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# **IMPLEMENTING ALTERNATIVE PAYMENT MODELS UNDER MACRA**

***How the Federal Government  
Can Accelerate  
Successful Health Care  
Payment Reform***

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First Edition

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# Implementing Alternative Payment Models Under MACRA

## EXECUTIVE SUMMARY

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) creates two alternative paths by which Medicare payments to physicians will evolve over the next decade:

- Under the **Merit-Based Incentive Payment System (MIPS)**, Medicare payments to physicians for individual services will increase or decrease by 4%-9% based on the physician's performance on measures of quality of care, resource use, clinical improvement, and use of electronic health records.
- Physicians participating in one or more **Alternative Payment Models (APMs)** will be exempt from MIPS, receive a 5% bonus, and receive higher annual increases in their Medicare payments.

MACRA creates strong incentives for physicians to participate in Alternative Payment Models, and it specifically encourages the development of "Physician-Focused Payment Models," in order to address the many problems with current payment systems that MIPS cannot solve.

The success of MACRA in improving the quality and affordability of health care services will depend heavily on how the Department of Health and Human Services (HHS) implements the provisions of the law relating to Alternative Payment Models and Physician-Focused Payment Models. There are three key areas where administrative decisions and resources could either encourage rapid development and implementation of innovative and successful payment models, or deter innovation and impede the progress in payment reform that Congress wanted to support:

- The regulations defining Alternative Payment Models and alternative payment entities.
- The processes used for soliciting, reviewing, and approving Physician-Focused Payment Models.
- The systems and resources available to implement Physician-Focused Alternative Payment Models.

### 1. Implementing MACRA Requirements for Alternative Payment Models

MACRA contains only a small number of requirements for Alternative Payment Models, each of which is defined in simple, broad language. The regulations implementing MACRA should also be simple and flexible in order to encourage innovation in payment reforms. There are three sets of interrelated requirements regarding Alternative Payment Models (APMs): (1) the types of alternative payment models that can be used; (2) requirements for the alternative payment entity receiving payments under the APM, and (3) the minimum proportion of a physician's services or patients paid for through an APM.

### Eligible Types of Alternative Payment Models

MACRA requires that an Alternative Payment Model be either a model defined in Section 1115A of the Social Security Act (other than a health care innovation award); part of the shared savings program in section 1899 of the Social Security Act; a demonstration under section 1866C; or a demonstration required by federal law. Section 1115A authorizes the use of any Alternative Payment Model that "addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures" and that is "expected to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending." Imposing any additional or more restrictive requirements in regulations than this would unnecessarily limit innovation.

### Requirements for Alternative Payment Entities

MACRA appropriately recognizes that in many cases, special organizational arrangements will need to be created in order to receive and allocate payments under an Alternative Payment Model, and it defines these as "alternative payment entities." HHS should avoid creating unnecessarily detailed regulations specifying the way alternative payment entities should operate, so that physicians and other providers have as much flexibility as possible to create efficient organizational structures that address their specific needs. However, for physician-focused alternative payment models, it will be important to require that alternative payment entities are controlled by physicians in order to ensure that the payments are used to support the physician practices and the care they deliver to patients.

**Level of Financial Risk:** MACRA requires that for Medicare payments, an eligible alternative payment entity must bear "financial risk for monetary losses" under an alternative payment model that is "in excess of a nominal amount." An alternative payment entity's "financial risk for monetary losses" under an alternative payment model should be defined as the potential difference between the amount of costs the entity incurs or is obligated to pay as part of the alternative payment model and the amount of revenues that it could receive under the APM. "More than nominal" risk for APMs should be defined using the maximum reduction amounts that are used in MIPS. In 2019, since a physician's payments could be reduced by 4% under MIPS even with no change in the physician's costs, an alternative payment entity should be viewed as being at "more than nominal financial risk" if the amount of costs that it incurs under an alternative payment model could exceed the amount of revenue it receives under the model by at least 4%. That threshold would then increase to 5% in 2020, to 7%

in 2021, and to 9% in the year 2022, since these are the maximum percentage adjustments in payment under MIPS in those years.

**Use of Electronic Health Records:** MACRA also requires that participants in an alternative payment model “use” certified EHR technology. The regulations regarding use of EHRs in APMs should only require that clinical data about the patients receiving care supported by the alternative payment model should be stored in a certified electronic health record system.

**Use of Quality Measures:** Finally, MACRA requires that payments under an APM be based on quality measures “comparable” to the quality measures in the MIPS program. MACRA does not require the measures to be *identical* to those used in MIPS, nor should HHS require them to be the same, since the appropriate quality measures used in conjunction with alternative payment models will frequently be different than those used in MIPS. Since MACRA permits a physician practice to choose which quality measures are most appropriate to assess the practice’s performance under MIPS, HHS should give physician practices and alternative payment entities similar flexibility to choose which quality measures are most appropriate to use as part of an APM. Since MACRA does not specify the method in which quality measures should affect a physician’s payment under an APM, and in particular, it does not require that the standards of performance or the methods of adjusting payments be the same as the approaches used in MIPS, HHS should allow flexibility for APMs to use different approaches for adjusting payments based on quality than the methods used in MIPS.

### Calculating a Physician’s Revenues/Patients in Alternative Payment Models

The default requirement under MACRA is to evaluate the extent of participation by a physician or other clinician in APMs based on the proportion of that provider’s *revenues* that are associated with APMs. However, MACRA also authorizes the use of a “patient approach,” i.e., counting the *number of patients* receiving care under APMs and calculating the percentages on that basis instead of based on revenues. In order to encourage maximum participation in APMs, HHS should give all physicians the option to determine whether their participation in APMs should be measured through the percentage of their revenue that is coming from APMs or the percentage of their patients being cared for through APMs.

## 2. Soliciting, Reviewing and Approving Physician-Focused Payment Models

In order to be exempt from MIPS and to benefit from the incentives for APM participation under MACRA, physicians will need to have at least 25% of their Medicare payments or patients coming from an alternative payment model by 2019. Most physicians will not be able to achieve this goal unless more rapid progress is made in developing and implementing new physician-focused alternative payment models in Medicare than has occurred to date.

In order to accelerate the development and implementation of new physician-focused alternative payment models, MACRA established a process whereby individuals and stakeholders could submit proposals for physician-focused payment models for review by the federal government. This process has five components: (1) establishment of criteria for Physician-Focused Payment Models; (2) creation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC); (3) authorization for submission of proposed models to the PTAC; (4) review of submitted proposals by the PTAC; and (5) review and response by HHS. The success of this process in developing an adequate number of physician-focused alternative payment models by 2019 will depend heavily on (1) the criteria that are established by HHS, (2) the information required for submission of proposals; (3) the timeliness of the review of submitted proposals, and (4) the willingness and ability of HHS to implement an adequate number of well-designed physician-focused alternative payment models.

### Criteria for Physician-Focused Payment Models

MACRA requires HHS to issue regulations specifying criteria for physician-focused payment models, including models for specialist physicians, by November 1, 2016. The goal of these criteria should be to enable as many physicians as possible to make improvements in care they have identified for as many of their patients as possible:

- Not every physician-focused payment model will be an alternative payment model and not every alternative payment model will be a physician-focused payment model. A Physician-Focused Payment Model should be defined as either (1) a method of paying physicians that meets the requirements for an alternative payment model under MACRA, or (2) a mechanism for compensating a physician for the physician’s services as an integral component of an alternative payment model being managed by an alternative payment entity as defined in MACRA.
- The criteria established by HHS for physician-focused alternative payment models should be kept as simple as possible in order to encourage as much innovation as possible. The only essential criteria are those needed to ensure that a proposed model meets the criteria for alternative payment models defined in MACRA.
- Although a key goal of alternative payment models should be to control Medicare spending, the criteria established by HHS for physician-focused payment models should not require that a proposal demonstrate immediate or significant savings, since that is not required by the law.
- The criteria established by HHS for physician-focused payment models should not require the use of particular payment systems, organizational structures, or processes for delivering care.
- Finally, the criteria established by HHS for physician-focused payment models should not include criteria that are designed primarily to limit the number of potential proposals.

## Information Required for Submission of Proposals for Physician-Focused Payment Models

MACRA authorizes submission of proposals for physician-focused payment models to the PTAC, but it does not specify the content of such proposals. The information required as part of proposals for physician-focused payment models should be kept to the minimum amount possible in order to encourage physician practices and specialty societies to develop and submit proposals, particularly small practices with limited resources. It is particularly important to avoid requiring submission of information that applicants cannot obtain or cannot obtain except at a very high cost. For example, it is usually impossible for physicians and other providers to obtain the type of data on Medicare spending needed to carry out simulations of the impact of payment models. HHS will need to provide data and technical assistance to those developing proposals in order for the PTAC to make a full evaluation and recommendation regarding the proposal.

## Timeliness of Reviews of Submitted Proposals

MACRA does not establish specific deadlines for review of payment proposals. Given the urgency of controlling healthcare costs and improving the quality of healthcare services, and given the widespread recognition that significant payment reforms are essential to delivering higher-value care, it is essential that HHS establish an aggressive timetable with clear deadlines for reviewing and approving proposals for Physician-Focused Alternative Payment Models.

## Implementing Physician-Focused Alternative Payment Models in Medicare

It would obviously be a tremendous waste of time and energy on everyone's part if desirable payment models were developed and recommended by the PTAC but not implemented by HHS. Consequently, it will be essential that HHS create the necessary systems and processes so that it can implement physician-focused payment models recommended by the PTAC.

HHS needs to establish a much different approach to implementing alternative payment models than it has been using to date. Although the Affordable Care Act created the Center for Medicare and Medicaid Innovation (CMMI) in 2010 in order to accelerate the development and implementation of innovative payment and delivery models, relatively little progress has been made in improving the ways most physicians and other providers are paid for their services due to the slow and burdensome process CMMI has used to implement new payment models. A complete re-engineering of the processes HHS uses to implement alternative payment models is needed to make them less burdensome for both CMMI and participants. This re-engineering process should start with the goal that is implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from alternative payment models in 2019, 50% of revenues in 2021, and 75% in 2023. HHS should then work backward from those dates and design processes and timetables that will

achieve the goals. To ensure that the MACRA goals are achieved, HHS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.

Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make the problems worse. To date, these payment models have not been very successful in reducing costs because they do not provide the kinds of support that physicians need to redesign care. New physician-focused payment models should not be required to use the same flawed approaches that are being used in current CMS payment demonstrations.

It has been difficult for CMS to implement some types of new payment models because of the limitations of current coding and claims systems, but Congress has recognized this, and MACRA requires HHS to develop and implement new “patient condition groups,” “care episode groups,” and “patient relationship categories.” Codes for these new groups and categories are to be included on the claims that physicians submit for payment beginning in 2018. In order for these groups, categories, and codes to enable the implementation of better alternative payment models, they need to be designed to support a much broader range of APMs than CMS is using today. To achieve this, condition groups, care episode groups, and patient relationship categories should be developed in collaboration with physician groups and medical societies as MACRA explicitly requires.

