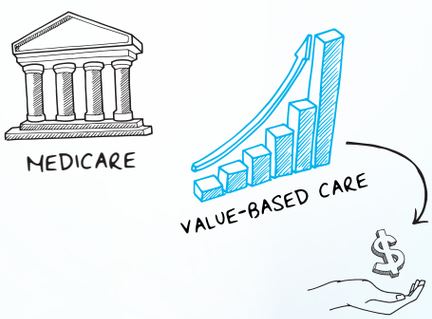
MEDICARE ADVANTAGE AND MACRA: ARE YOU READY FOR THE ALL-PAYER COMBINATION OPTION?

White Paper Part 1 of 3



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Introduction

A fundamental change is well underway in healthcare payment models, with a shift toward value over volume. While this transition is occurring industrywide, CMS is accelerating the pace of reform, largely through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This bipartisan legislation changes the way providers are reimbursed for traditional Medicare services through the Quality Payment Program (QPP), which over time ties an ever increasing portion of payment to quality.

Beginning in 2019, MACRA-modernized reimbursement methods will be extended to private industry payers, including Medicare Advantage, under the CMS All-Payer Combination Option.[1] Adopting payment models that align with this provision can help simplify administration, strengthen the fabric of trust between Medicare Advantage plans and providers, improve member/patient health outcomes, and enhance revenue for both plans and providers.

With Medicare-eligible beneficiaries increasingly choosing the Medicare Advantage option, such plans are on the path to becoming the predominant Medicare product offering. Enrollment in Medicare Advantage plans reached 35% of the Medicare-eligible population in 2017 (about 20 million) and is expected to rise to 50% by 2025 (about 38 million).[2] In this time of growth, plans should look strategically at untapped opportunity in value-based care and adopt payment models that can help support better member/patient outcomes and/or lower costs for older adult populations.

This is the first in a three-part white paper series that explores opportunities to leverage MACRA in Medicare Advantage. The second paper explains how to design advanced alternative payment models (A-APMs) that align with MACRA. The third paper discusses how to operationalize a collaborative approach with A-APMs to enhance success.

Complexity in Payment Models in the Shift to Value

Value-based payment (VBP) programs are shifting the focus of health plans from strictly managing healthcare (resource-oriented, fee-for-service contracts) to improving the overall measurable health status of the member (outcomes-oriented, value-based risk-bearing contracts). In this era of payment reform, some key questions Medicare Advantage plan executives should consider are:

- How can I differentiate between high-value and low-value care?
- How can I identify and reduce the low-value care?
- How should I view the 20% of healthcare costs that are not justified by medical evidence and are considered unnecessary care?[3]

These broad questions can be generally answered by implementing value-based care and payment programs. Nevertheless, specific strategies are needed today to put VBP into action and achieve success tomorrow. Medicare Advantage plans should review their current experience with VBP and their strategic plan for the future, evaluating where the healthcare industry currently stands and where it is heading in their markets. This can help determine the optimal timing and strategic implementation of both near-term and longer-term VBP approaches.

Today's healthcare providers are paid for healthcare services under a variety of models, which are generally categorized into four groups:

Category 1 – Traditional fee-for-service (FFS)
Category 2 – FFS with links to quality and value
Category 3 – Alternative payment models (APMs) using a FFS architecture
Category 4 – Population-based payment (PBP)

More advanced purchasing models, such as APMs (Categories 3 and 4), are intended to shift health risk management for attributed populations to provider groups allowing them to share in the upside gains or downside losses. Episode Payment Models (EPMs), also known as bundled payments, and shared savings through Accountable Care Organizations (ACOs) are some of the more popular examples. Further advanced risk-bearing models include PBP arrangements ranging from condition-specific (for example, Oncology Care Model) to comprehensive capitation where provider communities are wholly responsible and accountable for cost and quality outcomes for attributed patient populations.

The All-Payer Combination Option: Opportunity for Medicare Advantage

What is the All-Payer Combination Option under MACRA? Why should Medicare Advantage plans learn about it?

