) was a statutory formula, initially passed in 1997, and was meant to be used for calculating annual payment updates to physicians and other professionals under Medicare. The formula was designed to provide an incentive for physicians to be more efficient and rein in utilization, and to ensure that overall spending by Medicare on physician services did not grow faster than gross domestic product (GDP) growth. Tying the payment rate to national utilization rates provided little incentive for individual physicians to alter their behavior—and, in some years, application of the SGR formula would have resulted in significant cuts to physician payments. For several years, Congress passed a series of short-term "patches" (each referred to as a "doc fix") instead of passing a long-term repeal.

3 See MIPS adjustment overview **http://www.milliman.com/insight/2016/MIPS-adjustment-overview/**

4 See Advanced APMs and Qualifying APM Participant status **http://www.milliman.com/insight/2016/Advanced-APMs-and-Qualifying-APM-Participant-status/**

This paper explores both the challenges and the opportunities associated with participating in an Advanced APM and obtaining QP status, helping providers understand not only why this status may be desirable, but also what risks they might encounter along the way. Additionally, we highlight the need for careful evaluation regarding APM participation because the potential gains come with a new set of risks that most clinicians have not encountered.

This paper assumes a basic knowledge of currently available Advanced APMs as well as how the Centers for Medicare and Medicaid Services (CMS) will be measuring QP status and what the basic benefits of this status include. For more information on these topics, please see Advanced APMs and Qualifying APM Participant status.

Challenges with obtaining QP status

ACHIEVING PATIENT COUNT OR PAYMENT AMOUNT THRESHOLDS

In order to obtain QP status, a physician must have a certain percentage of patients or payment volume assigned to an Advanced APM. An Advanced APM is an alternative payment model (APM) that meets the following three criteria:

1. Uses certified electronic health record technology (CEHRT)
2. Provides for payment for covered professional services based on quality measures comparable to measures under the quality performance category under MIPS
3. Requires providers to bear financial risk for monetary losses that are in excess of a nominal amount or is a Medical Home Model expanded under section 1115A(c) of the Act

Medicare has provided clear guidance on which existing APMs are considered Advanced APMs under Medicare FFS. However, determining if a physician meets the patient or payment volume thresholds is more difficult. Tables 1 and 2 on page 2 show the patient and payment volume thresholds by payment year. The performance year (or measurement year) is two years prior to each payment year.

QPs will not only have to participate in Advanced APMs, but also meet the volume thresholds outlined above. Discussed below are potential challenges with obtaining the qualifying APM volume thresholds.

1. **Identifying Advanced APMs.** As shown in Figure 1, payers beyond Medicare FFS become an optional part of the QP criteria in payment year 2021 based on participation in appropriate payment models in 2019.[5] In order for CMS to recognize other payer APMs (i.e., non-Medicare FFS APMs), providers must submit information regarding the Advanced APM to CMS, including the following:[6]
   - Payment arrangement information (to assess whether the payment arrangement meets the criteria to be an Other Payer Advanced APM), including information on financial risk arrangements, use of certified EHR technology, and payment tied to quality measures
   - For each payment arrangement, the amounts of payments for services furnished through the arrangement, the total payments from the payer, and the number of patients furnished any service through the arrangement
   - The total number of patients furnished any service, by payer

5 Note that these other payers may include Medicare Advantage plans.

6 81 Fed. Reg. 77478 (November 4, 2016).

FIGURE 1: THRESHOLDS FOR QUALIFYING APM PARTICIPANT STATUS BY YEAR

PATIENT COUNT METHOD			
INCENTIVE 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			
INCENTIVE 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 BY YEAR

PATIENT COUNT METHOD			
INCENTIVE 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			
INCENTIVE 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%

Details on how and when this information is to be submitted have not been finalized,[7] but will, at a minimum, create an administrative hurdle for providers. In addition to the provider requirements, payer support is needed as outlined below.

- Payers can obtain early determinations of potential Advanced APM arrangements by submitting program details 60 days prior to the start of the performance period (e.g., by November 2, 2018, for the 2019 performance year – the first performance period to have the all-payer option).[8]
- Payers must attest to the accuracy of all information submitted by providers, including the reported payment and patient data – or the data will be excluded by CMS.[9]

2. **Meeting Medicare FFS Advanced APM's participation thresholds throughout all payment years.** For performance years 2017 and 2018 (incentive payment years 2019 and 2020), the QP criteria is based on Medicare FFS patient and payment volume. After performance year 2018, QPs must still meet lower Medicare FFS volume thresholds for Advanced APMs and higher volume thresholds for their entire risk arrangement suite including both Medicare FFS and other payer Advanced APMS.

