Proposed MACRA Rules: Your APM Strategy for Risk Readiness

written by Theresa Hush | June 8, 2016

If you chose not to participate in Medicare ACOs or Bundled Payments in recent years, CMS is planning to change your mind. Proposed MACRA Rules reveal a complex carrot-and-stick approach to inducing providers into risk models. Make no mistake: it's just a matter of when, not if, you participate in one of the Alternative Payment Models (APMs).

It will pay (literally) to begin planning your path to risk now. Here are five important provisions in the Proposed Rules that you need to understand:

> Full qualification as an Advanced APM earns a 5 percent lump sum bonus, exemption from participation in MIPS, higher fee schedule updates and incentives through your APM. These are the carrots, and CMS is counting on these to encourage participation in higher risk APMs. But here's the fine print:
> Only an Advanced APM can exempt providers from the need to participate in MIPS completely. If you are currently participating in a Medicare ACO or other APM model, you may think you're already covered and can continue your PQRS exemption into the MIPS world. Unfortunately, this is not always true. Your ACO has to meet a higher bar for risk, called an Advanced APM, in order to qualify you for this exemption, and your revenues and patient count need to be significantly tied to APMs. But if you are in a MSSP Track 1 ACO, you will still need to participate in MIPS; however, the calculations for your MIPS scoring will be tied to your ACO. With other APMs, such as Bundled Payments for Comprehensive Joint Replacement and Million Hearts, the providers must participate in the full MIPS program solely tied to their group performance.
> Under any Advanced APM, participating provider groups must bear some risk. The

Proposed Rules require that risk be tied to the difference between expected and actual expenditures, and that at least 30 percent of this must be borne by the APM and flow down to participating provider entities. Total risk for any APM participating group must amount to 4 percent of expected total expenditures of attributed patients. But the APM can waive application risk to providers at minimal spending over expected levels.
Your options to participate in an Advanced APMs will be limited in Year 1. Most ACOs right now do not pass along risk to providers based on expenses. The list of Advanced APMs include ACOs (Track 2 and 3 Medicare Shared Savings Program), Next Generation ACOs, Pioneer ACOs, Oncology Care risk models, End Stage Renal Disease models, Comprehensive Primary Care Plus and some Patient Centered Medical Home models.
Most providers will participate in MIPS in 2017, even those in APMs. Few ACOs will qualify as Advanced APMs, and CMS will calculate providers based on MIPS data. But for Shared Savings ACO participants, the process will not change much from current quality reporting under the ACO. Furthermore, you will not be separately penalized for the resource use (one of the MIPS scoring areas) apart from the ACO's own internal arrangements for applying incentives or sanctions.

What You Can Do Now

1. You are starting from zero.

If you didn't participate in PQRS reporting as the penalties continued to go up, or you participated by a claims process—and/or you never realized that you were also penalized under the Value Modifier program—it's time to catch up. Like it or not, you will be participating in MIPS. The program is broader and so are the ramifications for your revenues and patients.

First, it's time to make arrangements as to how you will meet the reporting requirements for quality, clinical performance improvement activities and advanced use of your EHR. CMS will calculate your cost score based on claims. Having a vendor—and the key is ongoing access to your continual performance results—will help you not only to meet reporting, but also to begin focusing on performance. Your options are:

Qualified Registry;
Qualified Clinical Data Registry (QCDR);
Your EHR;
CMS Web Interface, if your group is large;
Take your chances by "flying blind" and let CMS calculate your quality.

If you are a larger group, you will also need to use a qualified survey vendor to report your patient satisfaction, or CAPHS, results. You will need to get familiar with the regulations, how you will be scored and what this could mean to your revenues.

2. You participated in PQRS and Meaningful Use previously and are not in an APM.

Many providers looked at PQRS and MU as bureaucratic hoops and did not recognize that they were also tied to performance measurement incentives and penalties in the Value Modifier. All of that is now part of MIPS. Even if you're not participating in an ACO, fully participating in MIPS is your game plan for readiness for an APM later, should you have a good option to participate.

The four scoring components under MIPS—Quality, Resources, Clinical Improvement, and Advancing Care Information—will be more integrated, but the value of MIPS comes from using the data throughout the year to evaluate and improve performance. Take these two steps to realize this value:

> Create a strong performance improvement process for your organization, with focus on patient outcomes and resources used to generate those outcomes; and
> Adopt technology to help you track and improve performance, determine what is working, and see performance change (or not) over time. The two most viable options are the QCDR and your EHR. Both are already involved in MIPS and can help you build your population health and improve performance. Note, however, that they are very different and each has unique circumstances for best fit.

3. You are already a participant in an APM, but you are not at risk.

This scenario applies to the vast number of providers who are in ACOs, but are in Track 1. Over time, these APMs will evolve and adopt a stronger risk model in order to provide the incentive to their providers to continue participation. Also, it is likely that networks will adopt multi-risk models to optimize outcomes and costs, consisting of ACOs, specialty providers in Bundled Payment APMs, with central primary services under one or more core Patient Centered Medical Homes. What do you need to do?

> Understand your MIPS scoring profile, especially your quality and cost scoring. Participating in MIPS will help you calculate where you are compared to your ACO partners (and also help to determine your risk in that partnership). In 2016, prepare by evaluating your practice QRUR to see where you stand. And speaking of your own QRUR, has the APM shared similar reports of other providers? Since you will be bearing risk based on how everyone performs, it's crucial to ask for some data on the entire group. Evaluate your participation method with the APM. Are all the providers in your group participating, and are you localized in your geographic area or spread out among various regions? Your qualification as an Advanced APM provider will be based on a composite of all your APM participations, plus which ones are advanced. Engage a consultant to assist

in the calculation of your optimal participation strategy.
Engage with your ACO on the areas that will impact CMS calculations about your APM:

Quality—Is it a once-a-year measurement process, or do you have an ongoing method of tracking clinical quality services and patient outcomes?
Resources—Are you sharing data on costs in the ACO, and how are you targeting areas of improvement? What tools are you using to help hone your solutions to resource issues, and what interventions are being tested?
Clinical Performance Improvement Activities—Are you just doing the basics, such as patient outreach? What processes and technology are you using to really improve outcomes (see above recommendations for providers not yet in APMs)?
Benchmarking, risk adjustment, and data outside your area—Are you participating in public health reporting and other efforts that will improve your capabilities for managing patients, and making the most of your native EHR capabilities for connectivity?

Review your technology and solutions. Many ACOs overspend here, reaching for something that can do it all. Choose instead multiple best-of-breed solutions that can help you test and innovate on a small scale before a comprehensive roll-out.

4. You are already participating in an Advanced APM.

If you are in this rare group, chances are that you are already somewhat familiar with risk and what it will mean to you. But there is always more to master. Now is the time to make sure that you have the tools for risk readiness described for providers who are not as far along the spectrum. Everyone is still learning about all the different risk models, even if you are already in one that includes risk.

As the stakes get higher—and they will—every provider must understand how to participate in a program where every dollar of resources is counted for what it provides to patients. The CMS Quality Payment Program model is based on a fundamental principle: Costs can be controlled while maintaining quality; this is achieved by capping costs through risk. Whether that risk is voluntarily structured (APMs) or legislated (MIPS) is up to you, but one thing MACRA has made very clear: you are no longer writing the rules.

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