There will need to be multiple types of APMs in order for physicians in all specialties to participate and in order for all patients to benefit. At a minimum, HHS should create the administrative capabilities to implement seven different types of physician-focused APMs that can be used to address the most common types of opportunities and barriers that exist across all physician specialties. These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.
2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital

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tal or other facility to choose the most appropriate facility for the treatment and to give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.

5. **Warranted Payment for Physician Services.** This APM would give a physician the flexibility and accountability to deliver care with as low a rate of complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

HHS should begin immediately to implement the administrative systems needed to support all of these types of payment models. This would not only ensure that the APMs can be implemented by 2019, but it would encourage physician groups and medical specialty societies to design payment models in a common framework, which will reduce implementation costs for HHS. If there are insufficient staff or resources at HHS to support implementation of a sufficient number of new alternative payment models to enable all physicians to participate, additional resources should be provided to achieve the necessary "bandwidth." Failing to allocate sufficient resources to implement alternative payment models that will save money for the Medicare program would be penny wise and pound foolish.

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# I. MACRA AND ALTERNATIVE PAYMENT MODELS

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## A. What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015, commonly known as “MACRA,” was approved on a bipartisan basis by Congress<sup>1</sup> and signed into law by the President on April 16, 2015. In addition to repealing the Sustainable Growth Rate (SGR) formula, which had been annually threatening to make 25-30% cuts in physicians’ payments for services to Medicare beneficiaries, MACRA created two alternative paths by which Medicare payments to physicians would evolve over the next decade:

- **MIPS:** The default path is called the Merit-Based Incentive Payment System (MIPS). MIPS is a pay-for-performance system in which the standard amounts that a physician is paid for services provided to Medicare beneficiaries will be increased or decreased each year based on the physician’s performance compared to other physicians on a series of measures regarding quality of care, resource use, clinical improvement, and “meaningful use of certified EHR technology.”
- **APMs:** Alternatively, if a physician achieves a minimum threshold of participation in one or more Alternative Payment Models (APMs), the physician would (1) be exempt from MIPS, (2) receive a lump sum bonus equal to 5% of their total Medicare payments, and (3) receive a higher annual increase in the standard Medicare payment rates for all of their services than would physicians participating in MIPS.

## B. What are “Alternative Payment Models” and Why Do We Need Them?

The significant financial incentives MACRA awards to physicians who participate in Alternative Payment Models make it clear that Congress wanted to encourage physicians to participate in APMs rather than MIPS. However, these incentives are not the only reason for physicians to participate in APMs. Properly designed APMs can give physicians the ability to achieve far greater improvements in the quality and affordability of care for their patients than MIPS, because APMs can overcome the barriers to better care that exist in the current payment system in ways that MIPS cannot.

### 1. The Payment Barriers in Current Fee-for-Service Payments

The current fee-for-service payment system used by Medicare and most health plans to pay physicians and other providers has two serious weaknesses<sup>2</sup>:

- **Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians and other providers for many services that would benefit patients and help reduce avoidable spending. For example, there is generally no payment or inadequate payment for:
  - ◆ responding to a patient’s phone call about a symptom or problem, which could help the patient avoid the need for far more expensive services, such as an emergency department visit;
  - ◆ communications between primary care physicians and specialists to coordinate care, or the time spent by a physician serving as the leader of a multi-physician care team, which can avoid ordering of duplicate tests and prescribing conflicting medications;
  - ◆ communications between community physicians and emergency physicians, and short-term treatment and discharge planning in emergency departments, which could enable patients to be safely discharged without admission;
  - ◆ providing proactive telephone outreach to high-risk patients to ensure they get preventive care, which could prevent serious health problems or identify them at earlier stages when they can be treated more successfully;
  - ◆ spending time in a shared decision-making process with patients and family members when there are multiple treatment options, which has been shown to reduce the frequency of invasive procedures and the use of low-value treatments;
  - ◆ hiring nurses and other staff to provide education and self-management support to patients and family members, which could help them manage their health problems more effectively and avoid hospitalizations for exacerbations;
  - ◆ providing palliative care for patients in conjunction with treatment, which can improve quality of life for patients and reduce the use of expensive treatments; and
  - ◆ providing non-health care services (such as transportation to help patients visit the physician’s office) which could avoid the need for more expensive medical services (such as the patient being taken by ambulance to an emergency department).
- **Financial penalties for delivering a different mix of services.** Under current fee-for-service (FFS) payment systems, physician practices and other providers lose revenue if they perform fewer procedures or lower-cost procedures, but the costs of operating physician practices, hospitals, etc. generally do not decrease proportionately (if at all), which can cause financial losses. For many types of procedures, most of the savings payers experience does not come from the payments that are made to physician practices, so significant savings for Medicare and other payers can still be achieved without financially penalizing physician practices. The most severe impact under FFS is that physician practices and other providers do not get paid at all if they suc-

ceed in keeping their patients healthy and the patients do not need health care services.

## 2. The Weaknesses of MIPS

The Merit-Based Incentive Payment System (MIPS) created under MACRA does not directly solve the major problems with the fee-for-service system for physicians:

- **MIPS does not change the services for which payments are made.** MIPS does not create any new Medicare payments for high-value services that are not currently covered by Medicare; it can only adjust the size of payments for the services that are currently paid for under the current fee schedule. Under MIPS, if a physician achieved improvements in quality or overall resource use by delivering one or more unpaid services, the physician could potentially receive higher payments for other services that are paid for under fee-for-service, but there would be no assurance that the increased revenues from the higher payments on other services would be sufficient to cover the costs of delivering the unpaid services that were needed to achieve those revenues. If the delivery of an *unpaid* service resulted in the need for fewer *paid* services, the physician practice could receive less total fee-for-service revenue, even with higher payments due to MIPS. Moreover, under MIPS, a physician can only receive higher payments if other physicians receive reductions in their fee-for-service payments, so if all physicians were to deliver the unpaid services and achieve similar improvements in quality or resource use, none of them would receive higher payments, and their practices would incur net financial losses even though they had delivered higher-value care for their patients and the Medicare program.
- **MIPS makes arbitrary changes in payment amounts.** The adjustments in the amounts of payments under MIPS are fixed in size and cannot be changed to ensure they cover the new costs incurred by a physician practice to deliver services differently or to offset the losses resulting from delivery of fewer services. Under MIPS, if a physician practice improved the health of its patients so much that 10% fewer services were needed by the patient, the practice's payments could not be increased by more than 4-9%. This could cause the practice to suffer financial problems even though the majority of the savings achieved by the Medicare program were likely due to reductions in services other than those delivered by the practice itself, such as fewer laboratory tests, imaging studies, and hospitalizations.

The bonuses and penalties under MIPS may provide an “incentive” for physicians to try to improve quality or reduce overall spending, but since the barriers in the underlying payment system remain unchanged, a physician may not have adequate resources to achieve improvements, and the financial losses the physician practice experiences if it *tries* to improve care could exceed the penalties it would face for not trying at all.

## 3. The Advantages of APMs

In contrast, a properly designed Alternative Payment Model (APM) can directly address the barriers under the current payment system that prevent delivery of higher quality, more affordable care. For example, an APM could pay the physician practice directly for the costs of a high-value service that is not paid under the current Medicare fee schedule if the physician accepted accountability for using that service to achieve improvements in quality or reductions in overall resource use. An APM could pay the physician practice based on its ability to address the patient's health problem rather than based on how many or what types of services the physician delivers; this could protect the physician practice against financial losses when it finds ways to treat a patient's health problem in ways that reduce overall spending for Medicare and other payers.

To achieve these advantages, however, an Alternative Payment Model must be *properly designed*. The fact that a payment system is *different* from the traditional fee-for-service payment system or MIPS does not automatically mean that it is *better*. As discussed in more detail in Section III-F, many of the alternative payment models currently being implemented in Medicare not only fail to address the problems in the current payment system, they can actually make things worse for physicians who want to improve care and reduce spending. Moreover, many of the Medicare payment models are not applicable to small physician practices or specialty practices. Consequently, as discussed in more detail in Section III, MACRA specifically encourages the development of *physician-focused* payment models.

*The fact that a payment system is different from the traditional fee-for-service payment system does not automatically mean that it is better. Many of the alternative payment models currently being implemented in Medicare not only fail to solve the problems in the current payment system, they can actually make things worse for physicians who want to improve care and reduce spending.*

In order to be successful in improving care for patients, reducing spending for Medicare and other payers, and maintaining financial viability for physician practices – a physician-focused alternative payment model must have three characteristics<sup>3</sup>:

- a. **Flexibility in Care Delivery.** To be successful, a physician-focused APM must be designed to give physicians sufficient flexibility to deliver the services patients need in the most efficient and effective way possible. If the current payment system does not pay for specific services needed to improve outcomes or reduce spending on other types of services, the APM must authorize payment for those services.
- b. **Adequacy and Predictability of Payment.** To be both successful and sustainable, a physician-focused APM must provide adequate and predictable resources to enable physician practices to cover the costs of delivering high-quality care to patients. Achieving savings for Medicare and other payers is only a desirable goal if it does not jeopardize access to care or the quality of care for patients. Moreover, it is impossible for physicians to make investments in facilities and equipment and to recruit, train, and retain high-quality personnel if they cannot predict how much they will be paid for their services. Payments must also be appropriately risk-adjusted based on characteristics of patients that increase their need for services, and limits must be placed on the total amount of financial risk that physicians face.
- c. **Accountability for Costs and Quality That Physicians Can Control.** In order to be successful and sustainable, a physician-focused APM must also be explicitly designed to assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians should only be held accountable for aspects of spending and quality they can control or influence.

*The goal of physician-focused APMs should not be to simply shift financial risk from payers to physician practices, but rather to give physician practices the resources and flexibility they need to take accountability for the aspects of costs and quality they can control or influence.*

The goal of physician-focused APMs should not be to simply shift financial risk from payers to physician practices, but rather to give physician practices the resources and flexibility they need to take accountability for the aspects of costs and quality they can control or influence. Similarly, the success of a payment model in improving care does not depend on the amount of financial risk in the payment model, but on whether the payment model provides sufficient payment to enable physicians to take accountability for costs and quality that the physicians can control. In some cases, a small change in the current payment system, such as payment for a specific type of service in addition to existing FFS payments, may be all that is needed to support better out-

comes and lower overall costs. In other cases, a more significant change may be needed, such as restructuring payments for many different services delivered by multiple providers.

## C. What is Needed for Successful Implementation of Physician-Focused APMs Under MACRA?

Although the passage of MACRA in 2015 provided a statutory framework for the development and implementation of Physician-Focused Alternative Payment Models that could significantly improve both the quality and affordability of care, success will depend on how the Department of Health and Human Services (HHS) implements the law. This report describes three key aspects of implementation where administrative decisions could either encourage rapid development and implementation of innovative and successful APMs, or deter innovation and impede the progress in payment reform that Congress wanted to support:

- **The regulatory interpretations of MACRA's requirements regarding Alternative Payment Models.** Section II of this report provides a detailed description of what MACRA requires and discusses how those requirements should be interpreted and implemented.
- **The processes used for soliciting, reviewing, and approving Physician-Focused Payment Models.** Sections III A, B, C, and D of the report describe the processes that MACRA establishes for reviewing proposals for Physician-Focused Payment Models and how they could be most effectively implemented.
- **The systems and resources HHS needs to put in place in order to implement a sufficient number of properly-designed Physician-Focused APMs by 2019.** The final section of the report (Section III-F) discusses how to ensure timely implementation of an adequate number and diversity of successful Physician-Focused Alternative Payment Models.