To understand how a Medicare Advantage plan can contract strategically in payment reform with providers under MACRA, one must first understand the criteria for a CMS A-APM, how providers qualify, and how Medicare Advantage plans can help providers achieve their volume thresholds through the All-Payer Combination Option.

For an APM to qualify as a CMS A-APM, it must meet the three MACRA statutory requirements:

- Providers are using certified electronic health record technology (CEHRT),
- Entity is using measures that are comparable to the Merit-based Incentive Payment System (MIPS), and
- The model bears "more than nominal financial risk" or is part of an expanded Medical Home Model under the CMS Innovation Center such as the Comprehensive Primary Care Plus (CPC+) model.

Nominal risk requires the A-APM to have marginal risk ≥ 30%, a minimum loss ratio capped at 4%, and total risk ≥ 3% of the expected A-APM expenditures. For 2018, CMS also added a revenue-based nominal risk standard for total risk of 8% for A-APMs under revenue models, effective through performance year 2020 (see Table 1 for examples of A-APMs that meet the MACRA standards for 2018).

Providers associated to the A-APM must then meet a two-part qualifier to be considered a Qualified Participant (QP) with a CMS-contracted A-APM. By qualifying for the A-APM track, providers are not subject to MIPS differential payments and are eligible to receive an automatic 5% bonus of their total Part B allowable charges. The A-APM in which a provider participates may meet the nominal risk standard, but the provider must also be running enough volume through the model to qualify for A-APM participation. The volume threshold for performance year 2018 is set at having ≥ 25% of the provider's Part B payments or ≥ 20% of their Medicare patients under the model.[4]

Effective January 2019, MACRA requires CMS to expand A-APMs into the private sector. Providers will be able to qualify for the A-APM track using the Medicare-only option or using the All-Payer Combination Option, which allows an eligible provider to use a combination of participation in A-APMs with Medicare and other payers to become a QP starting in the 2019 performance year. Specifically, the All-Payer Combination Option has three requirements for eligible providers to attain QP status:

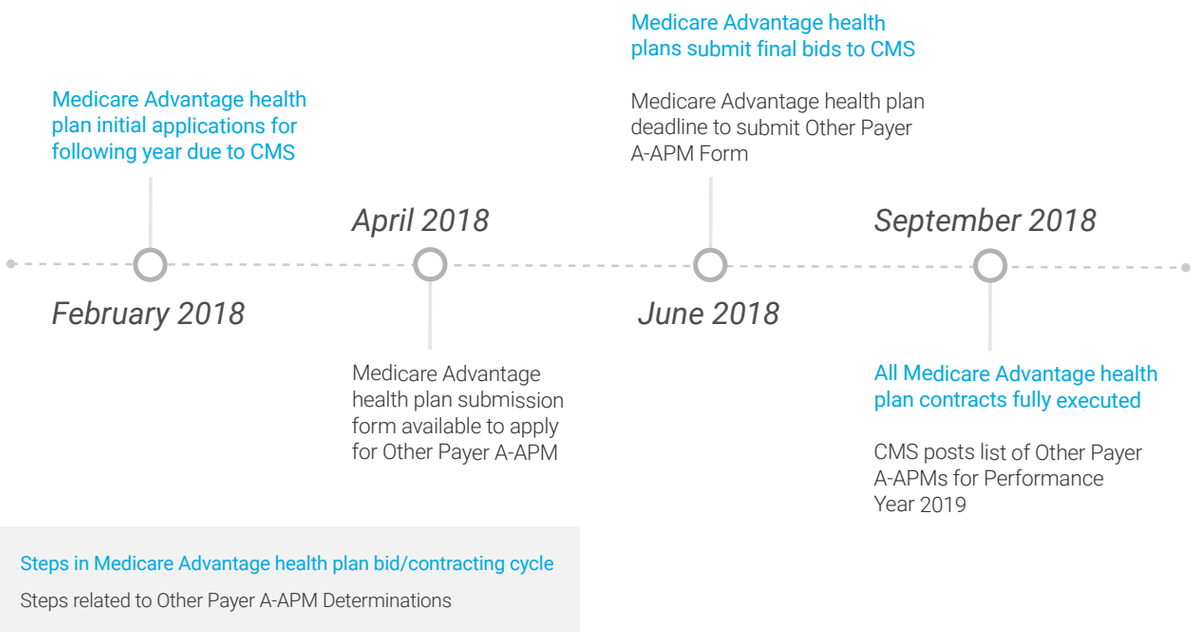
1. Sufficient participation with a Medicare A-APM,
2. Sufficient participation in an Other Payer A-APM, and
3. Data submission regarding the required payment amounts and patient counts.

