PANDEMIC

St. Louis Physicians at the Forefront

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Medicare Alternative Payment Models: What Choices Are Available to Physicians?

New programs offer more options

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The U.S. health care system is in the process of shifting from traditional fee-for-service payment to value-based alternative payment models (APMs).[1] APMs are one of two methods under the Quality Payment Program (QPP), in which providers may achieve positive payment adjustments based upon the achievement of various quality and performance measures.

APMs may provide an alternative to physicians and small medical groups in a similar geographic area that seek to remain independent (i.e., not employed by hospitals or medical groups), while providing them the opportunity to band together to take advantage of the larger economies of scope and scale inherent in bigger organizations, as well as allowing them to potentially increase their reimbursement. There are a variety of APM options from which to choose, which range as to the required level of shared savings, shared loses (i.e., risk) and covered beneficiaries, among others. This article will briefly discuss some of these options available to physicians.

1. Accountable Care Organizations (ACOs)

The ACO model holds groups of health care providers responsible for the quality and cost of health care delivery provided to a patient population.[1,2] ACOs that achieve spending and quality targets designated by payers then receive a share of the savings (or share in losses if they surpass the spending target).[3] ACOs are organized in a variety of legal and governance structures and can have varied contracts with payers (both federal and private), depending on the size and members of the ACO.[4]

Medicare Shared Savings Program (MSSP). The most widely used ACO program,[5] the MSSP is in the midst of a paradigm change. All new or renewing MSSP contracts had to shift to either the Basic Track or Enhanced Track beginning July 1, 2019.[6] Under the Basic Track, eligible ACOs participate in a "glide path" along five track levels, wherein they incrementally shift from a one-sided (upside risk only) model to a two-sided (upside and downside risk) model. There are some inducements for ACOs to move to higher-risk models, including:

- The SNF three-day waiver, which waives the requirement for an inpatient hospital stay prior to receiving SNF services;[7] and,
- The Beneficiary Incentive Program, which allows ACOs to directly furnish incentive payments to Medicare beneficiaries to ensure access to primary care resources.[8]

Advanced APM status is only available to MSSP ACOs assuming the most downside risk. Providers who participate in an Advanced APM do not have to participate in the Merit-based Incentive Payment System (MIPS), and those providers are eligible for an additional 5% incentive bonus.[9]

Next Generation ACOs. The Next Generation ACO (NGACO) model, established in 2016, aims to build upon the experience of the Centers for Medicare & Medicaid Services (CMS) in operating the Pioneer ACO Model and the MSSP.[10] While this model is generally similar to the MSSP, its primary differences are listed below:

- The minimum number of required beneficiaries is 10,000 (in contrast to the MSSP minimum of 5,000)
- The potential shared savings (rewards) and losses (risks) are greater than in the MSSP:
    a. Arrangement A allows shared savings/losses up to 80% for the first three-year contract, then up to 85%
    b. Arrangement B allows shared savings and losses up to 100%
- A minimum savings rate/minimum loss rate is not utilized
- The benchmark is configured utilizing a "hybrid approach" that takes into account historical and regional costs (instead of just historical costs).[11]

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Those providers that want to remain independent are seeking to relieve these financial and administrative burdens, in part, through teaming up with competing physicians in similar circumstances.

2. Direct Contracting Models

The directing contracting model builds upon both MSSP and the NGACO model, e.g., by introducing capitation, a new financial methodology with advanced benchmarking and an enhanced beneficiary alignment methodology.[12] Commencing in 2021, the new model may be appealing to a variety of providers, as it is more primary care focused and allows smaller entities to participate.[13] Moreover, the model aims to offer beneficiaries with complex chronic conditions more options and higher quality care.

Unique to the model is the structure of the value-based arrangements. Entity participations, referred to as direct contracting entities (DCEs), operate under a common legal structure, wherein one group contracts with CMS and effectively serves as a health plan administrator to its providers. The model focuses less on quality measures and more on outcomes and beneficiary experience.[14] There are currently two DCE participation options:

- **Professional:** The lowest risk-sharing arrangement, with 50% shared savings/losses. This option also requires participation in Primary Care Capitation, a risk-adjusted monthly payment for enhanced primary care services.[15]
- **Global:** The highest risk-sharing arrangement, with 100% shared savings/losses (full risk). This option also requires participation in either Primary Care Capitation or Total Care Capitation, a capitated risk-adjusted monthly payment for all Medicare services provided by participants.[15]

3. BPCI Advanced Model

On January 9, 2018, CMS launched BPCI Advanced, which qualifies as an Advanced APM.[16] In this program, participating providers can earn incentive payments for 35 different clinical episodes (31 inpatient and 4 outpatient) if all of the beneficiary's expenditures during that episode and the subsequent 90-day period fall below a specified spending target, while concurrently maintaining or improving upon seven specific quality measures. The initial version of BPCI Advanced runs through December 31, 2023.[17]

4. Other CMS Models

There are a number of other voluntary CMS payment models, for specific episodes of care, which qualify as Advanced APMs, including:

1. Comprehensive End-Stage Renal Disease Care (CEC) Model – *"designed to identify, test and evaluate new ways to improve care for Medicare beneficiaries with…ESRD"*
2. Comprehensive Primary Care Plus (CPC+) – *"a …primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation"*
3. Oncology Care Model (OCM) – *"payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients"*
4. CJR Payment Model – *"aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements."*[9]

Conclusion

The shift to value-based reimbursement, upon which APMs rely to incentivize providers to achieve better outcomes at lower cost, has caused independent physicians to experience tightening reimbursement at the same time they are being required to heavily invest in information technology that aggregates the requisite data required to report to payers. Those providers that want to remain independent are seeking to relieve these financial and administrative burdens, in part, through teaming up with competing physicians in similar circumstances, in order to pool their intellectual and management capital, e.g., resources, knowledge and skills, as well as their financial capital, to survive, and even thrive, in the face of this paradigm shift. Through APMs, those physicians who want to remain independent have a viable option going forward. To decide what is best for a particular physician or practice, CMS offers a number of technical assistance resources on their website. CMS suggests that those interested in joining an APM:

(1) *"Learn about specific [APMs] and how to apply;"* and,

(2) *"Apply to an [APM] that fits your practice and is currently accepting applications."*[18]

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