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# II. DEFINING ALTERNATIVE PAYMENT MODELS UNDER MACRA

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## A. What MACRA Requires

MACRA created three sets of interrelated requirements regarding Alternative Payment Models (APMs). (See the Appendix for the full text of the APM provisions under MACRA.) Because MACRA is focused on how physicians and other clinicians should be paid and creates two choices for payment (MIPS and APMs), the law both defines what *qualifies* as an APM for physicians and it also defines minimum thresholds for an individual physician's or other clinician's *participation* in APMs.

1. **Requirements for the physician or eligible professional.** Beginning in 2019, in order to be considered a *qualifying APM participant* ("QP") (and thereby exempt from MIPS and eligible for bonus payments and higher payment updates) a physician or other eligible professional must either:

- a. receive at least 25% of their total Medicare payments for the covered professional services they furnish through an *alternative payment entity* (see point 2 below), or
- b. in situations permitted by the Secretary of HHS, deliver services supported through an alternative payment entity to at least 25% of their patients.

In 2021, the minimum percentages increase to 50%, and in 2023, the minimum percentages increase to 75%. However, beginning in 2021, the percentages can be met either in terms of Medicare payments alone or through a combination of Medicare payments and payments from other payers, as long as at least 25% of Medicare payments or Medicare patients (if permitted by HHS) are in APMs, and as long as the payments from other payers meet the requirements for non-Medicare alternative payment models (see point 4 below).

The law also allows physicians to be classified as a *partial qualifying APM participant* ("partial QP") if the percentages of participation are no more than 5 percentage points lower than the requirements needed to be a qualifying APM participant (i.e., the threshold for partial QP status would be 20% of Medicare revenues or patients in APMs in 2019, 45% of Medicare or total payments in APMs beginning in 2021, and 70% of Medicare or total payments in APMs beginning in 2023).

2. **Requirements for the alternative payment entity.** An *alternative payment entity* must:

- a. be participating in an *alternative payment model* (see point 3 below); and
- b. either:
  - (i) bear financial risk for monetary losses under the alternative payment model in excess of a nominal amount; or
  - (ii) be designated as a medical home expanded under Section 1115A(c) of the Social Security Act.

3. **Requirements for an alternative payment model under Medicare.** An *alternative payment model* for Medicare payments must:

- a. be a model defined in Section 1115A of the Social Security Act (other than a health care innovation award), be part of the shared savings program in section 1899, be a demonstration under section 1866C, or be a demonstration required by federal law;
- b. require participants to use certified EHR technology; and
- c. provide for payment for covered professional services based on quality measures comparable to the quality measures in MIPS.

4. **Requirements for an alternative payment model from payers other than Medicare.** The requirements for an alternative payment model from other payers differ slightly from the requirements for Medicare payments. In order to be considered as part of an alternative payment model, payments from non-Medicare payers are required to be made under "arrangements" in which:

- a. quality measures comparable to the quality measures in MIPS apply;
- b. certified EHR technology is used;
- c. with respect to Medicaid beneficiaries, the physician or eligible professional participates in a medical home that meets criteria comparable to medical homes expanded under Section 1115A(c) of the Social Security Act; and
- d. with respect to individuals not on Medicaid, the physician or eligible professional participates in an entity that bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

Note that MACRA does not in any fashion regulate or restrict the kinds of payment models that other payers can use to pay physicians or other providers. However, if a physician or other provider wants to count payments from non-Medicare payers toward the minimum proportion of revenues or patients needed to be considered a “qualifying APM participant” or “partial qualifying APM participant,” then those payments must meet the requirements in point 4 above. Other payment models from other payers may be beneficial for patients, payers, and the provider, but unless they meet the standards established in MACRA, they would not count toward the thresholds needed for physicians to be exempt from MIPS and to receive the payment bonuses and updates authorized under MACRA.

## B. How MACRA’s Requirements Should Be Implemented in Regulations

MACRA contains only a small number of requirements for Alternative Payment Models, each of which is defined in simple, broad language. If Congress had wished to create detailed requirements for the structure of APMs, it could have done so, since it created extremely detailed specifications for how the Merit-Based Incentive Payment System (MIPS) should be structured. Consequently, the small number of requirements for APMs in MACRA and the flexible language used to describe those requirements should not be seen as a void to be filled with extensive HHS regulations.

The following sections discuss how each of the requirements of MACRA should be defined in order to encourage as much innovation as possible in the development and use of APMs and to minimize the administrative burden on physicians and other providers in implementing APMs.

### 1. Eligible Types of Alternative Payment Models in Medicare

As noted above, MACRA requires that an Alternative Payment Model be either:

- a model defined in Section 1115A of the Social Security Act (other than a health care innovation award);
- part of the shared savings program in section 1899 of the Social Security Act;
- a demonstration under section 1866C; or
- a demonstration required by federal law.

#### a. Payment Models Under Section 1115A

Section 1115A was added to the Social Security Act in 2010 by the Patient Protection and Affordable Care Act. It established the Center for Medicare and Medicaid Innovation under HHS and defined a process for testing and expanding “innovative payment and service delivery models.” Section 1115A does not specifically discuss “alternative payment models,” so the provisions of that section only apply to APMs under MACRA to the extent that MACRA requires it.

What MACRA says is that a “model under section 1115A (other than a health care innovation award)” can be considered an “alternative payment model.” Section 1115A defines 24 different payment models (four of these were added by MACRA) but explicitly states that CMS is not limited to implementing only these models.<sup>6</sup> The only requirement in Section 1115A limiting which payment models CMS can select to implement is that “there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” MACRA presumably excluded Health Care Innovation Awards because they are not payment models *per se*, but rather they are innovative service delivery models supported with time-limited grant funds. Many of these projects have been successful in improving care and reducing costs but they cannot continue unless an alternative payment model is created to support them on an ongoing basis because of the barriers that exist in the current payment system.

Importantly, MACRA does *not* require that a payment model described in Section 1115A had to have been tested and evaluated by the Center for Medicare and Medicaid Innovation (CMMI) or expanded nationally in order to qualify as an alternative payment model. If Congress had wished to limit APMs to models that CMMI had evaluated or the Secretary had expanded, it could easily have done so. Indeed, in defining an alternative payment entity, MACRA specifies that the entity must either (a) bear financial risk or (b) be a “medical home expanded under section 1115A(c).” The phrase “expanded under section 1115A(c)” is not used anywhere in MACRA to restrict APMs, but is only used to automatically designate medical homes that are expanded under section 1115A(c) as alternative payment entities.

In addition, Section 1115A(b)(3) explicitly states that HHS shall **not** require that a model be budget neutral initially in order to implement it. It further states that HHS can continue implementation of a model as long as the model is **expected** to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending. If a payment model is not expected to achieve one of these goals, HHS is authorized to *modify* it as well as terminate it. There is no statutory limit on how long a payment model may be continued or how many times it may be modified before a final determination is made that it cannot achieve the statutory goals and that it must be terminated.

**MACRA does not require that a payment model has to have been tested and evaluated by the Center for Medicare and Medicaid Innovation (CMMI) or expanded nationally in order to qualify as an alternative payment model.**

Consequently, any APM that “addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures” and that is “expected to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending” should be viewed as an alternative payment model that meets the requirements of MACRA. Imposing any additional or more restrictive requirements in regulations would unnecessarily limit innovation.

#### b. Payment Models Under Section 1899

Section 1899 was also added to the Social Security Act in 2010 by the Patient Protection and Affordable Care Act.<sup>7</sup> It created a new Medicare payment program titled the “Shared Savings Program.” This is the statutory authorization that CMS has used to implement the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs). Consequently, the Medicare Shared Savings Program would qualify as an APM under MACRA.

Although the title of Section 1899 is “Shared Savings Program,” subsection 1899(i) allows HHS and CMS to use payment models other than shared savings to support ACOs. To date, CMS has not used this authority to implement any other payment models, but MACRA creates a new reason to do so.

Section 1899(i)(2) explicitly authorizes the use of “partial capitation” in addition to shared savings. The law states that under partial capitation payment, an ACO would be “at financial risk for some, but not all, of the items and services covered under parts A and B, such as some or all physicians’ services or all items and services under part B.” The law states that payments to an ACO for items and services for beneficiaries for a year under the partial capitation model should be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by HHS. Finally, the law permits, but does not require, HHS to limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk.

More significantly, Section 1899(i)(3) authorizes the use of “any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished” to Medicare beneficiaries. The only restriction is that payments must be designed in a way that does not result in Medicare spending more for the services covered by the payment model than would have been spent in the absence of the payment model.

Consequently, a wide range of payment models would be eligible to be considered as APMs under MACRA if appropriate changes are made to the CMS regulations that are currently used to implement Section 1899.

#### c. Payment Models Under Section 1866C

Section 1866C of the Social Security Act was added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Titled the Health Care Quality Demonstration Program, it was originally intended to last for a period of 5 years, but the time limit was removed by the Patient Protection and Affordable Care Act in 2010.

The Health Care Quality Demonstration Program authorizes the use of “alternative payment systems” for “health care groups.” There is no restriction on the nature of the alternative payment system, other than that the aggregate expenditures during the entire demonstration period must be no greater than what would have been expended otherwise.

A “health care group” can be either:

- a group of physicians
- an integrated health care delivery system; or
- an organization representing regional coalitions of physician groups or integrated delivery systems

Significantly, in addition to changes in payment, the Health Care Quality Demonstration Project authorizes modifications to the benefits available to Medicare beneficiaries under Medicare Parts A and B or to the benefits available through a Medicare Advantage plan. It also authorizes the Secretary of HHS to waive other requirements of the Medicare program.

CMS only implemented 3 demonstration projects under the law.<sup>8</sup> However, the authorization to implement additional projects remains in effect. Consequently, **Section 1866C could potentially be used to authorize APMs that cannot meet the criteria under Section 1115A or Section 1199.**

#### d. Payment Models Under Demonstrations Required by Federal Law

Congress has mandated a number of demonstrations over time. For example, the Affordable Care Act mandated a National Pilot Program on Payment Bundling. Payment models established under these demonstrations would qualify as APMs under MACRA. In some cases, there are time limits on the authorization of payment models under these demonstrations.