The Other Payer A-APM thresholds require combined Medicare and Other Payer A-APM payments to total 50% of overall reimbursement or a combined 35% of their total patients.

This provision from MACRA – the All-Payer Combination Option – opens a new avenue for Medicare Advantage plans to work with providers in win-win partnerships. Aligning A-APMs with MACRA can help Medicare Advantage plans leverage APM momentum to accelerate advancement toward VBP. Measures can be harmonized to support other health plan objectives including Star Ratings and Healthcare Effectiveness Data and Information Set (HEDIS) performance. By adopting A-APMs that help providers meet their QPP requirements, Medicare Advantage plans can help strengthen relationships with providers and help them achieve the CMS lump sum 5% incentive payment.

To support the All-Payer Combination Option in performance year 2019, Medicare Advantage plans must initiate the process to become qualified with Other Payer A-APMs in 2018. CMS will make determinations related to Other Payer A-APMs prior to each QP Performance Period. The form for submission to CMS should be available to begin application by April 2018 with a June 2018 deadline for submission to CMS. CMS should make a decision to accept the proposed APM by September 2018. Other payer qualification will be made each year thereafter following a similar cadence.

TIMELINE FOR MEDICARE ADVANTAGE AND OTHER PAYER A-APM DETERMINATIONS FOR PROVIDER PERFORMANCE YEAR 2019



CMS estimates that in 2018 about 300 other payers will initiate this vetting process, including 150 Medicare Advantage plans, 50 Medicaid plans, and 100 multi-payers.[1]

Considering the direction and timing for key aspects of VBP, Medicare Advantage plans have a substantial opportunity to improve relationships and help increase acceptance of value-based payment among providers by qualifying as an Other Payer.

The All-Payer Combination Option signals A-APMs as the ultimate, industrywide end-game for the purchase of health value. Each year as requirements to meet QP status become more enticing with higher rewards, recognition of value, and strong VBP alignment, providers will increasingly seek A-APM payment arrangements with MA or MA-PD plans. A focus on strong, mutually beneficial relationships with providers centered on shared goals for higher quality and lower costs can become a market differentiator for Medicare Advantage plans, thus helping these plans build stronger provider networks and greater member satisfaction.

Adopting Tested A-APMs Into Provider Contracts

As a Medicare Advantage plan, if you want to become an Other Payer, which A-APM models might you pursue?

A great deal of experimentation in payment innovation is occurring at the federal level under the Centers for Medicare and Medicaid Innovation Center (CMMI or Innovation Center), where CMS is testing a variety of APMs, including population-based payment models. Some of these APMs are risk bearing and meet the MACRA statutory and CMS regulatory qualifications for A-APMs. Medicare Advantage plans that adopt these tested models in their own contracts with providers can help minimize some of the complexity for providers in this volume-to-value transition.

Table 1 describes the recently announced 2018 CMS Innovation Center A-APMs for Medicare Advantage plan consideration.[5]

