THE ACADEMY ADVISORS

MACRA FINAL RULE SERIES: PART 4

# ADVANCED ALTERNATIVE PAYMENT MODELS: STRUCTURE & OUTLOOK

Clinicians meeting certain thresholds of practicing through Advanced Alternative Payment Models ("Advanced APMs")—deemed Qualifying APM Participants ("QPs")—will have three distinct benefits under MACRA—QPs will be excluded from the reporting and scoring requirements of the Merit-based Incentive Payment System ("MIPS"), from 2019 through 2024 will be eligible for an incentive payment equal to 5 percent of the prior year's Part B professional service payments, and beginning in 2026 will receive a higher annual update than clinicians practicing in MIPS. This fourth brief in our series will explore the requirements clinicians will have to meet to become QPs—focusing on the changes from the Proposed Rule to the Final Rule—as well as the outlook for Advanced APM participation over the next several years.

## QP Determination Methodology

CMS finalized that, generally, the QP determination will occur at the APM Entity level. As such, either every clinician participating in the APM Entity will either become a QP or will not. CMS created three criteria which determine whether an APM Entity—and every clinician practicing within it—will qualify for the benefits associated with Advanced APM participation:

1. The APM model will need meet certain quality, EHR use, and financial risk requirements established by CMS.

2. The APM Entity will need to maintain an official Participation List to confirm that a certain group of clinicians are participating in the model.

3. Clinicians practicing within the APM Entity—collectively—must meet specified payment amount or patient count thresholds.

If the above three steps are achieved during a performance period, all of the clinicians in the Advanced APM Entity would be designated QPs for the payment year that occurs two years later.

## Advanced APM Criteria

CMS finalized the following three criteria for determining whether an APM will qualify as an Advanced APM:

1. The APM must require the use of Certified EHR Technology ("CEHRT")

2. The APM must evaluate quality of care using evidence-based measures, comparable to those used in MIPS

3. The APM must require that entities incur more than a nominal amount of financial risk for spending above a set benchmark

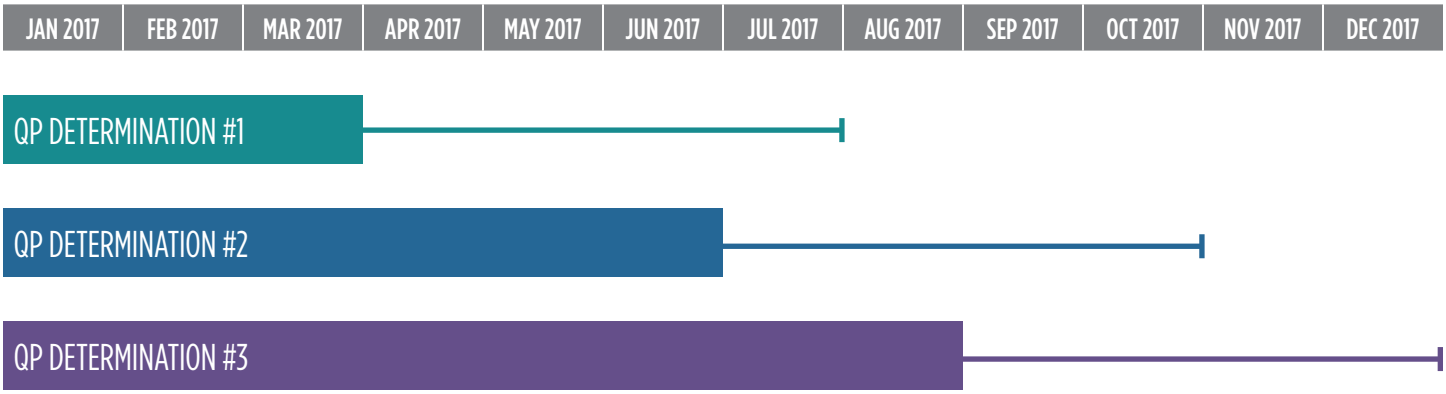
In the Final Rule, CMS established a more flexible set of definitions for these criteria than were initially proposed. The quality requirement is broad enough that it should not exclude any Medicare model, the CEHRT requirement was lessened, and—of particular note—the financial risk requirements were both simplified and lessened. While CMS had proposed that models would need to meet total risk, marginal risk, and minimum loss rate criteria, the agency finalized only the total risk requirement, and reduced the total risk required from at least 4 percent of expected expenditures to at least 3 percent of expected expenditures.

