MACRA Alternative Payment Models

Medicare Incentives for New Models of Care

Some psychiatrists and other clinicians may qualify for Medicare incentives for participating in new models of care and delivery that improve quality, lower health care spending, or both. This is one of the two pathways of the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA). The other pathway is the quality reporting and incentive program known as the Merit-Based Incentive Payment System (MIPS). Both programs began with reporting in 2017 and lead to payment adjustments starting in 2019. Each fall, the Centers for Medicare and Medicaid Services (CMS) issues a final rule which establishes new regulations, policies, and guidelines for the program.

Who Can Earn APM Incentive Payments?

Qualifying Participants (QPs) are physicians, clinicians, and group practices with substantial revenue or patients in one or more "advanced" alternative payment models (Advanced APMs). They must appear on the Participation List of an APM Entity on March 31, June 30, or August 31 of the performance year.

APM Entities are entities that participate in an Advanced APM through direct agreement with CMS or another payer, or through federal or state law or regulation.

QPs and APM Entities enjoy three advantages:

- APM Entities that meet their targets are eligible to receive an annual 5 percent "APM Incentive Payment" each year from 2019 through 2024. This is given as a lump sum to the Medicare enrolled TIN (tax identification number) affiliated with the APM Entity. The amount is based on the total Medicare payments for Part B services in the prior year, for all QPs in that APM Entity.
- QPs are excluded from MIPS reporting requirements and MIPS payment adjustments, even after the Advanced APM incentives are no longer available.
- QPs receive slightly higher annual "updates" (increases) in their Medicare Part B payments starting in 2026. Their annual increase will be 0.75 percent, while others will receive 0.25 percent.

There are three routes to qualify as a QP, as determined through claims analysis:

- By receiving a major portion of their total Medicare payments for Part B services through an Advanced APM – at least 25 percent in 2017 or 2018; 50 percent in 2019 or 2020; and 75 percent in 2021 or 2022.
- By having a significant portion of their Medicare Part B patients in an Advanced APM – at least 20 percent in 2017 or 2018; 35 percent in 2019 or 2020; and 50 percent in 2021 or 2022.
- Starting in 2019, these criteria may also be met through participation in non-Medicare payment arrangements under the "All-Payer Combination Option."

Partially Qualifying Participants (PQPs) have a slightly lower percentage of revenue or patients tied to Advanced APMs than QPs. Their participation does not earn a 5 percent incentive payment (for their APM Entity), and PQPs do not qualify for the higher annual update that starts in 2026. However, PQPs who decide not to participate in the MIPS program are exempt from MIPS payment adjustments.

Eligible Clinicians are defined more broadly for Advanced APMs than for MIPS. They include physicians and all non-physician practitioners, such as clinical psychologists, clinical social workers, nurse practitioners, physician assistants, physical and occupational therapists, etc.

What is an Advanced APM?

CMS must approve all Advanced APMs. Every model must meet four threshold criteria in order to be considered for Advanced APM status:

- First, the model must be either approved by the CMS Innovation Center; or part of the Medicare Shared Savings Program; or a certain type of federal demonstration program.
- Second, the model must require its participants to use certified electronic health record technology (CEHRT). Any hospital within the APM must also use CEHRT.
- Third, the model must tie at least some payments to performance on one or more quality measures comparable to those under the MIPS program. These may include measures used by qualified clinical data registries (QCDRs). At least one outcome measure is required, if an appropriate MIPS outcome measure is available.
- Fourth, the APM Entity must agree to bear more than "nominal" financial risk for monetary losses. CMS may withhold, reduce, or require payment if expenditures exceed expected targets.

What is the Nominal Risk Standard?

Medicare and All-Payer Advanced APMs: Defining "nominal risk" for Medicare and All-Payer Advanced APMs depends on several factors. When an APM Entity includes hospitals, risk is defined using Part A and B revenues. If the APM Entity only includes physicians, only Part B revenue is considered.

- **Lower standards for some Medical Home Models:** Medical Home Models focus on improving primary care and include mostly primary care (or multispecialty) practices with primary care practitioners who offer primary care services.
    - The risk standards are lower for APM Entities that participate in CPC+ Round 1, and APM Entities with less than 50 eligible clinicians that participate in a Medical Home Model. They must risk losing at least 2.5 percent of the "average estimated total Medicare Parts A and B revenue of all providers and suppliers" in that APM Entity, for the 2017 performance period. This drops to 2 percent for 2018, then rises to 3 percent for 2019; 4 percent for 2020; and 5 percent for 2021 and later.
    - If the CMS Innovation Center expands any Medical Home Models, participants in those models will be exempt from the nominal risk requirement.
- **Higher standards for Other Advanced APMs:** For performance periods 2017 through 2020, APM Entities participating in other Medicare and All-Payer Advanced APMs must risk losing an average of at least 8 percent of the Entity's revenues under Medicare Parts A and B. This standard also applies to APM Entities that participate in a Medical Home Model and have 50 or more eligible clinicians. Standards for 2021 and beyond will be set in future rulemaking.