TABLE 1: POTENTIAL A-APM MODELS FOR MEDICARE ADVANTAGE PLANS

Name	Description	CMS Participants
Bundled Payments for Care Improvement (BPCI) Advanced	A new voluntary, retrospective EPM that will test 32 clinical episodes (29 inpatient and three outpatient) beginning October 1, 2018 and running through December 31, 2023. Payment will be tied to a target spend and quality performance.	Recently Announced
Comprehensive Care for Joint Replacement (CJR)	Hospitals are held financially accountable for quality and cost of a CJR episode that includes the acute and 90-days post-acute care. Services are tied to care associated with MS-DRGs 469 and 470. The model is mandatory in 34 metropolitan statistical areas, and entities are required to use CEHRT.	Mandatory for 377 Hospitals*
Comprehensive ESRD Care (CEC) Model	An End-Stage Renal Disease (ESRD) Seamless Care Organization (ESCO) of dialysis clinics, nephrologists, and other providers; accountable for Parts A and B spending and patient-centered care delivery.	37 ESCOs**
Comprehensive Primary Care Plus (CPC+) Model	A three-part payment system that includes a care management fee paid per member per month (PMPM) (risk-adjusted); performance-based incentive (prospectively paid with a retrospective reconciliation) based on experience, quality, and total cost of care; and Medicare Physician Fee Schedule payment. The model exists in 18 regions: AR, CO, HI, MI, greater Kansas City of KS and MO, MT, ND, NE, NJ, greater Buffalo of NY, North Hudson-Capital region of NY, OH and Northern KY region, OK, OR, greater Philadelphia region of PA, RI, and TN.	Practices: 2,893 Providers: 13,000+ Payers: 61

Name	Description	CMS Participants
Medicare Shared Savings Program (MSSP) ACO Track 1+	Accountable care model that contracts with a legal entity comprised of physicians, hospitals, and other patient resources to promote the Triple Aim with costs tied to the total Medicare spend per beneficiary for an attributed patient population. Track 1+ assumes a limited amount of downside risk – less than Tracks 2 and 3.	55
Medicare Shared Savings Program (MSSP) ACO, Tracks 2 and 3	Accountable care model that contracts with a legal entity comprised of physicians, hospitals, and other patient resources to promote the Triple Aim with costs tied to the total Medicare spend per beneficiary for an attributed patient population. Tracks 2 and 3 share in both savings and losses (Track 3 having higher risks/ rewards) with Medicare.	Track 2: 8 Track 3: 30
Next Generation ACO Model	The model is similar to MSSP ACOs but assumes higher levels of financial risk and offers greater rewards. It includes care management and patient engagement measures, has strong patient protections, and includes benefit enhancement waivers for telehealth, post-discharge home visits, and three-day skilled nursing facility.	58
Vermont Medicare ACO Initiative	State-specific, Medicare ACO initiative that includes Medicaid, based on the Next Generation ACO model.	1

*There are 491 CJR eligible hospitals, but 114 hospitals were exempt due to low volume, rural area practice, and/or participation in a previous CMS BPCI program.
**This number reflects the total number of contracted entities; however A-APM status only applies to ESCOs bearing two-sided risk.

Each of these models meets the three MACRA criteria to be considered an A-APM:

1. Use certified electronic health record technology (CEHRT)
2. Use quality measures comparable to MIPS
3. Either bear "more than nominal financial risk" or be part of an expanded Medical Home Model under the CMS Innovation Center

Incentivizing Quality and Value: The Role of MIPS

With APMs playing such a prominent role, what does this mean for MIPS? Will MIPS remain a driver of VBP for provider networks?

MACRA is a Medicare cost containment law that repealed the Medicare Sustainable Growth Rate formula. Effective January 1, 2019, the Medicare Physician Fee Schedule (MPFS) becomes frozen. If eligible providers want to earn more than the MPFS, there are two payment paths available: MIPS or an A-APM. Both options are designed to incentivize value over volume.

Most providers will begin on the MIPS path, representing the first step toward departure from the MPFS wherein eligible providers will be paid differentially based on a Composite Performance Score (CPS). The CPS is calculated on earned points from 0-100 achieved in four weighted measurement areas (see Glossary for more information about MIPS). CMS estimates that approximately 621,700 providers will be impacted by MIPS in 2018. In contrast, CMS estimates that 185,000-250,000 eligible providers will participate in an A-APM and be exempt from MIPS in 2018.