## 2. Requirements for Alternative Payment Entities

### a. Defining an Alternative Payment Entity

MACRA appropriately recognizes that in many cases, special organizational entities will need to be created to receive payments under an Alternative Payment Model. For example:

- Two different specialists in separate practices may want to share a bundled payment in order to support a collaborative effort to care for patients with specific kinds of health problems or combinations of health problems. To do so, they will likely want to create a new corporate entity (such as a limited liability corporation) to accept the bundled payments and then divide the revenues between the two practices.
- An independent physician practice and community hospital that want to jointly manage a bundled payment for all of the care delivered during a hospitalization may want to create a Physician-Hospital Organization (PHO) or other entity to receive and allocate the bundled payment.
- Multiple small physician practices who want to work together to manage an alternative payment model for a population of patients could create or use an Independent Practice Association (IPA) to accept the payment and allocate it among the practices.

HHS should avoid creating unnecessarily detailed regulations specifying the way alternative payment entities should operate, so that physicians and other providers have as much flexibility as possible to create efficient organizational structures that address their specific needs. However, for physician-focused alternative payment models (which are discussed in more detail in Section III below), it will be important to require that alternative payment entities are controlled by physicians in order to ensure that the payments are used to support the physician practices and the care they deliver to patients.

### b. Defining “More Than Nominal Financial Risk” for Medicare Payments

MACRA requires that for Medicare payments, an eligible alternative payment entity must bear “financial risk for monetary losses” under an alternative payment model that is “in excess of a nominal amount.”

#### How Should “Financial Risk?” Be Defined?

The term “financial risk for monetary losses” in MACRA clearly refers to *losses in the operations of the alternative payment entity*, not to losses or increased spending in the Medicare program. The gains or losses of the alternative payment entity are a function of both the *costs that the alternative payment entity incurs* to implement the model and the *revenues it receives under the model*. If the alternative payment entity hires or pays for new staff to deliver services to patients under the alternative payment model, if it acquires new or different equipment to deliver services, or if it incurs other kinds of expenses to implement the alternative payment model, and if

those expenses are not automatically or directly reimbursed by Medicare, then the alternative payment entity is accepting financial risk for monetary losses.

Although many people seem to think that “financial risk” is only associated with alternative payment models, there is financial risk involved in any payment system other than one which reimburses physicians or other providers for their actual costs. Today, physician practices incur financial risk for monetary losses under the fee-for-service payment system because the costs they incur for office space, equipment, and staff are not directly reimbursed by Medicare, and if the practice does not deliver enough services to generate fee-for-service payment revenues in excess of those costs, it could be forced to declare bankruptcy. **The measure of a good alternative payment model should not be how much it increases financial risk for physician practices and other providers, but rather how effectively it realigns their financial risk so that financial losses result from delivering lower quality care rather than fewer services.**

Financial risk cannot be defined simply in terms of the potential reduction in revenues the alternative payment entity could receive from Medicare. The alternative payment entity could easily incur monetary losses under an alternative payment model even if the entity has no obligation to repay losses that the Medicare program has incurred, as long as the entity could incur costs that exceed its payments. **For example, even under an “upside only” shared savings model, a physician practice or other provider incurs financial risk if it incurs costs to implement programs that are designed to reduce Medicare spending, since the provider could fail to qualify for the shared savings payment it needs to pay for those costs.**

It is also not appropriate to measure the amount of risk accepted by a physician practice or other provider in terms of the percentage change in total Medicare spending for which the provider is responsible. A small percentage change in Medicare spending could represent a very large percentage of a provider’s revenues, particularly the revenues of a small provider, and it would represent an even larger percentage of that provider’s *profit margin*. **Because the payments to a physician practice generally represent only a small percentage of total Medicare spending on a patient’s care, a physician practice could be forced out of business if it is held responsible for paying for even a very small percentage change in the total Medicare spending for the practice’s patients.**

*The measure of a good alternative payment model should not be how much it increases financial risk for physician practices and other providers, but rather how effectively it realigns their financial risk so that financial losses result from delivering lower quality care rather than fewer services.*

Consequently, an alternative payment entity's "financial risk for monetary losses" under an alternative payment model should be defined as the potential difference between the amount of costs the entity incurs or is obligated to pay as part of the alternative payment model and the amount of revenues that it could receive under the APM. The greater the costs it incurs or the lower the revenue it could potentially receive, the greater the financial risk it will face under the APM.

### **How Should "More than Nominal" Financial Risk Be Defined?**

If Congress had wanted alternative payment entities to accept *substantial* financial risk, it could easily have explicitly required that, so it is clear that in using the term "more than nominal financial risk," Congress did not mean "substantial" financial risk. Logically, "more than nominal" risk should also be significantly less than what would be considered "substantial" risk.

For 20 years, CMS has defined "substantial financial risk" for physician practices receiving payments from Medicare Advantage plans. Section 422.208 of the Code of Federal Regulations<sup>10</sup> defines "substantial financial risk" as a situation in which more than 25% of a physician practice's payment is at risk based on services that the physician practice does not deliver itself, or a situation in which capitation payments could vary by more than 25%. Consequently, the threshold for "more than nominal" risk in MACRA would need to be set well below a 25% variation in an alternative payment entity's revenues relative to its costs.

In MACRA, Congress has placed all physicians' payments "at risk" under the Merit-Based Incentive Payment System (MIPS). In the initial year of the program (2019), physician payments could be reduced by 4%, and the maximum reduction increases to 9% in 2022. These amounts are presumably "more than nominal" if Congress expected them to influence physician performance on the measures defined in MIPS, which includes resource measures.

Consequently, "more than nominal" risk for APMs should be defined using the maximum reduction amounts that are used in MIPS. In 2019, since a physician's payments could be reduced by 4% under MIPS even with no change in the physician's costs, an alternative payment entity should be viewed as being at "more than nominal financial risk" if the amount of costs that it incurs under an alternative payment model could exceed the amount of revenue it receives under the model by at least 4%. That threshold would then increase to 5% in 2020, to 7% in 2021, and to 9% in the year 2022, since these are the maximum percentage adjustments in payment under MIPS in those years.

### **c. Defining "More Than Nominal Financial Risk" for Commercial Payers**

As noted earlier, MACRA uses a somewhat different definition of financial risk for payments coming from payers other than Medicare or Medicaid. In order for such payments to count toward the 50% threshold beginning in 2021 and the 75% threshold beginning in 2023, the physician or other eligible professional must participate in an

entity that bears more than nominal financial risk "if actual aggregate expenditures exceeds expected aggregate expenditures." The proper interpretation of the term "aggregate expenditures" depends on the structure of the payment model itself. For example,

- If the physician practice is receiving a fixed bundled payment under the APM to cover a range of services for patients, then the term "aggregate expenditures" would apply to the practice's expenditures on those services for all patients covered by the APM. The amount of the bundled payment would typically be defined so that the aggregate revenues from the payments for all patients the practice cares for would be adequate to cover the practice's expected aggregate expenditures for services to those patients. **The practice's financial risk would then be defined as the maximum amount it has to spend if its actual expenditures exceed the bundled payment revenues.** The maximum will depend on whether the payer agrees to an outlier payment, "stop loss," or "risk corridor" limiting the amount by which the actual expenditures can exceed the payments.
- If the physician practice is being paid for individual services but the amounts of those payments are reduced if the aggregate amount of payments exceeds a threshold (e.g., an episode budget), then the term "aggregate expenditures" would apply to the payer's payments to the physician practice, and **the practice's financial risk would be defined as the amount by which its payments would be reduced if the total payments from the payer exceed the threshold.**

Once the method of calculating risk is defined for a commercial payment model, the same definition of "more than nominal" described in the previous section for Medicare payments can be applied to the risk under the commercial payments.

### **d. Use of EHR Technology**

MACRA requires that participants in an alternative payment model "use" certified EHR technology. After several years of HHS trying to define "meaningful use" of EHRs, there is widespread agreement that detailed requirements regarding how clinicians should use EHRs have increased costs and harmed quality rather than improving it. Since MACRA simply requires "use" of the EHR, **regulations regarding use of EHRs in APMs should only require that clinical data about the patients receiving care as part of the alternative payment model be stored in a certified electronic health record system.** It is impossible to prescribe how a physician or other provider should "use" the technology beyond this without potentially interfering with the provider's flexibility to deliver services in the most effective way or imposing unnecessary costs and administrative burdens on the provider. A physician practice participating in the APM will have a strong incentive to use the EHR if the EHR has capabilities that will improve the practice's success, regardless of any specific requirements imposed by HHS. Any specific requirements for "use" of EHRs that are imposed in regulations should be treated as a cost that increases the financial risk for a physician practice to participate in the APM if the cost is not explicitly supported by the APM itself.

## e. Use of Quality Measures

MACRA requires that payments under an APM be based on quality measures “comparable” to the quality measures in the MIPS program. **MACRA does not require the measures to be identical to those used in MIPS, nor should HHS require them to be the same;** indeed, the appropriate quality measures used in conjunction with alternative payment models should be expected to be different than those used in MIPS for two reasons:

- To the extent that quality measures are intended to protect patients against receiving low quality care, there will be different incentives for underuse, overuse, and misuse of services by physicians and other providers in an alternative payment model than under the current fee-for-service system. For example, more quality measures designed to protect against *underuse* of services may be needed in an APM that holds providers accountable for spending, whereas *fewer* quality measures designed to protect against *overuse* of services would be needed in the APM.
- To the extent that quality measures are intended to encourage improvements in care, physicians may be able to achieve improvements in different aspects of care using the flexibility and resources under an APM than they could under the standard physician fee schedule. As noted in Section I, many high-value services are not paid for today; the bonuses and penalties created under MIPS would not solve this problem, whereas an APM could enable one or more of these high-value services to be delivered, so different quality measures may be appropriate.

Not only should quality measures for APMs differ from those under MIPS, quality measures will differ for different APMs. Since different alternative payment models will focus on different types of patients and health conditions and will address different barriers in the current payment system, the appropriate quality measures for those APMs will also differ. **Since MACRA permits a physician practice to choose which quality measures are most appropriate to assess the practice’s performance under MIPS, HHS should give physician practices and alternative payment entities similar flexibility to choose which quality measures are most appropriate to use as part of an APM.**

If there are not evidence-based measures that are directly relevant to the aspect of quality that is of concern, HHS should not attempt to substitute for this by requiring the use of *irrelevant* quality measures, since this could jeopardize the success of the model. Instead, efforts should be made to develop appropriate measures as part of the measure development process created under MACRA. **If HHS requires the physicians or other providers in an APM to collect or report on quality measures in addition to those that are part of the design of the APM, the costs of collecting and reporting those measures should be treated as increasing the financial risk for a physician practice to participate in the APM.**

MACRA does not specify the method by which quality measures should affect a physician’s payment under an APM, and in particular, it does not require that the stand-

ards of performance or the methods of adjusting payments be the same as the approaches used in MIPS. **HHS should allow flexibility for APMs to use different approaches for adjusting payments based on quality than the methods used in MIPS.**

## 3. Calculating a Physician’s Revenues/Patients in Alternative Payment Models

The default requirement under MACRA is that the extent of participation by a physician or other clinician in APMs be evaluated by calculating the proportion of that provider’s *revenues* that are associated with APMs. However, MACRA also authorizes the use of a “patient approach,” i.e., counting the *number of patients* receiving care under APMs and calculating the percentages on that basis instead of based on revenues.

