Alternative Payment Models (APMs)
Advanced APMs and MIPS APMs
MACRA Final Rule Guide

On October 14, 2016, CMS released the final rule on the Quality Payment Program (QPP), which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The final rule establishes regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015. The new law changes the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

This guide summarizes the Advanced APM provisions of the final rule and includes information on MIPS APMs, which offer the opportunity for physicians participating in certain models to receive credit under the MIPS program. ASCRS has also developed guides on the full QPP and each of the four components of MIPS, and will continue to provide additional resources and training materials to assist ASCRS•ASOA members in complying with the program beginning January 1, 2017, for payment January 1, 2019.

What is an Advanced APM?

CMS is encouraging participation in Advanced APMs. Eligible clinicians who participate in advanced APM entities that meet certain revenue or patient thresholds each year will receive a 5% bonus for each year from 2019 to 2024. Advanced APMs are a subset of APMs that meet the requirements under MACRA.

CMS defines an Advanced APM as a model that:

• Involves more than nominal risk of financial loss,
• Includes a quality measure component, and
• Has the majority of participants using certified EHR technology (CEHRT).

Advanced APMs include Accountable Care Organizations (ACOs) with two-sided risk and medical homes expanded by CMS’ innovation center.

For 2017, to impact 2019 payment, the following are considered Advanced APMs:

• Medicare Shared Savings Program (two-sided models: Tracks 2 and 3)
• Next Generation ACO Model
• Comprehensive End-Stage Renal Disease (ESRD) Care (large dialysis organization arrangement)
• Comprehensive Primary Care Plus (CPC+)
• Oncology Care Model (OCM) (two-sided risk track available in 2018)

There are currently no ophthalmology specific advanced APMs. In addition, current available models are, for the most part, focused on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Track 1 ACOs, but since those models do not include two-sided risk, they are not considered advanced APMs and will not be eligible for bonus payments under the APM category. In the final rule, CMS noted that it was in the final stages of approving updated requirements for a Track 1 Plus model, which would incorporate a lower level of two-sided risk and is expected to be included in the list of approved models for 2018.
In future years, ophthalmologists may be able to participate in bundled payment models, such as for cataract surgery, built off of episode-based resource use measures currently under development. There are no formal proposals currently in development for ophthalmic surgery bundled payment models, but there are models in development for non-ophthalmic procedures. ASCRS is providing input to CMS through technical expert panels on the development of the episode-based resource use measures—particularly to ensure costs are accurately attributed and risk adjustment is included—and monitoring surgical community efforts to develop bundled payment APMs.

**Qualifying Participants and Partially Qualifying Participants**

To receive a bonus payment for participation in an Advanced APM, a provider, or group of providers billing through a common tax ID (TIN), must be considered a Qualifying Participant (QP). A provider’s QP status is determined by his or her participation in an Advanced APM entity that collectively meets certain revenue or patient thresholds.

For 2019, based on performance year 2017, providers are considered QPs for participating in an Advanced APM entity for which either:

- The collective Part B payments for services delivered by the Advanced APM entity’s clinicians to patients who are attributed to that entity is at least 25% of the payments for services delivered by the entity’s clinicians to all patients who could, but may not, be attributable to the entity (“attribution-eligible”).
- The collective number of patients who receive services delivered by the Advanced APM’s clinicians and who are attributed to that Advanced APM is at least 20% of the number of all patients who are attribution-eligible and received services delivered by the Advanced APM’s clinicians.

Clinicians participating in APMs that achieve those thresholds will be excluded from MIPS requirements. These percentages of payment amounts or patients required to qualify for the APM bonus will increase in future years.

Physicians participating in Advanced APM entities that fall short of requirements for the incentive payments, but meet lower thresholds, would be considered Partial QPs and able to choose whether they would like to receive a payment adjustment through MIPS. In order to opt out of the MIPS payment adjustment, the clinician must participate in an Advanced APM entity that collectively reached lower thresholds of Medicare payments or patients. For 2019 and 2020, the collective threshold is 20% of eligible Medicare payments or 10% of eligible Medicare patients for partial participation. Partial QPs do not qualify for the 5% bonus payment under the APM category.