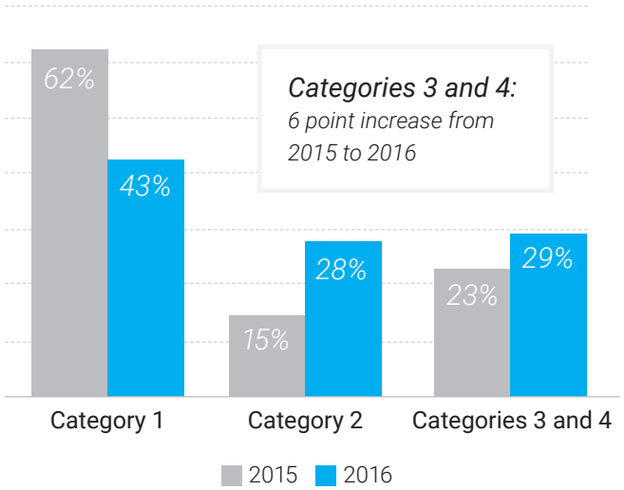
Medicare Advantage plans should be aware that the MIPS program may be replaced if the Medicare Payment Advisory Commission (MedPAC) recommendation is pursued. In mid-January 2018, MedPAC voted 14-2 to end MIPS due to what it believes are flaws in the measures, the program's complexity, and the reporting burden it places on providers. MedPAC is proposing a Voluntary Value Program that would operate on a withholding basis (2% suggested) that would measure a larger group of providers for value-payment eligibility. Although designated as "voluntary," non-participation would result in a loss of the withheld dollars.[6]

Payment Reform and APM Adoption Industry-Wide

With this view into where the CMS is heading with payment reform, what is happening in the rest of the industry? CMS programs are undergoing a great amount of change, so what other trends indicate this is an opportune time to adopt A-APMs in contracts with providers?

CMS is facilitating the move to pay for value over volume. But CMS is not alone. The shift toward VBP is occurring industrywide. Notably and particularly relevant to Medicare Advantage plans that are preparing for strategic alignment in VBP contracts with providers, participation in APMs is on the rise. The Health Care Payment Learning and Action Network (HCPLAN) annual health plan survey showed that by the end of 2016, around 29% of healthcare payments had moved into APMs or population-based payment.[7] An earlier HCPLAN analysis shed some light on this percentage specifically for Medicare Advantage plans, estimating 41% of Medicare Advantage healthcare dollars had moved into APMs such as population-based payment models.[8]

FIGURE 1: *DOLLARS SHIFTING AWAY FROM FFS TOWARD APM AND POPULATION-BASED PAYMENTS*



Approximately $354.5 billion in national healthcare spending was paid through APMs in 2016.[9] This represents a 6% increase from 2015 (see Figure 1) and reveals the opportunity that exists for Medicare Advantage plans today.

With the use of APMs and population-based payment poised to accelerate, this is an advantageous time for Medicare Advantage plans to continue on the path to adopting APMs. The MACRA 2018 final rule will advance APMs industrywide as provisions begin to impact other payers beyond traditional Medicare. This regulation sets forth the process for health plans and providers to align with advanced APMs effective January 2019. Whether a Medicare Advantage plan is currently contracting with providers through A-APMs or planning to do so in future, MACRA alignment can enable long-term program sustainability and provider success.

Conclusion

All segments of healthcare are moving toward value-oriented reimbursement models. MACRA is accelerating this transition in Medicare and creating incentives and a favorable environment for Medicare Advantage and other plans to succeed with value-based contracts. Now is an opportune time for Medicare Advantage plans to align strategically with the direction in value-based payment. As providers become incentivized to enter risk-sharing arrangements, this may accelerate their acceptance of risk-sharing with Medicare Advantage plans, particularly those plans that are aligned strategically to help providers succeed with MACRA measures.

Glossary

APM and A-APM: Alternative Payment Model and Advanced Alternative Payment Model

An APM is a payment approach that gives added incentive payments to healthcare providers who achieve high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. A-APMs are a subset of APMs. In A-APMs, providers earn more for taking on some risk related to patients' outcomes.

ACO: Accountable Care Organization

An ACO is a group of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to avoid unnecessary duplication of services and prevent medical errors. When an ACO succeeds both in delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves for the Medicare program.