MACRA gives the Secretary of HHS the discretion as to whether and when to permit this approach. **In order to encourage maximum participation in APMs, HHS should give all physicians the option to determine whether their participation in APMs should be measured through the percentage of their revenue that is coming from APMs or the percentage of their patients being cared for through APMs.** In general, Medicare payments that are made directly to physicians represent only a small proportion of the total Medicare spending on the physicians’ patients. In some cases, the biggest opportunity for savings to Medicare may be associated with patients who represent only a small proportion of a physician practice’s revenues, and so it would be inappropriate to discourage a physician from participating in an APM for those patients simply because it affects only a small proportion of the physician’s own revenue.

In order to make the process as simple as possible for physicians and other eligible professionals, the thresholds could be defined as follows:

### a. Threshold Based on Percentage of Revenue

- Any payment that the physician or clinician receives directly from an alternative payment entity that is specifically related to the care of a Medicare beneficiary (or a patient of another payer, when calculating percentages of total revenues under APMs) should be counted toward the threshold. For example, if the physician or clinician is paid by the alternative payment entity based on the number or types of services delivered or the number of patients cared for, those payments would be counted toward the threshold.
- Any payment or portion of payment that the physician or other clinician receives from Medicare under traditional fee-for-service payment systems (or from another payer, when calculating percentages of total revenues under APMs) should also be counted toward the threshold if that payment, or the service or patient for which that payment was made, is part of an alternative payment model managed by an alternative payment entity. In addition, if the physician is eligible to receive a separate payment from the alternative payment entity and/or required to make a payment to the alternative payment entity based on the physician’s performance or the entity’s performance, any such

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payments made to the physician would be counted toward the threshold and any payments made by the physician to the entity would be deducted from the payments counted toward the threshold. For example, if the physician is part of a Medicare Shared Savings Program ACO or a retrospectively reconciled episode payment model as part of the CMS Bundled Payments for Care Improvement (BPCI) demonstration, the physician would be paid directly by CMS for his or her services, not by the ACO or BPCI episode initiator. If the physician shares financially in the reconciliation of any gains or losses under the payment model, then those shares should be counted as payments from an alternative payment model.

- If payments from the alternative payment entity are made to the physician's or clinician's practice and the practice then compensates the physician/clinician on a different basis than the way the payment to the practice is made, the practice would need to establish a method for calculating the proportion of the physician's/clinician's compensation that is derived from the payments made by the alternative payment entity. For example, if the physicians in the practice are paid a salary, then the fraction of their salary that is treated as coming from the Alternative Payment Entity could be calculated based on the proportion of the practice's revenues coming from the Alternative Payment Entity.
- The sum of all of these payments received during a period of time should then be divided by the total payments the physician or eligible professional received during that same period of time to determine whether that physician/clinician meets the threshold defined in the law. The physician/clinician should have the option of computing the payment thresholds on a cash or accrual basis, whichever is simpler for them.

#### **b. Threshold Based on Patient Counts**

- If all of the services the physician/clinician delivers to a particular patient are compensated through an alternative payment entity (or through the physician's/clinician's practice using payments made to the practice by the alternative payment entity), that patient should be counted 100% toward the threshold.
- If only a portion of the services the physician/clinician delivers to the patient are compensated through an alternative payment entity, then the physician/clinician should be able to partially count that patient toward the threshold. The fraction of the patient to be counted should be defined using a methodology established and approved as part of the alternative payment model.
- The sum of all of these "total patient equivalents" should then be compared to the total number of unique patients receiving services from the physician/clinician during the relevant period of time to determine whether that individual meets the threshold established in the law.

# III. DEVELOPING AND IMPLEMENTING PHYSICIAN-FOCUSED PAYMENT MODELS UNDER MACRA

In addition to the provisions defining APMs and participation thresholds that are described in Section II, MACRA contains provisions specifically designed to encourage the development and use of “Physician-Focused Payment Models.”

## A. What is a Physician-Focused Payment Model?

Some people have found the wording in MACRA confusing because it does not explicitly state that “physician-focused payment models” should be alternative payment models, nor does it require alternative payment models to be physician-focused payment models. It is unlikely that Congress was trying to define two completely different types of payment models in MACRA, but rather it was acknowledging the simple fact that not every physician-focused payment model will be an alternative payment model and not every alternative payment model will be a physician-focused payment model for the reasons described below. Moreover, it seems clear that MACRA intended that physician-focused payment models should be integrally related to alternative payment models, since the provisions governing physician-focused payment models are part of the section of MACRA titled “Promoting Alternative Payment Models.”

### Many, But Not All APMs Will Be Physician-Focused Payment Models

Not every alternative payment model will be “physician-focused” simply because many types of care will be delivered jointly by physicians and other providers. For example, in its Acute Care Episode Demonstration, CMS made a bundled payment to physicians and hospitals for inpatient orthopedic and cardiovascular procedures. The payment could only be paid to a Physician-Hospital Organization controlled jointly by the physicians and hospitals. This would easily meet the criteria for an alternative payment model with the PHO serving as the alternative payment entity, but the payment and the accountability for success were *shared* by the physicians and hospitals, they were not focused solely or primarily on physicians. In contrast, many types of care are delivered solely or primarily by physicians, and for these types of care, alternative payment models can and should be “physician focused.” For example, payments made to support primary care medical homes can be defined in ways that meet the criteria for alternative payment models, and the principal focus of these models will be on enabling primary care physicians to deliver better care to their patients and reduce spending by Medicare and other payers in the process, so they should clearly be considered “physician-focused.” Similarly, many specialists provide

all or most of their services in their offices, not in hospitals or other facilities; they need alternative payment models to give them the flexibility and resources to improve care for their patients, and those payment models would also clearly be “physician-focused” APMs.

### Physician-Focused Payment Models Are Also Needed Within Larger APMs

In addition, there is a need for methods of changing the ways that physicians are paid as part of larger alternative payment models. For example, in alternative payment models that involve bundled or global payments for services delivered by both physicians and other providers such as hospitals or home health agencies, there needs to be a way of compensating the physicians differently in order to overcome the barriers created by traditional fee-for-service approaches. This is particularly true when payment models are implemented with “retrospective reconciliation” approaches such as those used by CMS in its Shared Savings (MSSP) and Bundled Payments for Care Improvement (BPCI) programs. Under these models, the physicians and other providers delivering services as part of the Accountable Care Organization or the BPCI episode continue to be paid under existing CMS fee for service systems; the total spending relevant to the payment model is compared to a budget and then a reconciliation payment is made to the ACO or BPCI entity which it can then allocate among participating physicians and other providers. However, the individual physicians may not be able to change care in ways that will make the ACO or BPCI episode team successful if there is no fee-for-service payment (or inadequate payment) for one or more high-value services. A physician-focused payment model could involve making adequate Medicare payments for the currently unpaid or underpaid services in order to support the success of the overall ACO or BPCI episode team. These would certainly be “physician-focused payment models,” but they would not need to directly meet the criteria for an alternative payment model.<sup>9</sup>

### Defining Physician-Focused Payment Models

In light of the above, the following two-part definition for a Physician-Focused Payment Model could be used:

**A Physician-Focused Payment Model is either:**

- (1) a method of paying physicians that meets the requirements for an alternative payment model under Section 1833(z)(3) of the Social Security Act, or**
- (2) a mechanism for compensating a physician for the physician’s services as an integral component of an alternative payment model being managed by an alternative payment entity as defined in Section 1833(z)(3).**

A payment model in sub-category (1) can be termed a “Physician-Focused Alternative Payment Model,” and a payment model in sub-category (2) can be termed an “APM Physician Compensation System.”

## B. Processes Created by MACRA to Encourage Physician-Focused Payment Models

In order to be exempt from MIPS and to benefit from the incentives for APM participation under MACRA, physicians will need to have at least 25% of their Medicare payments or patients coming from an alternative payment model by 2019. Most physicians will not be able to achieve this goal unless more rapid progress is made in developing and implementing new physician-focused alternative payment models in Medicare.

In order to accelerate the development and implementation of new physician-focused alternative payment models, MACRA established a process whereby individuals and stakeholders could submit proposals for physician-focused payment models for review by the federal government. This process has five components:

- (1) **Establishment of Criteria for Physician-Focused Payment Models.** MACRA requires HHS to issue regulations specifying criteria for physician-focused payment models, including models for specialist physicians. These must be issued no later than November 1, 2016, after two efforts to obtain public input – a request for information<sup>12</sup>, and a notice of proposed rulemaking. HHS is also authorized by MACRA to update the initial criteria through subsequent rulemaking.
- (2) **Creation of the Physician-Focused Payment Model Technical Advisory Committee.** MACRA establishes a permanent and independent Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposals for physician-focused payment models. The Assistant Secretary for Planning and Evaluation (ASPE) at HHS is required to provide technical and operational support for the Committee, and the CMS Office of the Actuary is required to provide actuarial assistance as needed to the Committee. The eleven members of the PTAC were appointed by the Comptroller General in September 2015, and they began their work in 2016.<sup>13</sup>
- (3) **Authorization for Submission of Proposed Models.** MACRA authorizes “individuals and stakeholder entities” to submit proposals for physician-focused payment models to the Committee “on an ongoing basis” if the individuals and entities believe the proposals meet the criteria established in the HHS regulations.
- (4) **Review of Submitted Proposals.** MACRA requires the PTAC to periodically review models that are submitted, prepare comments and recommendations regarding whether the models meet the criteria established under regulations, and submit the comments and recommendations to the Secretary of HHS.
- (5) **Review and Response by HHS.** MACRA requires the Secretary of HHS to review the comments and recom-

mendations submitted by the PTAC and post a detailed response on the CMS website.

**How successful the process established under MACRA will be in developing an adequate number of physician-focused alternative payment models by 2019 will depend heavily on (1) the criteria that are established by HHS, (2) the information required for submission of proposals; (3) the timeliness of the review of submitted proposals, and (4) the willingness and ability of HHS to implement an adequate number of well-designed physician-focused alternative payment models.**

## C. Criteria for Approval of Physician-Focused Payment Models

As noted above, MACRA requires HHS to issue regulations specifying criteria for physician-focused payment models, including models for specialist physicians, by November 1, 2016. **The goal of these criteria should be to enable as many physicians as possible to make improvements in care they have identified for as many of their patients as possible.** This will maximize savings for Medicare as well as maximize the number of Medicare beneficiaries receiving better care. **In order to achieve this goal:**

- **The criteria established by HHS for physician-focused payment models should be kept as simple as possible** in order to encourage as much innovation as possible. The only essential criteria are those needed to ensure that a proposed model meets the criteria defined in MACRA. Section II-B above describes how the criteria for an alternative payment model can be defined in ways that meet the requirements of the law without creating unreasonable burdens on physicians or precluding small practices from participating.
- Although a key goal of alternative payment models should be to control Medicare spending, **the criteria established by HHS for physician-focused payment models should not require that a proposal demonstrate immediate or significant savings.** In fact, for payment models authorized under Section 1115A, the law states that HHS shall **not** require that a model be budget neutral initially and that models can be implemented as long as they are **expected** to either (a) improve the quality of care without increasing spending, (b) reduce spending without reducing the quality of care, or (c) improve the quality of care and reduce spending. While Section 1115A requires HHS to *focus* on models “expected to reduce program costs ... while preserving or enhancing the quality of care received by individuals receiving benefits...”, CMS is not prohibited from implementing models which will improve quality without increasing spending, and the criteria established by HHS should not preclude such models from being proposed.
- **The criteria established by HHS for physician-focused payment models should not require the use of particular payment systems, organizational structures, or processes for delivering care.** In particular, payment models should *not* be required to follow the formula CMS has been using in most of its payment initiatives to date, i.e., making no changes in the fee-for-service system, holding individual physicians accountable for the costs of all services their patients receive from all pro-

viders, and adjusting payment amounts based on shared savings calculations for attributed patients. As discussed in more detail in Section III-F, these approaches are extremely problematic for physicians and patients, and they are contributing to the poor results that have been achieved so far under these payment models, so new proposals should not be forced to follow these same approaches.