Given the finalized criteria, the following models will be deemed Advanced APMs for the 2017 performance year:

- Medicare Shared Savings Program ("MSSP") ACO Track 2
- MSSP ACO Track 3
- Next Generation ACO
- Comprehensive End-Stage Renal Disease Care Model (both LDO and non-LDO arrangements)
- Comprehensive Primary Care Plus Model ("CPC+") [1]
- Oncology Care Model (two-sided risk arrangement)

## QP Determination Timeline

CMS finalized a method for QP determination which would allow clinicians practicing in APMs to be informed of QP determination prior to the MIPS reporting period. The agency will look at three "snapshot periods" during each performance year to determine which clinicians are QPs. During each determination period, CMS will calculate whether the group of clinicians on the APM Entity's Participation List collectively meet either the payment amount or patient count thresholds. CMS will inform participations of their QP determination approximately four months after the end of each snapshot period.




For the first two performance years, clinicians will only be able to become QPs through participating in Medicare Advanced APMs; however, beginning in 2019, clinicians may also become QPs through a combination of participation in Medicare Advanced APMs and Other Payer Advanced APMs, which incorporate Medicaid and commercial models, to include certain Medicare Advantage arrangements.

[1] For clinicians practicing in both CPC+ and any MSSP model, the MSSP participation solely will determine QP eligibility. That said, clinicians practicing in both MSSP Track 1 and CPC+ will not be eligible for QP determination.

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022+ |
|---|---|---|---|---|---|
| % MEDICARE **PAYMENTS** THROUGH ELIGIBLE APMS | | | | | |
| 25% | | 50% | | 75% | |
| % MEDICARE **PATIENTS** THROUGH ELIGIBLE APMS | | | | | |
| 20% | | 35% | | 50% | |

| % ALL-PAYER **PAYMENTS** THROUGH ELIGIBLE APMS | |
|---|---|
| 50%<br>*Minimum 25% Medicare* | 75%<br>*Minimum 25% Medicare* |
| % ALL-PAYER **PATIENTS** THROUGH ELIGIBLE APMS | |
| 35%<br>*Minimum 20% Medicare* | 50%<br>*Minimum 20% Medicare* |

## Outlook for Advanced APM Participation Opportunity

CMS announced shortly after the release of the Final Rule that there will be increasing opportunity for clinicians to participate in Advanced APMs over the next couple of years. The agency announced the implementation of a new MSSP Track 1+ model to begin in 2018—incorporating less risk than the currently available ACO models, but enough to qualify as an Advanced APM—as well as the expansion of voluntary bundled payment models and new. Additionally, CMS announced that it will reopen applications for CPC+ and for the Next Generation ACO model for the 2018 performance year.

While change is unlikely at least for the 2017 performance year, the impending administration of President-elect Trump introduces uncertainty for 2018 and beyond. Of particular relevance to Advanced APM participation, Republicans have generally been critical of the Centers for Medicare and Medicaid Innovation ("CMMI"), which is the primary vehicle used by CMS to establish new payment models. The prospect of CMMI's elimination, without an equivalent organization in its place, introduces significant ambiguity around both the creation of new demonstration payment models, and the sustainability of existing models.

**NATHAN BAYS**
**GENERAL COUNSEL & EXECUTIVE DIRECTOR**
**703.647.1028**
**NATHAN@HMACADEMY.COM**

**CAITLIN GREENBAUM**
**DIRECTOR, HEALTH POLICY & STRATEGY**
**703.647.3184**
**CAITLIN@HMACADEMY.COM**