If a physician participates in multiple Advanced APMs, and one of the APM entities he or she participates in does not meet the collective thresholds, CMS will determine if the individual physician’s total participation in multiple APM entities meets the thresholds for the year. If the sum of the individual provider’s participation in multiple entities hits the threshold, he or she receives the 5% bonus and is exempted from MIPS.

**Note:** All physicians must report through MIPS for the first performance year. CMS will calculate whether APM entities meet thresholds at the end of the performance year. In the final rule, CMS announced—to the extent possible—that if it can determine from historical data whether an APM entity is likely to meet the threshold, it will notify the participants and exempt them from MIPS.
Revenue or Patient Thresholds for Advanced APMs

CMS finalized thresholds for the percentage of eligible payments or eligible patients derived through Advanced APM entities.

Requirements for Incentive Payments for Significant Participation in Advanced APMs
(Advanced APM entities must meet payment or patient requirements.)

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MIPS APMs – Including Medicare Shared Savings ACOs Track 1

Physicians also have the opportunity to earn points in MIPS by participating in certain APMs and Advanced APMs that CMS determines to be “MIPS APMs.” Each year, CMS will release a list of MIPS APMs prior to the performance period.

For 2019, based on 2017 performance, CMS has approved the following APMs as MIPS APMs:

- Medicare Shared Savings Program Tracks 1, 2, and 3
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model

To earn MIPS points from a MIPS APM, a provider must:

- Be included in the participant list of a non-Advanced APM that CMS has determined to be a MIPS APM, or
- Be included in the participant list of an Advanced APM entity that did not meet the thresholds to be eligible for the bonus payment and, therefore, elect to participate in MIPS.

For models that CMS determines to be “MIPS APMs,” in 2017 participants will:

- Report the required quality measures for the APM through the APM entity (if an APM entity does not report data on behalf of individuals or groups participating in the APM, those physicians will be required to report quality data on their own);
- Report data for the Advancing Care Information Category on their own; and
- Automatically earn all of the total available points for the Improvement Activities category score.

MIPS APM Scoring Standard

Similar to determining the thresholds for participation in Advanced APMs, CMS will award the same final MIPS score to all the participants in a MIPS APM entity—including for data they reported individually or as a group under a single TIN. Under the terms of the models considered MIPS APMs, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, CMS will score the Advancing Care Information and Improvement Activities collectively as well. CMS will use an average score of all the participants’ scores for Advancing Care Information to determine a group score. All participants in the MIPS APMs will receive the same total available score for Improvement Activities.

For each model approved as a MIPS APM, CMS re-weighted the MIPS categories to reflect the design of the particular model.

- For all Medicare Shared Savings ACOs and Next Generation ACOs, category weights are: 50% Quality, 0% Cost, 20% Improvement Activities, and 30% Advancing Care Information.
- For all other models, category weights are 0% Quality, 0% Cost, 25% Improvement Activities, and 75% Advancing Care Information.
The MIPS APM entity’s final MIPS score will be applied to the participants in the entity at the TIN/NPI level. If a physician participates in multiple MIPS APMs, CMS will award that physician the score from whichever MIPS APM he or she participates in that has the highest final score.

**MIPS APM Participation**

Physicians may participate in MIPS APMs at the individual or group level. Not all physicians billing under a particular TIN are required to participate in a MIPS APM entity if one or more physicians billing under that TIN elects to participate in a MIPS APM. Certain specialties, such as ophthalmology, are permitted to participate in more than one ACO.

CMS will determine providers’ eligibility to be scored under the MIPS APM scoring standard by checking three times during the performance year to confirm that individuals or groups are listed on the APM entities’ participant lists. **CMS will check the lists on March 31, June 30, and August 30 of the performance year.**

If a provider is on the list at any time, he or she will be considered as participating in the APM entity. If a provider only participates in the APM entity for a portion of the year, but is only on the list at one or two of the designated dates on which CMS checks the list, he or she is still considered a participant.

**Other Payer APMs**

Other Payer APMs include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and other Medicare-funded plans. **Beginning in 2021** (performance year 2019), these other payers will count toward APM thresholds. However, the 5% bonus for significantly participating in an Advanced APM will be based on traditional Medicare and will not include Medicare Advantage payments.

**Additional Resources**

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@asco.org or 703-591-2220.