- Finally, **the criteria established by HHS for physician-focused payment models should not include criteria that are designed primarily to limit the number of potential proposals.** To the extent that priorities need to be established in implementing proposed models, they should be established *after* the proposals are reviewed, not before they are even submitted. For example, the Request for Information (RFI) issued by CMS in September 2015 indicated that it was considering requiring that proposed payment models be “primarily focused on the inclusion of participants ... who have not had the opportunity to participate in another physician-focused payment model with CMS because such a model has not been designed to include their specialty” and that payment models “aim to directly solve a current issue in payment policy that CMS is not already addressing in another model or program.” Although it should be a *priority* for HHS to ensure that there is at least *one* alternative payment model in which every specialist can participate, the fact that CMS has designed one model that it believes includes that specialty does not mean that model will work for every physician in that specialty or that a new APM proposed by physicians in that specialty would not achieve better results. Similarly, the fact that CMS is attempting to address a payment issue in an existing model or program does not mean that it is doing so as successfully as possible for all types of physician practices, and a new APM proposed by physicians may well be able to achieve far better results.

## D. Information Required for Submission of Proposed Models

MACRA authorizes submission of proposals for physician-focused payment models to the PTAC, but it does not specify the content of such proposals. Although it will be impossible for the PTAC to review and make recommendations regarding models without adequate information, **the information that proposals for physician-focused payment models should be required to contain should be kept to the minimum amount possible** in order to encourage physician practices and specialty societies to develop and submit proposals, particularly small practices with limited resources. Anecdotal information indicates that many physician practices do not even attempt to participate in some CMS payment programs because of the burdensome amount of information required to submit an application and the limited timeframes established to do so. Similarly, the 19 factors that the Center for Medicare and Medicaid Innovation currently uses to evaluate payment models<sup>14</sup> go far beyond what is necessary to determine whether a payment model would be likely to meet the requirements of MACRA, and requiring

submission of information relevant to all of these criteria would make it extremely difficult for small physician practices or medical societies to propose physician-focused alternative payment models.

**It is particularly important to avoid requiring submission of information that physicians and other developing proposals cannot obtain or cannot obtain except at a very high cost.** For example, although it would obviously be desirable for the PTAC to see financial simulations of the impact of a payment model on Medicare spending, it is usually impossible for physicians and other providers to obtain the type of data on Medicare spending needed to carry out such simulations. Although HHS has made considerable progress in making a broader array of Medicare data available on a more timely basis, most of the available data are fragmented, limited in detail, and several years old, and they generally cannot be used to support an adequate analysis of alternative payment models.

To enable the PTAC to effectively evaluate payment model proposals without making it too difficult for groups to submit them, it would be desirable if the PTAC and HHS could establish a two-step process for evaluation. If a proposal meets an initial set of criteria, HHS could provide the group submitting the proposal with the data or technical assistance needed in order for the PTAC to make a full evaluation and recommendation regarding the proposal.

## E. Process and Timetable for Reviewing and Recommending Proposals

MACRA does not establish specific deadlines for review of payment proposals. It merely authorizes proposals to be submitted to the PTAC “on an ongoing basis,” it requires the PTAC to “periodically” review proposals and submit comments and recommendations to the Secretary of HHS, and it requires the Secretary of HHS to post a detailed response on the CMS website with no deadline for doing so.

Given the urgency of controlling healthcare costs and improving the quality of healthcare services, and given the widespread recognition that significant payment reforms are essential to delivering higher-value care, **it is essential that HHS establish an aggressive timetable with clear deadlines for carrying out all of the steps defined in MACRA. It is important that proposals for physician-focused payment models be reviewed quickly, that prompt feedback be provided to those proposing the models, and that timely guidance be provided to other groups that are developing proposals.** The following would be an appropriate timetable to follow:

- The PTAC should accept proposals for physician-focused payment models no less often than quarterly.
- If a proposal does not include all of the necessary information for a complete review, the PTAC should make a determination within 90 days as to whether the proposal has the potential to meet the criteria for a physician-focused alternative payment model, and if so, the PTAC should request the additional information from the individual or entity that submitted the proposal. If the proposing entity needs information from

HHS to complete the application, the PTAC and HHS should attempt to provide that information and assistance within 60 days.

- If a proposal is submitted with all of the required information, it should be reviewed by the PTAC and a determination made as to whether it meets the criteria for a physician-focused payment model within 90 days.
  - ◆ If the proposal *does not* meet the criteria, the PTAC should provide feedback to the proposer as to why it does not, along with advice on what could be done to revise the proposal.
  - ◆ If the proposal *does* meet the criteria, the PTAC should inform the proposer and submit a recommendation to that effect to the Secretary of HHS.
- HHS staff should review each proposal submitted to the PTAC and provide its comments on the proposal to the PTAC before the PTAC makes its decision about whether to recommend the proposal for implementation. If the PTAC recommends implementation, the Secretary of HHS should post her comments on the proposal on the HHS website as required by MACRA, and the comments should explicitly indicate any reasons why HHS would not be able to implement the model by 2019.
- If a rejected proposal is revised and resubmitted, PTAC should re-review it within 60 days and either approve it or reject it.

## F. Ensuring Implementation of Well-Designed Physician-Focused APMs in Medicare

MACRA stops short of requiring that HHS implement physician-focused payment models recommended by the PTAC. It would obviously be a tremendous waste of time and energy by both those proposing physician-focused payment models and the members of the PTAC if desirable payment models were reviewed and recommended by the PTAC but not implemented by HHS. Consequently, **it will be essential that HHS create the necessary systems and processes so that it can implement physician-focused payment models recommended by the PTAC as well as alternative payment models involving other kinds of providers.**

It is clear that **HHS needs to establish a different approach to implementing alternative payment models than it has been using to date.** Although the Affordable Care Act created the Center for Medicare and Medicaid Innovation in 2010 in order to accelerate the development and implementation of innovative payment and delivery models, relatively little progress has been made in improving the ways most physicians and other providers are paid for their services. As the American Medical Association has stated, “Five years after CMS was authorized to implement ‘new patient care models’... Medicare still does not enable the majority of physicians to pursue ...opportunities to improve care in ways that could also reduce costs. Today, despite all of the demonstration projects and other initiatives that Medicare has implemented, most physicians – in primary care and other specialties – still do not have access to

Medicare payment models that provide the resources and flexibility they need to improve care for their Medicare patients. Consequently, most Medicare patients still are not benefiting from regular access to a full range of care coordination services, coordinated treatment planning by primary care and specialist physicians, support for patient self-management of their chronic conditions, proactive outreach to ensure that high-risk patients get preventive care, or patient decision-support tools. As a result, the Medicare program is paying for hospitalizations and duplicative services that could have been avoided had physicians been able to deliver these high-value services.”<sup>15</sup>

### 1. Creating a More Efficient Approach to Implementing APMs at HHS

One key reason for this slow progress is that the Center for Medicare and Medicaid Innovation (CMMI) has created a far more complex and resource-intensive process than is required or necessary to implement alternative payment models. Under most of the payment demonstrations that it has implemented to date, 18 months or more have elapsed from the time an initiative is first announced to the time when providers actually begin to receive different payments. Many proposals for alternative payment models have been submitted to CMMI that have not been implemented. This is not because the staff at CMMI are slow or incompetent, but because of the complex, expensive, and time-intensive process they have created for designing the initiative, selecting participants, managing the payments, and evaluating the results as part of any payment model they test.

This process is extremely burdensome and expensive for CMMI to administer, it dramatically reduces the number of alternative payment models that can be implemented, and it is also extremely burdensome for providers who are interested in participating in the initiatives that CMMI does attempt to implement. Many providers have decided not to even apply to participate in otherwise desirable CMMI programs and others have dropped out of the programs in the early phases solely or partly because of the cost and time burden of participating.

These burdensome processes are not required by either the Affordable Care Act or MACRA. If HHS were to attempt to implement every new alternative payment model using the approaches that are currently being used by

*The Center for Medicare and Medicaid Innovation (CMMI) has created a far more complex and resource-intensive process than is required or necessary to implement alternative payment models. This process dramatically reduces the number of alternative payment models that can be implemented, and it discourages physicians and other providers from participating.*

CMMI, it would take many years before even a fraction of the physicians in the country would have the ability to meet the APM requirements under MACRA. This would mean relatively few Medicare beneficiaries could benefit from the higher quality care that would be possible under APMs and the Medicare program would not achieve the savings that APMs could generate.

**A complete re-engineering of the processes HHS uses to implement alternative payment models is needed. This re-engineering process should start with the goal that is implicit in MACRA – every physician should have the opportunity to receive at least 25% of their revenues from alternative payment models in 2019, 50% of their revenues in 2021, and 75% in 2023. HHS should then work backward from those dates and design processes and timetables that will achieve the goals.**

*HHS should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes that do not add value or that impede achieving the goals that Congress has set.*

Just as many physicians, hospitals, and other healthcare providers are now re-engineering their care delivery processes to eliminate steps that do not add significant value, HHS should use Lean design techniques and other approaches to identify and eliminate all steps and requirements in its implementation processes that do not add value or that impede achieving the goals that Congress has set.

Moreover, since MACRA allows alternative payment models to be implemented using statutory authorizations other than Section 1115A (the enabling legislation for CMMI), HHS should use all of the options available under MACRA in order to implement desirable alternative payment models in the most efficient way possible.

In order for a physician to be participating in an APM during 2019, the processes for approving and implementing the APM and for approving the physician's participation in the APM will have to be completed no later than the end of 2018. However, **in order for physicians to succeed under APMs, they will need to have sufficient lead time to form or join an alternative payment entity and to redesign the processes by which they deliver care with the flexibility provided by the APM, and so both the structure of the APM and the approval for a physician's participation will need to be completed long before the end of 2018.** Some physician groups and medical specialty societies have already developed physician-focused alternative payment models that should be able to meet the criteria under MACRA; these could and should be implemented as soon as 2017.

