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THE ACADEMY ADVISORS

POLICY BRIEF:

ADVANCED ALTERNATIVE PAYMENT MODELS

INTRODUCTION

On July 12th, the Centers for Medicare and Medicaid Services (CMS) released the Medicare Access and CHIP Reauthorization Act (MACRA) Proposed Rule for 2019. With significant changes for both the Merit Based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (A-APM) tracks, CMS continues to evolve the Quality Payment Program (QPP) to align with broader administrative priorities. This brief will focus on the major changes proposed for the Advanced APM track of the QPP and implications for large providers.

ADVANCED ALTERNATIVE PAYMENT MODELS

The QPP creates two types of Advanced APMs:

MEDICARE A-APMS	OTHER PAYER A-APMS
APMs designated in by MACRA	Payment models adhering to specific CMS regulations—these include the requirement that 50% of participating eligible clinicians use certified EHR technology*; that the payment model utilizes quality measures comparable to MIPS including one outcome measure; and that model participants bear more than nominal risk.
• Bundled Payments for Care Improvement Advanced (BPCI-A) • Comprehensive Care for Joint Replacement (CJR) Track 1 • Next Generation ACO • Medicare Accountable Care Organization Track 1+ Model • ESRD Care Model (2-sided risk) • Comprehensive Primary Care Plus (CPC+) • Oncology Care Model (OCM) (2-sided risk) • Medicare Shared Savings Program (MSSP) - Track 2 and 3 • Vermont ACO Medicare Initiative	• Medicare Advantage Plans • Medicaid Plans • 1876 Cost Plans • Programs of All Inclusive Care for the Elderly (PACE) plans

* In 2019, CMS proposes to increase this threshold to 75%.

CMS has designated four Medicaid Plans as Other Payer A-APMs for the 2019 performance period and is in the process of making other model determinations through the Eligible Clinician Initiated Submission Form. If a participant submits a model for consideration, CMS will verify that the model meets Other Payer A-APM criteria.

UPDATES TO APM REQUIREMENTS IN 2019

- **A greater percentage of A-APM participants will be required to attest to EHR use.**
  In line with their EHR adoption effort, CMS will increase the requirements within A-APMs for EHR use. In 2020, CMS will require that at least 75% of eligible clinicians use Certified EHR Technologies, up from 50% in 2019.
- **CMS clarified and updated their definitions of A-APM quality measures.**
  A-APM quality measures must be endorsed by a consensus-based entity *or* must appear on the finalized list of MIPS measures *or* must be otherwise determined by CMS to be evidence-based, reliable, and valid. All A-APMs must report at least one outcome that meets these criteria.

- **The risk requirements for A-APMs have been extended for future program years.**
  A-APMs must adhere to the revenue-based on nominal amount standard. The 8% revenue-based nominal amount standard will remain in place through 2021-2024 performance period.
- **Multi-year flexibilities have been added in 2019 and 2020 for Other-Payer A-APMs.**
  Once a multi-year payment arrangement has been determined to be an Other Payer APM by CMS, the model will not need to be re-evaluated by CMS yearly unless there are substantial changes impacting its ability to meet APM criteria.

PARTICIPATION THRESHOLDS FOR A-APMs

In 2019, eligible clinicians must receive 50% of Medicare Part B payments or see 35% of Medicare patients through a **Medicare Advanced APM** to be considered a Qualifying Participant (QP). CMS will calculate both the payment amount and patient count thresholds and utilize whichever is most favorable towards achieving QP designation.

ALL PAYER COMBINATION OPTION

For eligible clinicians that participate in both a Medicare Advanced APM and an Other Payer Advanced APM, CMS will utilize the All-Payer Combination Option to count billing and patients from both types of A-APMs towards QP status.

CMS estimates that 4 APM entities, 8 TINs, and 80 ECs will utilize the All-Payer Combination option in 2019 to achieve QP status, though the use of this pathway is projected to grow in later years as additional Other Payer Advanced APMs are approved.

To achieve QP through the All Payer Combination Option:

1. Meet the Medicare minimum: Eligible clinicians or groups must meet a minimum volume through a Medicare APM. For 2019, eligible clinicians must receive 25% of Part B payments or see 20% of Medicare patients through a Medicare APM.

2. Meet the overall payment or patient count thresholds: Once the Medicare minimum has been met, CMS will evaluate whether a clinician meets the overall QP threshold. In aggregate, the eligible clinician or group should receive at least 50% of Part B payments or see 35% of Medicare patients through a combination of Medicare A-APMs and Other Payer A-APMs.

PAYMENT YEAR	2021	2022	2023+
QP PAYMENT AMOUNT THRESHOLD			
Medicare Minimum	25%	25%	25%
Total	50%	50%	75%
PARTIAL QP PAYMENT AMOUNT THRESHOLD			
Medicare Minimum	20%	20%	20%
Total	40%	40%	50%

PAYMENT YEAR	2021	2022	2023+
QP PATIENT COUNT THRESHOLD			
Medicare Minimum	20%	20%	20%
Total	35%	35%	50%
PARTIAL QP PATIENT COUNT THRESHOLD			
Medicare Minimum	10%	10%	10%
Total	25%	25%	35%

CMS will use the most advantageous threshold calculation—using either payment amount or patient count—to determine the Medicare minimum threshold. The All-Payer threshold will also be calculated based on the more beneficial method, regardless of which threshold was used to calculate the Medicare minimum. If CMS receives any combination of QP determination requests at the TIN-level, APM Entity level, or individual level, the agency will make QP assessments at all requested levels. QP status will be determined on the basis of the assessment that is most advantageous to the eligible clinician.

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