   Currently, the following Advanced APMs are available under Medicare FFS in 2017: Medicare Shared Saving Program (MSSP) Tracks 2 and 3, the Next Generation ACO (NGACO) Model, Comprehensive Primary Care Plus (CPC+), the Comprehensive ESRD Care Model (CEC) Large Dialysis Organization (LDO) and non-LDO two-sided risk arrangements, and the Oncology Care Model (OCM) two-sided risk arrangement.

   CMS has also indicated that it intends to make several episode-based payments into Advanced APMs as well, including a newly proposed coronary artery bypass graft (CABG), acute myocardial infarction (AMI), and surgical treatment of hip and femur fracture treatment (SHFFT) episode payment models (EPMs) as well as the existing Comprehensive Care for Joint Replacement (CJR) Model.[10] Potential QPs will need to evaluate the Advanced APMs available under Medicare FFS and have a strategy for meeting the volume thresholds.

3. **Submitting volume data for non-Medicare FFS patients.** Because the 2017 and 2018 performance years are based solely on Medicare FFS and because CMS is designing the measurement to be consistent with how patients are attributed under the appropriate APMs, there should be little confusion about how the Advanced APM volume percentage is calculated.

   For the 2019 and later performance years, clinicians will need to submit patient volume information by payer. CMS has not finalized the submission format; however, clinicians will need to make sure that they receive the necessary data feeds from payers to support the submissions to CMS. Additionally, the payers will be required to attest to the accuracy of the data submission in order for CMS to consider the data under the All-Payer Combination Option.

4. **Having a backup plan.** Failure to achieve QP status will result in one of two outcomes, either 1) becoming a Partial QP or 2) participating in MIPS. Partial QPs have lower volume thresholds as shown in Figure 2 above. Therefore, clinicians who intended to become QPs, but did not quite meet the volume threshold, may become Partial QPs. Partial QPs do not receive a 5% lump-sum incentive payment, but can opt out of MIPS. If clinicians fail to meet the QP and Partial QP thresholds, then they will be subject to MIPS. Clinicians will need to assess the potential outcomes and have a back-up plan for success under MIPS if there are doubts about the clinicians' ability to meet the QP and Partial QP requirements.
5. **Year-to-year changes.** Clinicians who are targeting QP status will need to have a strategy that reflects the year-to-year changes in the QP criteria.

PATIENT ATTRIBUTION COMPLEXITIES

QP volume thresholds are defined by two key values:

1. Attributed beneficiaries
2. Attribution-eligible beneficiaries

For the Medicare Option, attributed beneficiaries are based on each APM's respective attribution rules, such as the assigned beneficiaries for an MSSP accountable care organization (ACO), aligned beneficiaries of the Next Generation ACO Model, or attributed beneficiaries of the OCM Model. For the attributed beneficiaries, MACRA therefore has the same counting rules as each Advanced APM.

For the Medicare Option, attribution-eligible beneficiaries are Medicare FFS beneficiaries with at least one evaluation and management service performed by an eligible clinician during the QP Performance Period.[11]

7 81 Fed. Reg. 77480 (November 4, 2016).

8 81 Fed. Reg. 77479 (November 4, 2016).

9 81 Fed. Reg. 77480, ibid.

10 CMS (July 19, 2016). Proposed Rule: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR). Retrieved August 10, 2016, from **https://innovation.cms.gov/Files/x/advancing-care-coordination-nprm.pdf**.

11 Note that the exact definition of attribution-eligible beneficiaries is more complex that what is described above—for example, the beneficiary must not have Medicare as a secondary payer, must be 18 years of age, a U.S. resident, etc. Please see the MACRA final rule for specifics.

Because the definition of attribution-eligible beneficiaries is quite broad and the same beneficiary may be attribution-eligible for multiple eligible clinicians, it will be impossible for eligible clinicians to capture 100% of their eligible beneficiaries. Further, it may be difficult or impossible for eligible clinicians participating in Advanced APMs to meet the qualification thresholds, especially in the later years of the program (e.g., 50% of Medicare FFS patients is the requirement of the Medicare Option in the patient count method for 2023 and beyond).

