Advanced Alternative Payment Model Bonus Considerations for CMS

The Medicare Access and CHIP Reauthorization Act (MACRA) intended to accelerate the transition of traditional Medicare from fee-for-service (FFS) to advanced alternative payment models (APMs). To incentivize this transition, MACRA included a 5% bonus for qualifying participants in APMs that meet certain criteria. The intent of this incentive was to encourage increasing participation in advanced APMs over time.

Topline Request: CMS should ensure that MACRA's goals are achieved by holding the current patient count threshold stable for 2021.

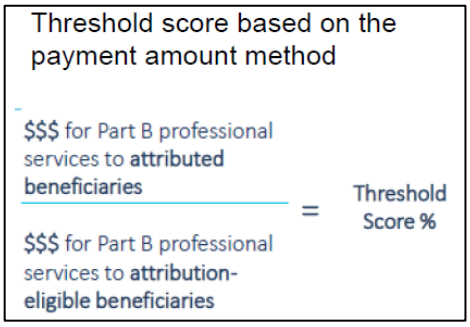
The MACRA Thresholds for Advanced APM Bonus Eligibility: HHS Retains Flexibility to Set Thresholds

To be bonus eligible, alternative payment models must meet certain criteria related to quality, use of electronic health records, and bearing financial risk. Also, advanced APM entities must meet specific threshold criteria—measured either by their percentage of revenue or patients—to achieve Qualifying APM Participant (QP) status. Meeting these thresholds allows advanced APMs to receive a 5 percent incentive payment and avoid the Merit-based Incentive Payment System (MIPS). Therefore, MACRA authors designed these thresholds to ensure increasing levels of participation in advanced APMs over time.

	2017-2018	2019-2020	2021 & Beyond
Medicare Payments	25%	50%	75%
Medicare Patients	20%	35%	50%

The MACRA statute established payment thresholds but *provided flexibility to the Secretary of HHS to set the patient count thresholds*.[1] CMS subsequently set the patient count threshold through regulations.[2]

To calculate the thresholds, CMS uses a formula that looks at the attributed beneficiary population over the attribution-eligible population (all beneficiaries that were attributed plus those that could have been but were not attributed). To determine the potentially attributable population, CMS includes beneficiaries that have had at least one evaluation and management service furnished by an eligible clinician or group in the APM.



[1] "The Secretary may base the determination of whether an eligible professional is a qualifying APM participant . . . by using counts of patients in lieu of using payments and using the same or similar percentage criteria . . . as the Secretary determines appropriate." Social Security Act, 1833(z)(2)(D).

[2] Note that there are other thresholds for consideration, including partially qualifying participant thresholds

The attributed population is determined depending on the model. For example, in Next Gen, beneficiaries are generally aligned based on whether they receive the plurality of their primary care services from a Next Gen participant provider.

The Problem: How the Thresholds are Working in Practice

While the escalating participation thresholds and the 5 percent incentive payment were intended to encourage greater participation in advanced APMs, the experience on the ground has been the opposite. This is in part because of the interplay between the mechanics of the attribution model in Next Gen with the calculation of the formula for the thresholds. The problem particularly impacts specialists participating in total cost of care models like Next Gen.

When a specialist is included as a participating provider, CMS aggregates all of the specialist's Medicare Part B claims for covered professional services for purposes of the MACRA threshold. This will include specialty services for patients who are attributed to the ACO, but also includes specialty services for patients who see a different primary care physician and therefore are not attributed to the ACO. Once the specialist provides eligible services, as defined by the QP Attribution Eligibility Criteria, the beneficiary becomes part of the "attribution eligible" denominator. Patients with no connectivity to the ACO will then be counted against the ACO in calculation of the MACRA threshold. In some cases, the ACO has no insight into where that patient receives primary care services and no ability to shift those patterns of care.

The remedy that many ACOs have used to address this flaw in the methodology is to remove specialists from their ACOs, thereby removing the impact that the specialists have on growing the denominator for the threshold calculation. However, this is the exact opposite result of what was intended when the MACRA thresholds were created: reducing rather than increasing the number of physicians and patients participating in APMs.

Lack of Transparency Hinders Provider Responsiveness

The problem of specialist attribution is compounded by a lack of transparency in the bonus calculation process. While ACOs are made aware of the number of Medicare patients, allowed charges, and covered services attributable to their participating providers, they are not readily informed whether the entirety of these patients and services are being applied in the ACOs threshold calculations. As discussed above, these calculations are especially important when it comes to attribution of specialist payments and patients. ACOs don't have enough information to determine how their participating providers are performing relative to the MACRA thresholds, and whether they are on track to achieve the incentive payment. A lack of timely, readily available information prevents ACOs from accurately planning and budgeting for future operations and expenses.

Response to COVID-19 Outbreak

The coronavirus outbreak and its impact on the American health care system present additional challenges for ACOs striving to meet the MACRA patient and payment thresholds. For many of us, resources have been redployed from our advanced APM work to COVID-19 work. An increase in the bonus payment thresholds places additional burden on APM participants to meet these levels at a time when all possible resources are devoted to combatting COVID-19.

Recommendations

The escalating MACRA thresholds were intended to continue to drive higher levels of participation in models over time. However, in practice, they are having the opposite effect – causing ACOs to drop certain types of providers from their networks. To address this problem, CMS should:

- Use its regulatory authority to freeze the patient count threshold at current levels.
- Provide ACOs and DCEs with advanced APM incentive payment information about amounts paid at the QP level.
- Provide a specific date range for when payments will be distributed.
- Create a process for APM entites and QPs to request corrections to their incentive payment amounts.
- Create a process for APM entities and QPs to determine their near real-time performance relative to the patient and payment thresholds.