CPS: Composite Performance Score

The CPS is the total score for providers taking the MIPS path under MACRA and is used to determine positive, neutral, or negative payment adjustment. CPS is calculated on earned points from 0-100 achieved in four weighted measurement areas.

EHR: Electronic Health Record

An EHR is an electronic version of a patient's medical chart and includes clinical data relevant to a patient's care; for example, demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory results, and radiology reports.

To meet the CDC definition of a basic EHR, the following features must be present: patient history and demographics, patient problem lists, physician clinical notes, comprehensive list of patients' medications and allergies, computerized orders for prescriptions, and ability to view laboratory and imaging results electronically.

EPM: Episode Payment Model

Often referred to as a bundled payment, an EPM targets a specific spend to a group of providers for the multiple services patients receive during a defined episode of care for a triggered procedure or defined condition (for example, diabetes). Provider organizations enter into payment arrangements that include comprehensive financial and performance accountability during episodes of care.

FFS: Fee-For-Service

Providers receive a fee for each service rendered with no link to quality or value, typically tied to a contractually agreed amount.

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

In addition to reauthorizing the Children's Health Insurance Program, MACRA is bipartisan Medicare cost containment legislation that repeals the Medicare Sustainable Growth Rate formula – established in 1997 and never implemented – intended to be used to compute Medicare payments for physicians' services. MACRA created the new Medicare payment programs that have become known as the CMS Quality Payment Program, which changes the way Medicare pays providers, incentivizing value over volume.

MPFS: Medicare Physician Fee Schedule

A fee schedule is a complete listing of fees used by Medicare to pay physicians or other providers/suppliers during a given year. This list of fee maximums is used to reimburse providers on a fee-for-service basis.

MIPS: Merit-based Incentive System

MIPS is one of two payment tracks providers can choose under the Quality Payment Program. To be in the program, providers (physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists) who participate in MIPS receive a payment adjustment based on evidence-based and practice-specific quality data. Providers will be paid differentially based on a Composite Performance Score (CPS). The CPS is calculated on earned points from 0-100 achieved in four weighted measurement areas:

- Quality – Measures previously submitted to CMS under the Physician Quality Reporting System and consisting of 271 measures can be reported by providers using claims, uploaded CSV file, web interface, electronic health record (EHR) directly, or qualified registry.
- Resource Use – Data is analyzed from claims.
- Advancing Care Information – Formerly known as the CMS EHR Incentive Program or "Meaningful Use," there are 11-15 measures reported through attestation and similar vehicles as under Quality, but relate to health IT adoption and use.
- Improvement Activities – These measures focus on patient-centeredness and engagement, including 112 available activities reported using attestation, qualified registry, and/or EHR directly.

PBP: Population-Based Payment

PBP is the most comprehensive form of payment in the spectrum of VBP arrangements. In this payment model, providers are rewarded for meeting targets for specific populations for either condition-specific care or comprehensive care. Payment and risk are shared across the provider community based on the collective care and health status of the patient. PBP models reside in payment Categories 3 and 4 in the CMS and Health Care Payment Learning and Action Network payment classification. PBP models in both categories hold providers accountable for the full continuum of patient care, from preventive to end-of-life care. The models are structured to encourage providers to deliver high-quality, well-coordinated, person-centered care within a defined population-based budget.

QP: Qualified Participant

QPs are providers who qualify for the CMS Quality Payment Program's A-APM track by having enough volume run through a recognized CMS A-APM arrangement. QPs are not subject to MIPS differential payments and are eligible to receive an automatic 5% bonus of their total Part B allowable charges for the performance year. To qualify, they must have a certain percentage of Part B payments for professional services or patients furnished part B professional services through an A-APM.

QPP: Quality Payment Program

The QPP is a new system of payment created by CMS under authority granted by MACRA for providers who care for Medicare patients. With this system of payment, MACRA changes the way Medicare rewards providers, focusing on value over volume. The QPP has two payment tracks providers can choose from: A-APMs or MIPS.

VBP: Value-Based Payment

VBP programs tie healthcare provider compensation to measurable improvements in quality of care, member/patient health outcomes (including experience), and cost or resource use, often in a risk-bearing relationship.

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