When determining the threshold score to compare with the values shown in Figure 1 above, the numerator and denominator are based on the attributed and attribution-eligible beneficiaries. Specifically, CMS will calculate the threshold in two ways and provide each eligible clinician the most advantageous score. In the first case, CMS plans to use the payment amounts for all professional services covered by Medicare Part B that are furnished by eligible clinicians for the relevant populations (attributed or attribution-eligible beneficiaries). In the second case, CMS plans to use the number of unique beneficiaries for each APM. In cases where an eligible clinician participates in multiple APMs, the unique beneficiaries in episode-based APMs (e.g., OCM) will be added to the unique beneficiaries in the non-episode-based APMs (e.g., NGACO) and then compared with the denominator. This means that a single beneficiary may be counted twice—for example, once under the Next Generation ACO and once under OCM.

For the All-Payer Combination Option, each eligible clinician must submit and attest to the accuracy of additional data in two areas:

1. Payment amounts and/or number of patients furnished any service through the Other Payer Advanced APM for each payer
2. The sum of total payment amounts and/or number of patients furnished any service from each payer

In both cases, certain payments, patients, or payers may be excluded from these amounts as defined in the regulations. These components act as proxies for the attributed and attribution-eligible beneficiaries' payment amounts and patient counts for purposes of calculating the threshold scores. When calculating the All-Payer Combination scores, these values are added to the Medicare payments or patient counts as appropriate. As with the Medicare Option, scores will be calculated both ways (payment-based and patient-count-based) and the most advantageous applied.

Take for example the practice financial breakdown in the table in Figure 3.

Under the Medicare Option, the practice would achieve the following percentages:

- Patient Count Method: 2,000/5,000 = 40%
- Payment Amount Method: $7.5M/$15.0M = 50%

Under the All-Payer Combination Option, the practice would achieve the following all-patient percentages:

- Patient Count Method: 3,000/10,000 = 30%
- Payment Amount Method: $11.5M/$32.5M = 35.4%

Based on the different methods and options, this practice would sometimes meet the QP threshold and would sometimes fall short. For example, from 2019 to 2022, the practice meets the QP threshold based on both methods under the Medicare Option. However, beginning in 2023, they fall short under either the patient count or the payment amount methods with Medicare alone. While they meet the Medicare requirements for the All-Payer Combination Option, they fall short overall. Based on these numbers, the practice would be a Partial QP (based on the Medicare Option patients or payments) beginning in 2023. If it wanted to be a QP after 2023, it would need to increase either the percentage of non-Medicare FFS patients or payments engaged in Advanced APMs, or increase the percentage of Medicare patients or payments engaged in such Advanced APMs.

Because of the patient attribution complexities, clinician groups that wish to become QPs will need to understand both their numerators and denominators under the Medicare Option and, for performance year 2021 and forward, under the All-Payer Combination Option. Ideally, CMS will begin to provide clinician groups with information on their denominators based on current Medicare FFS experience.

FINANCIAL DOWNSIDE OF ADVANCED APMS

In order to achieve QP status, an eligible clinician is necessarily participating in an Advanced APM requiring more than nominal financial risk. While some eligible clinicians may succeed financially under the Advanced APM, others may not. In most cases, Advanced APMs will include downside risk for both the Part B payments that are affected by the MACRA legislation as well as Part A payments.

FIGURE 3: PRACTICE FINANCIAL BREAKDOWN

PAYER	TOTAL PATIENTS	PATIENTS ALIGNED TO ACOS	TOTAL PAYMENTS	TOTAL PAYMENTS ON ACO-ALIGNED PATIENTS
MEDICARE FFS	5,000	2,000	$15.0M	$7.5M
OTHER PAYER 1	*2,500*	*0*	*$10.0M*	*$0*
OTHER PAYER 2	*2,500*	*1,000*	*$7.5M*	*$4.0M*
TOTAL OTHER PAYERS	5,000	1,000	$17.5M	$4.0M
TOTAL PATIENTS	**10,000**	**3,000**	**$32.5M**	**$11.5M**

The maximum annual benefit that eligible clinicians may achieve under the Advanced APM track is equal to 5% of their aggregate Part B payments (and this incentive payment only exists for payment years 2019 through 2024), but the maximum risk may be substantially more given the inclusion of Part A payments in shared savings and episode-based payment models. For example, the downside risk under the Next Generation ACO program is up to 15% of total Part A and Part B spending for attributed beneficiaries. If eligible clinicians do not have systems in place to achieve the benchmarks or cost targets necessary under their Advanced APMs, the risk of losses may exceed the potential benefits.