Special Rules for Medicaid Medical Home Models and Other Payer Advanced APMs: APM Entities in Medicaid Medical Home Models must risk losing at least 3 percent of average estimated total revenue of the participating providers (and other entities) for the 2019 performance period. This increases to 4 percent for 2020, and 5 percent for 2021 and later. Other Payer Advanced APMs are subject to special risk standards for marginal risk, total risk, and minimum loss ratio.

Which Models Qualify as Advanced APMs?

CMS has approved these models as Advanced APMs.

1. Bundled Payments for Care Initiative Advanced (BPCI Advanced) Voluntary Bundled Payment Model
    - Beginning in performance year 2019.
2. Comprehensive Care for Joint Replacement (CJR) Payment Model: Track 1 - CEHRT
3. Comprehensive End-Stage Renal Disease Care (CEC) Model: Large Dialysis Organization (LDO) and two-sided risk arrangements

4. Comprehensive Primary Care Plus (CPC+) Model
    - Participants that join CPC+ in 2018 must be in an organization with no more than 50 eligible clinicians to be considered in an Advanced APM.
5. Medicare Accountable Care Organization (ACO): Track 1+ Model
    - Beginning in performance year 2018.
6. Medicare Shared Savings Program ACOs: Tracks 2 and 3
7. Next Generation ACO Model
8. Oncology Care Model (OCM): Two-sided risk arrangement
9. Vermont Medicare ACO Initiative: Part of Vermont All-Payer ACO Model
    - Advanced APM status applies only to APM payments under Medicare.
    - Other payer arrangements will receive separate determinations.

Will There be More Advanced APMs in the Future?

The MACRA supports creation of a portfolio of APMs allowing participation by a broad range of physicians and other practitioners. More models are likely to be added in the future, but the process is slow and cumbersome. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) evaluates proposals for physician/clinician focused models with Medicare as a payer. Several have been recommended for testing and possible adoption. However, it will take time for these to be evaluated, and CMS has also terminated some Advanced APMs.

Starting with 2019 participation, arrangements under Medicaid, CMS-Multi-Payer Models, and Medicare Advantage Health Plans may qualify as "Other Payer Advanced APMs." This becomes an option for other payer arrangements starting in 2020. Those approved will be listed on the CMS website. The last year to qualify for 5 percent incentives is 2022, and the last year those will be given is 2024. But QPs will continue to be exempt from MIPS, and they will receive higher annual updates starting in 2016.

What Does This Mean for psychiatrists?

CMS projected only about 300 psychiatrists would qualify as QPs in Advanced APMs in 2017. CMS expects a total of 185,000 to 250,000 eligible clinicians to qualify as QPs in 2018 but gave no specific projections for psychiatry or other specialties. Psychiatrists who participate in a Medicare ACO may have the best chance of earning QP or PQP status. None of the current Advanced APMs focus on mental health or substance use disorders (MH/SUDs), although some have a mental health component. For

example, CPC+ encourages behavioral health integration; CPC+ practices can bill for collaborative care services; and Medicare ACOs have quality measures for depression.

The APA and other stakeholders are working to develop new payment and delivery models to improve care for patients with MH/SUDs. Unfortunately, the strict criteria for Advanced APMs, especially regarding financial risk and the use of CEHRT, are major hurdles. The record-keeping and reporting requirements are also extensive and complex. A fundamental issue is that most APMs are designed to eliminate wasteful spending and unnecessary services, while mental health care is plagued with poor access and inadequate payment. So the challenges and goals for new models of mental health care are very different from other APMs. CMS has also said that only states may apply for "Other Payer" Advanced APM status for Medicaid (Title XIX) plans. Applications will not be accepted from Medicaid managed care plans, which manage Medicaid MH/SUD benefits for many of the states. As a result, psychiatrists will likely continue to see few opportunities to participate in Advanced APMs or earn the related incentives.

RESOURCES

Where can I find other APA resources?

- The APA Payment Reform Toolkit is available at: psychiatry.org/PaymentReform.
- Information about the APA mental health registry, PsychPRO, is available at: https://www.psychiatry.org/psychiatrists/registry.

What CMS resources are available? CMS has many resources on the Quality Payment Program website (https://qpp.cms.gov) including:

- **QPP Resource Library:** https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html
    - **2018 QPP Final Rule Overview Fact Sheet:** https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf
    - **2018 QPP Final Rule Executive Summary:** https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf
- **APM Design Toolkit:** https://qpp.cms.gov/docs/QPP_APM_Design_Toolkit.pdf

Here is the website for the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee

What if I still have questions?

- APA members may consult APA staff experts by sending an email to qualityandpayment@psych.org, or by calling the Practice Management Helpline at 1-800-343-4671.
- CMS has a QPP Service Center that accepts questions from the public at QPP@cms.hhs.gov or 1-866-288-8292.