To ensure that the MACRA goals are achieved, **HHS should establish specific milestones that are designed to implement as many alternative payment models as possible and as quickly as possible.** For example, the following timetable would allow payments under an alternative payment model to begin flowing to a physician

within one year after the model is recommended by the PTAC:

- Once a physician-focused alternative payment model is recommended by the PTAC and approved by HHS, the applications that physician practices and alternative payment entities would need to complete in order to participate in the approved APM should be made available within 90 days.
- Physicians and alternative payment entities should be permitted to apply to participate in an approved APM no less frequently than twice per year.
- Applications to participate in an approved APM should be reviewed and approved or rejected within 60 days. Applications should only be rejected if an applicant cannot demonstrate that it has the ability to implement the model, not because of arbitrary limits on the size of the program. If an application is rejected, CMS should provide feedback to the applicant on the reasons for rejection and methods of correction. If a rejected application is revised and resubmitted, CMS should re-review it and approve or reject it within 30 days.
- CMS should implement an approved APM with the approved physician applicants no later than 90 days after the applications by physician practices to participate have been approved.
- Once a physician or other clinician begins to participate in an APM, they should be permitted to continue doing so as long as they wish to, unless CMS can demonstrate that Medicare spending under the payment model is higher than it would be under the standard physician fee schedule or that the quality of care for beneficiaries is being harmed.<sup>16</sup>

## 2. Creating the Capability at HHS to Implement a Broad Range of Physician-Focused APMs

A second key reason why only a small number of physicians are participating in alternative payment models under Medicare is the problematic structure of the current models that CMS and CMMI have been using. Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make them worse.

### a. Correcting the Problems With Current CMS Payment Models

As shown in the table on page 16, the components used in most CMS payment models are very problematic for physicians and therefore they are likely problematic for their patients as well. Although CMS may view some of these payment models as “physician-focused” because they are targeted at individual physicians or physician practices, the goal should be to create physician-focused payment models that are *successful* in improving care

# IMPROVEMENTS NEEDED IN CMS ALTERNATIVE PAYMENT MODELS

ELEMENTS FREQUENTLY USED IN CMS ALTERNATIVE PAYMENT MODELS	PROBLEMS FOR PHYSICIANS WITH THE CMS APPROACH	TYPES OF APPROACHES NEEDED FOR SUCCESSFUL PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MDOELS
<b>No changes are made to the underlying Medicare physician fee schedule</b>	<ul style="list-style-type: none"> <li>Physicians may not be able to afford to deliver new services needed to improve quality or reduce spending</li> <li>Improved outcomes may reduce physician revenues because patients need fewer billable services</li> </ul>	<ul style="list-style-type: none"> <li>Authorize payments for new types of high-value services</li> <li>Make payments based on patient conditions or outcomes rather than the number and types of services delivered</li> </ul>
<b>Individual physicians are held accountable for spending on all services their patients receive from all providers for all of the patients' health problems</b>	<ul style="list-style-type: none"> <li>Physicians cannot control all services their patients receive</li> <li>Physicians cannot control the prices of services delivered by other providers</li> <li>The payment model may only be designed to affect a subset of services</li> <li>Patients receive services for conditions other than those treated by the physician</li> <li>Physicians and other providers are forced to consolidate</li> </ul>	<ul style="list-style-type: none"> <li>Hold physicians accountable for the specific services related to the patient's condition that the physician can control or significantly influence</li> <li>Hold physicians accountable for utilization of services rather than spending, or adjust spending measures to exclude spending changes due to price changes</li> <li>Provide condition-based payments designed to support the care delivered by small teams of providers</li> </ul>
<b>Physicians are held accountable for large numbers of quality measures</b>	<ul style="list-style-type: none"> <li>Physicians may not be able to control all of the factors driving the quality measures or may not have adequate resources to do so</li> <li>Some quality measures may have little or nothing to do with the type of care or the patient condition that is being addressed</li> </ul>	<ul style="list-style-type: none"> <li>Hold physicians accountable for the specific types of quality measures likely to be affected by the change in payment</li> <li>Provide sufficient additional payment to cover the costs of improving quality in all of the desired areas</li> </ul>
<b>Payments and accountability measures are not risk adjusted based on characteristics of patients that affect costs and outcomes</b>	<ul style="list-style-type: none"> <li>Physicians are financially penalized for caring for sicker or higher-risk patients</li> <li>Physicians are forced to avoid serving higher-risk patients</li> </ul>	<ul style="list-style-type: none"> <li>Risk adjust or stratify payments based on the specific factors affecting costs and outcomes for the types of health conditions and services addressed by the payment model</li> <li>Allow physicians to assign patients to appropriate payment categories based on relevant clinical and non-clinical factors</li> </ul>
<b>Additional payments to the physician are dependent on shared savings calculations</b>	<ul style="list-style-type: none"> <li>Physicians who already have high levels of performance receive no additional resources</li> <li>Physicians who have overused expensive services in the past can receive large wind-fall bonuses</li> <li>Physicians receive larger shared savings bonuses for avoiding necessary care</li> <li>Payments to small physician practices are subject to uncontrollable random variation in spending</li> <li>Physicians experience cash flow problems waiting for shared savings payments</li> </ul>	<ul style="list-style-type: none"> <li>Provide adequate payment for the services physicians will need to deliver high quality care as long as physicians achieve or maintain good levels of performance</li> <li>Adjust payments only for physicians whose performance is better or worse than pre-defined good performance levels by statistically significant margins</li> <li>Base performance measures on avoidable spending rather than total spending</li> </ul>
<b>Additional payments and accountability measures are based on patients assigned using statistical attribution methods based on office visits</b>	<ul style="list-style-type: none"> <li>Patients who are healthy may not be attributed to the physician, making spending and quality measures look worse</li> <li>Physicians who use non-visit-based payments to improve care may lose the payments if patients make fewer visits</li> <li>Physicians may be attributed patients for whom they no longer provide care or who only see the physician for services unrelated to the payment model</li> <li>Hospitals are forced to acquire physician practices in order to share in payments</li> </ul>	<ul style="list-style-type: none"> <li>Allow physicians to designate which patients are having their care managed by the physician based on an agreement with the patient, not based on the number of office visits</li> <li>Provide bundled payments to physicians and other providers such as hospitals that allow them to jointly manage the care of patients and provide adequate financial support for their respective costs</li> </ul>

*Most of the payment models that are currently being implemented or tested by CMS use a very similar approach – no changes in the current fee for service structure, holding individual physicians accountable for the costs of all services their patients receive from all providers, adjusting payment amounts based on shared savings calculations for attributed patients, etc. – and these approaches not only fail to solve the problems in the current payment systems, they can actually make them worse.*

and improving costs in ways that are feasible for physician practices, particularly small practices, to implement. To date, these payment models have not been successful in reducing costs because they do not provide the kinds of support that physicians need to redesign care as discussed in Section I. **New physician-focused payment models should not be required to use the same flawed approaches that are being used in current CMS payment demonstrations.**

#### **b. Creating Coding Systems to Support Successful Physician-Focused Payment Models**

The table on page 16 also shows the kinds of approaches that should be used instead of the CMS approaches in order to design physician-focused APMs that enable physicians to successfully reduce spending by supporting better care to their patients in ways that are financially feasible for the physicians' practices. Some of these approaches have been difficult for CMS to implement in the past because of the limitations of current coding and claims systems, but Congress recognized this and MACRA requires HHS to develop and implement solutions. Specifically:

- **Patient Condition Groups.** MACRA requires the creation of “patient condition groups” based on a patient’s chronic conditions, current health status, and recent significant history, such as hospitalization or surgery. If properly designed, these groups will enable far better risk adjustment and acuity stratification than the methods used in Medicare payment programs today.
- **Care Episode Groups.** MACRA requires the creation of “care episode groups” that define the types of procedures or services furnished for particular clinical conditions or diagnoses. If properly designed, these groups will enable far better measures of the kinds of services and costs physicians can control or influence than the total cost measures used in Medicare payment programs today.
- **Patient Relationship Categories.** MACRA requires the creation of “patient relationship categories” and associated codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. If properly designed, these categories and codes will enable payments and accountability for

spending and quality to be far more accurate than the retrospective statistical attribution methodologies used in Medicare payment programs today.

MACRA establishes an aggressive timetable for developing and implementing these groups, categories, and codes. Beginning on January 1, 2018, appropriate codes are to be included on the claims that physicians submit for payment.

In order for these groups, categories, and codes to enable the implementation of better alternative payment models, they need to be designed with those payment models in mind. MACRA explicitly indicates that these groups, categories, and codes should be designed to support both MIPS and APMs, but in order for them to properly support successful APMs, **HHS will need to develop patient condition groups, care episode groups, and patient relationship categories in ways that support a much broader range of APMs than CMS is using today.** At a minimum, this should include all of the payment models described in the next subsection. **Condition groups, care episode groups, and patient relationship categories should be developed in collaboration with physician groups and medical societies as MACRA explicitly requires.<sup>17</sup>**

#### **c. Implementing Systems to Support Multiple Types of Physician-Focused Payment Models**

There is no single Physician-Focused Alternative Payment Model that will work for all physicians or their patients. Different medical specialties treat different kinds of health problems, and the opportunities to improve quality and reduce costs will differ for the different types of health problems addressed by physicians within each specialty and subspecialty. Moreover, the care delivery changes that are needed to address these opportunities will also differ by specialty, as will the barriers in the current payment system that need to be overcome in order for physicians to redesign care delivery for their patients.

This means there will need to be multiple types of APMs in order for physicians in all specialties to participate and in order for all patients to benefit. A good APM will overcome the *specific* payment system barriers a physician practice faces in pursuing the *specific* kinds of improvement opportunities available for the *specific* types of patient conditions the physicians in that practice treat. There is no need for complex and expensive changes in payment structures if simple changes will address the barriers. If paying for a new service code could enable a physician practice to deliver significantly better care at lower overall cost, there is no need to force the practice to find ways to manage a complex bundled payment. Conversely, if services need to be completely redesigned or if multiple types of physicians need to work closely together in order to deliver high-value care for a particular condition, a bundled condition-based payment may be essential, and physicians should not be forced to use shared savings or other payment models that do not provide the necessary flexibility.

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At a minimum, HHS should create the administrative capabilities to implement seven different types of physician-focused APMs that can be used to address the most common types of opportunities and barriers that exist across all physician specialties. These are:

1. **Payment for a High-Value Service.** Under this APM, a physician practice could be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.
2. **Condition-Based Payment for Physician Services.** Under this APM, a physician practice would have the flexibility to use the diagnostic or treatment options that address a patient's condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician's practice.
3. **Multi-Physician Bundled Payment.** Under this APM, two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
4. **Physician-Facility Procedure Bundle.** This APM would allow a physician who delivers a procedure at a hospital or other facility to choose the most appropriate facility for the treatment and to give the physician and facility the flexibility to deliver the procedure in the most efficient and high-quality way.
5. **Warranted Payment for Physician Services.** This APM would give a physician the flexibility and accountability to deliver care with as low a rate of complications as possible.
6. **Episode Payment for a Procedure.** This APM would enable a physician who is delivering a particular procedure to work collaboratively with the other providers delivering services related to the procedure (e.g., the facility where the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient's recovery or in treating complications of the procedure, etc.) in order to improve outcomes and control the total spending associated with the procedure.
7. **Condition-Based Payment.** Under this APM, a physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers who deliver services for the patient's condition in order to improve outcomes and control the total spending associated with care for the condition.