For those eligible clinicians participating in an Advanced APM that does have procedures in place to manage patients and control costs under a shared savings or episode-based payment model, oftentimes those savings are found by reducing hospital expenditures for attributed beneficiaries. For APM entities that are either owned by or working closely with hospitals, it may be very difficult to motivate these types of changes. A hospital may not want to leave inpatient beds vacant in pursuit of the 5% lump-sum incentive payment to eligible clinicians for Part B services as the loss of hospital revenue may exceed this payment (and the potential shared savings payout offered by the Advanced APM).

Opportunities associated with QP status

FINANCIAL OPPORTUNITIES

Despite the potential downsides to participating in Advanced APMs and seeing QP status, there are also potential financial benefits, including the following:

A lump-sum payment equal to 5% of their prior year's payments for Part B covered professional services. QPs can become eligible for this lump-sum incentive payment for years 2019 through 2024. Overall, this is the primary financial opportunity for QPs.

Insulation from the potential downside of the MIPS adjustment. In general, MIPS is a budget-neutral (i.e., zero-sum) program, with a financial downside of 4% in 2019, growing to 9% in 2022. Because QPs and Partial QPs are excluded from MIPS, they are not exposed to MIPS's downside and do not have to navigate the hundreds of quality and performance measures that make up MIPS.

Opportunities for positive results from the Advanced APM. Participation in Advanced APMs necessarily comes with potential risk to QPs, which will typically include an upside (and downside) for the provider.

Higher conversion factor increases starting in 2026. Starting in payment year 2026, QPs will receive a conversion factor increase of 0.75% compared with 0.25% for non-QPs. Over time, this could result in significantly higher payment rates for QPs versus non-QPs.

CLINICAL INTEGRATION BENEFITS

Several of the currently available Advanced APMs aim to align incentives across different types of providers. For example, ACOs encourage physicians and hospitals to work together to ensure beneficiaries receive appropriate care that can keep them healthy and out of hospitals. In many cases, however, individual physicians do not see the financial benefits of these programs without entering into what can be complex and time-consuming gainsharing arrangements. By providing a 5% lump-sum incentive payment to QPs, MACRA serves to create an even greater incentive for physicians to participate actively in Advanced APMs.

While other payer Advanced APMs do not contribute to QP threshold calculations until performance year 2019 (incentive payment year 2021), it's possible that the increased engagement physicians have in Advanced APMs that is due to MACRA will have trickle-down effects on other lines of business and patient populations beyond Medicare fee-for-service. This could serve to improve the quality of care and reduce costs for patients covered by other payers.

ANCILLARY BENEFITS

In addition to the benefits described above, there may be ancillary benefits to pursuing the Advanced APM track. The final rule lays out a process by which CMS will make data on MIPS scoring and Advanced APM participation publicly available through the Physician Compare website.[12] It is possible that this public reporting could drive patient opinion, signaling to Medicare beneficiaries that Advanced APM participants are going above and beyond in their efforts to contribute to providing high-quality, low-cost care.

Additionally, efforts to optimize APM performance may also improve scores across other quality reporting programs that could influence payments or patient opinions. For example, care management functions that are performed in pursuit of achieving an ACO's performance year benchmark may also have the effect of improving scores on readmissions, complication measures, or the Medicare Spending per Beneficiary measure, which are used in calculating hospital inpatient payment rates.

12 81 Fed. Reg. 77390-2 (November 4, 2016).

Discussion and conclusions

It will be important for eligible clinicians affected by MACRA to carefully consider the challenges and opportunities associated with attaining and maintaining QP status. Based on an eligible clinician's individual situation, the challenges may outweigh the risks or there may be certain strategies to maximize the potential benefits. The MIPS incentive payment could be as high as 22% in payment year 2019, given a perfect storm for the provider, while the lump-sum incentive payment to QPs is a flat 5% (along with any financial benefits from the Advanced APM itself). Milliman has the tools and expertise to assist providers in making the important decisions that will impact their financial and quality performance under MACRA.

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