More detail on each of these physician-focused Alternative Payment Models and examples of how they could be used to improve care for a wide range of patient conditions is available in a report developed by the American Medical Association and CHQPR entitled *A Guide to Physician-Focused Alternative Payment Models*.<sup>18</sup>

HHS should begin immediately to implement the administrative systems needed to support all of these types of alternative payment models. This would not only ensure that the APMs can be implemented by 2018, but it would encourage physician groups and medical specialty societies to design payment models in a common framework, which will reduce implementation costs for HHS.

Re-engineering the processes for implementing alternative payment models as discussed in Section III-F-1 above should dramatically increase the capacity of HHS to implement more payment models more quickly than it can today. However, **if there are insufficient staff or resources at HHS/CMS/CMMI to support implementation of a sufficient number of new alternative payment models to enable all physicians to participate, additional resources should be provided to achieve the necessary "bandwidth."** Failing to allocate sufficient resources to implement alternative payment models that will save money for the Medicare program would be penny wise and pound foolish.

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# ENDNOTES

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1. H.R. 2 (the Medicare Access and CHIP Reauthorization Act of 2015) passed the House of Representatives by a vote of 392-37 on March 26, 2015 and it passed the Senate by a vote of 92-8 on April 14, 2015.
2. Miller HD, Marks S. *A Guide to Physician-Focused Alternative Payment Models*. American Medical Association and Center for Healthcare Quality and Payment Reform, November 2015. Available at: <http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>
3. For a more detailed discussion of the components needed for a successful Alternative Payment Model, see Miller HD. *The Building Blocks of Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*, Network for Regional Healthcare Improvement, Center for Healthcare Quality and Payment Reform, and Robert Wood Johnson Foundation. April 2015. Available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>.
4. An “eligible professional” can be a physician; a physician assistant; a nurse practitioner; a clinical nurse specialist; a certified registered nurse anesthetist; a certified nurse-midwife; a clinical social worker; a clinical psychologist; a registered dietitian or nutrition professional; a physical or occupational therapist; a qualified speech-language pathologist; or a qualified audiologist.
5. The law defines the denominator of the percentage as the sum of Medicare payments (or patients) and payments (or patients) from all other payers except for the Department of Defense, the Veterans Affairs Administration, and state Medicaid programs that have no medical home program or alternative payment models available.
6. The full set of provisions of Section 1115A is available at [https://www.ssa.gov/OP\\_Home/ssact/title11/1115A.htm](https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm)
7. The full set of provisions of Section 1899 is available at [https://www.ssa.gov/OP\\_Home/ssact/title18/1899.htm](https://www.ssa.gov/OP_Home/ssact/title18/1899.htm)
8. Information on the demonstrations implemented under Section 1866C are available at <https://innovation.cms.gov/initiatives/Medicare-Health-Care-Quality/>
9. This approach was required in the successful Acute Care Episode (ACE) Demonstration conducted by CMS. More information on the ACE Demonstration is available at <https://innovation.cms.gov/initiatives/ACE/>
10. The provisions of CFR 422.208 can be found at <https://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol2/pdf/CFR-2002-title42-vol2-sec422-208.pdf>
11. For a more detailed discussion of how alternative payment models can be used for compensation of providers within larger alternative payment models, see Miller HD. *The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher-Value Health Care*. Available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf> .
12. The Request for Information was issued in September 2015 and the deadline for comments was later extended to November 17, 2015. The comments that were submitted can be found at [www.regulations.gov](http://www.regulations.gov).
13. Information about the PTAC is available at <https://aspe.hhs.gov/medicare-access-and-chip-reauthorization-act-2015>
14. These criteria are posted on the CMS website at <https://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf>
15. Letter from James L. Madara, MD, Executive Vice President and CEO, American Medical Association to Andrew M. Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services, November 17, 2015, pages 3-4.
16. Section 1115A of the Social Security Act explicitly permits the Secretary of HHS to continue a payment model as long as the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. Moreover, if a payment model is not achieving these goals, the law gives the Secretary of HHS the power to modify the payment model rather than terminate it. Decisions to continue or modify a model can be made before an evaluation of the model is completed.
17. Section 1848(r) of the Social Security Act, which requires the development of patient condition groups, care episode groups, and patient relationship categories, is titled “Collaborating with the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Measurement” and specifies detailed processes and timetables that HHS must follow to obtain input from physician specialty societies, practitioner organizations, and other stakeholders.
18. Miller HD, Marks S. *A Guide to Physician-Focused Alternative Payment Models*. American Medical Association and Center for Healthcare Quality and Payment Reform, November 2015. Available at: <http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>

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# APPENDIX

## PROVISIONS OF MACRA REGARDING ALTERNATIVE PAYMENT MODELS

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### MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

#### TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

#### SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

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#### (e) PROMOTING ALTERNATIVE PAYMENT MODELS.

#### (1) INCREASING TRANSPARENCY OF PHYSICIAN-FOCUSED PAYMENT MODELS.

Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended by adding at the end the following new subsection:

#### Section 1868 (c) PHYSICIAN-FOCUSED PAYMENT MODELS.

#### (1) TECHNICAL ADVISORY COMMITTEE.

#### (A) ESTABLISHMENT.

There is established an ad hoc committee to be known as the 'Physician-Focused Payment Model Technical Advisory Committee' (referred to in this subsection as the 'Committee').

#### (B) MEMBERSHIP.

#### (i) NUMBER AND APPOINTMENT.

The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

#### (ii) QUALIFICATIONS.

The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

#### (iii) PROHIBITION ON FEDERAL EMPLOYMENT.

A member of the Committee shall not be an employee of the Federal Government.

#### (iv) ETHICS DISCLOSURE.

The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

#### (v) DATE OF INITIAL APPOINTMENTS.

The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

#### (C) TERM; VACANCIES.

#### (i) TERM.

The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

#### (ii) VACANCIES.

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

#### (D) DUTIES.

The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

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(E) COMPENSATION OF MEMBERS.

(i) IN GENERAL.

Except as provided in clause (ii), a member of the Committee shall serve without compensation.

(ii) TRAVEL EXPENSES.

A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

(F) OPERATIONAL AND TECHNICAL SUPPORT.

(i) IN GENERAL.

The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

(ii) FUNDING.

The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out this paragraph (not to exceed \$5,000,000) for fiscal year 2015 and each subsequent fiscal year. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

(G) APPLICATION.

Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

**(2) CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.**

(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.

(i) RULEMAKING.

Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

(ii) MEDPAC SUBMISSION OF COMMENTS.

During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

(iii) UPDATING.

The Secretary may update the criteria established under this subparagraph through rulemaking.

(B) STAKEHOLDER SUBMISSION OF PHYSICIAN-FOCUSED PAYMENT MODELS.

On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

(C) COMMITTEE REVIEW OF MODELS SUBMITTED.

The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

(D) SECRETARY REVIEW AND RESPONSE.

The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

**(3) RULE OF CONSTRUCTION.**

Nothing in this subsection shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.

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## (2) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

### Section 1833 (z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.

#### (1) PAYMENT INCENTIVE.

##### (A) IN GENERAL.

In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model –

- (i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or
- (ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

##### (B) FORM OF PAYMENT.

Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

##### (C) TREATMENT OF PAYMENT INCENTIVE.

Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

##### (D) COORDINATION.

The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

#### (2) QUALIFYING APM PARTICIPANT.

For purposes of this subsection, the term ‘qualifying APM participant’ means the following:

##### (A) 2019 AND 2020.

With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

##### (B) 2021 AND 2022.

With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

###### (i) MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

###### (ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title), meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and

- meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);
- (II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and
- (III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.

For purposes of clause (ii)(I)—

- (I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and
- (II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—
  - (aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;
  - (bb) certified EHR technology is used; and
  - (cc) the eligible professional participates in an entity that—
    - (AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or
    - (BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(C) BEGINNING IN 2023.

With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.

An eligible professional—

- (I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—
  - (aa) payments described in clause (i); and
  - (bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title), meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);
- (II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and
- (III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.

For purposes of clause (ii)(I)—

- (I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and
- (II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—
  - (aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;
  - (bb) certified EHR technology is used; and
  - (cc) the eligible professional participates in an entity that—

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(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

**(D) USE OF PATIENT APPROACH.**

The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

**(3) ADDITIONAL DEFINITIONS.**

In this subsection:

**(A) COVERED PROFESSIONAL SERVICES.**

The term ‘covered professional services’ has the meaning given that term in section 1848(k)(3)(A).

**(B) ELIGIBLE PROFESSIONAL.**

The term ‘eligible professional’ has the meaning given that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

**(C) ALTERNATIVE PAYMENT MODEL (APM).**

The term ‘alternative payment model’ means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

- (i) A model under section 1115A (other than a health care innovation award).
- (ii) The shared savings program under section 1899.
- (iii) A demonstration under section 1866C.
- (iv) A demonstration required by Federal law.

**(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.**

The term ‘eligible alternative payment entity’ means, with respect to a year, an entity that—

- (i) participates in an alternative payment model that—

- (I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4));
  - and

- (II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i);

and (ii)

- (I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

- (II) is a medical home expanded under section 1115A(c).

**(4) LIMITATION.**

There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

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### **(3) COORDINATION CONFORMING AMENDMENTS.**

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended

(A) in subsection (x)(3), by adding at the end the following new sentence: “The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.”; and

(B) in subsection (y)(3), by adding at the end the following new sentence: “The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.”.

### **(4) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.**

Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(A) in subparagraph (B), by adding at the end the following new clauses:

(xxi) Focusing primarily on physicians’ services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

(xxii) Focusing on practices of 15 or fewer professionals.

(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services; and

(B) in subparagraph (C)(viii), by striking “other public sector or private sector payers” and inserting “other public sector payers, private sector payers, or statewide payment models”.

### **(5) CONSTRUCTION REGARDING TELEHEALTH SERVICES.**

Nothing in the provisions of, or amendments made by, this title shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)).

### **(6) INTEGRATING MEDICARE ADVANTAGE ALTERNATIVE PAYMENT MODELS.**

Not later than July 1, 2016, the Secretary of Health and Human Services shall submit to Congress a study that examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system. The study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

### **(7) STUDY AND REPORT ON FRAUD RELATED TO ALTERNATIVE PAYMENT MODELS UNDER THE MEDICARE PROGRAM.**

(A) STUDY.

The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

(i) examines the applicability of the Federal fraud prevention laws to items and services furnished under title XVIII of the Social Security Act for which payment is made under an alternative payment model (as defined in section 1833(z)(3)(C) of such Act (42 U.S.C. 1395l(z)(3)(C)));

(ii) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(iii) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(B) REPORT.

Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subparagraph (A). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.



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