

Participating in Alternative Payment Models: Are ACOs a Growing PM&R Participation Opportunity?

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Across the health care system, payers and purchasers have been pursuing opportunities to increase the value of their health care dollars by moving away from fee-for-service payment and toward payment models that hold health care providers accountable for the cost and quality of health care they deliver. The Patient Protection and Affordable Care Act (ACA)¹ provided significant new tools for the Medicare program to engage in this value-based transformation through the establishment of the Center for Medicare and Medicaid Innovation (Innovation Center) within the Centers for Medicare and Medicaid Services (CMS), which supports the development and testing of innovative health care payment and service delivery models. The ACA also established the Medicare Shared Savings Program (MSSP), which relies on Accountable Care Organizations (ACOs) to promote “accountability for a patient population and [coordinate] items and services under parts A and B and [encourage] investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”²

According to CMS, ACOs are “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.”³ Given the emphasis on coordinated care, ACOs are generally accountable for controlling beneficiaries’ total cost of care across all providers and health care settings.

CMS has developed several options for participation in ACOs using both MSSP and Innovation Center authority, many of which are discussed in greater detail below. As participation in such models grows, PM&R specialists could see increased opportunities to participate in ACOs. Therefore, understanding what they are and what PM&R involvement in them might look like will increase in importance.

Medicare Shared Savings Program (MSSP) ACOs

Section 3022 of the ACA codified ACOs as a permanent feature of the Medicare program under the Medicare Shared Savings Program. The MSSP currently includes 3 tracks (Tracks 1, 2, and 3), which vary from one another on several model parameters. One of the most significant differences, however, is the extent of risk and savings shared with participants under each track. Track 1 offers shared savings only, and participants are not responsible for taking on risk. Tracks 2 and 3 require downside risk in addition to shared savings, with higher levels of potential risk and savings included under Track 3. More recently, the Innovation Center introduced a separate track, Medicare ACO Track 1+, which offers downside risk at a lower level than Tracks 2 and 3.^{4,5} More than 80% of MSSP ACOs, however, participate under Track 1 and do not take on risk.⁶

While MSSP participants share savings based in part on total beneficiary medical spending, ACOs are also assessed on the quality of care that is delivered to the beneficiaries attributed to the ACO.⁷ ACOs have a specific set of quality metrics on which they are assessed, and performance on those metrics contribute toward determining the final shared savings rates for ACOs. Likewise, for MSSP tracks with downside risk, the proportion of losses shared by the ACO may also vary based on performance of the quality metrics.

Medicare Expansion of the ACO Concept Beyond MSSP

Believing that the ACO concept held promise in driving value-based payments, CMS also created what it referred to as the Pioneer ACO Model under Innovation Center authority. CMS recognized that some facilities and systems were more advanced in programs directed at coordinated care and sought to move them more quickly from sharing savings models to something closer to population health. The Pioneer ACO Model was implemented separate from the MSSP models and was designed to also align with private payer efforts in this arena. The Pioneer ACO model ran from 2012 to 2016.⁸

CMS also introduced the Next Generation ACO Model.⁹ This model builds on MSSP and the Pioneer ACO model and was designed to accommodate more advanced entities willing to assume higher levels of financial risk than required under MSSP tracks as well as provide higher potential rewards. The goal of the Next Generation Model is to “test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries.”¹⁰ As with the MSSP models, participants in the Next Generation ACO model are assessed on spending benchmarks as well as performance on quality metrics. Participants that fail to submit all the data required to calculate quality scores are not allowed to share in savings but are required to share losses.

The Role of ACOs under MACRA

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The passage of the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, further emphasized value-based transformation in the Medicare program and the role that ACOs and other accountable models play. Hallmarks of this legislation include the elimination of the flawed Medicare physician payment update mechanism called the Sustainable Growth Rate (SGR) formula and its replacement with 2 physician payment tracks intended to promote effective, high-value care: the Merit-Based Incentive Payment System (MIPS) and the Advanced APM track. The Advanced APM track, in particular, rewards physicians who deliver a significant amount of their services in the context of alternative payment models (APMs) that meet certain criteria, including a requirement that model participants take on downside financial risk. CMS calls these models “Advanced APMs,” and the physicians who meet the significant participation thresholds in these models (known as “Qualifying APM Participants” or QPs) will receive a 5% lump sum incentive payment for each year they qualify, from 2019 through 2024, as well as a higher payment update starting in 2026. QP status also exempts physicians from the reporting requirements and payment adjustments required under MIPS.

At time of publication, for 2018 participation, CMS has only designated 11 models as Advanced APMs.¹¹ Included in the 11 Advanced APMs are all the models discussed above (or variants thereof) that require two-sided risk. Note, however, that MSSP Track 1 has no downside risk and is therefore *not* an Advanced APM.

Physicians who have sufficient participation in the Advanced APM ACOs for a given performance year will qualify for the Advanced APM physician payment track and its 5% bonus for that year, based on performance for each year from 2017 through 2022. Additionally, these physicians will be exempt from MIPS reporting requirements and benefit from higher annual payment updates that take effect starting in 2026.

Physicians who participate in Track 1 MSSP ACOs, or who do not have sufficient participation in the Advanced APM ACOs (as specified based on statutory provisions and CMS regulations), will also benefit to a lesser extent, since CMS has specified that participation in these models enables ACO participants to benefit from special MIPS scoring accommodations intended to reduce burden and conflicting incentives between the ACO and MIPS programs. However, certain MIPS reporting requirements will continue to apply.

PM&R and ACOs

Because of their care coordination and population health management characteristics, the concept of the ACO is often viewed as a model almost solely directed at primary care clinicians. Further, current quality metrics are largely focused on primary and preventive care.¹² However, the Medicare Payment Advisory Commission (MedPAC) has identified increased participation of specialists in ACOs. Indeed, MedPAC's analysis of the 2015 ACO public use file showed that there were approximately twice as many specialists as primary care providers in MSSP ACOs.¹³

As ACOs evolve both in taking on additional risk and expanding the scope of services where they believe cost savings and quality improvement opportunities exist, ACO interest in partnering with specialists on activities directly related to specialty care could increase. In addition, professionals in the world of physical medicine could also provide a unique opportunity for ACOs that are seeking to provide better, more efficient care in the post-acute setting. Many programs to date have sought to drive value only in the individual siloes of Medicare's separate payment systems. For example, the Hospital Value-Based Purchasing Program just focuses on inpatient hospital services, and the MIPS program focuses on Medicare Physician Fee Schedule services. However, with ACO programs that seek care improvement and efficiencies system-wide, the value that PM&R specialists provide could present a quantifiable opportunity for ACOs while encouraging patient access to the important services delivered by physiatrists.

Lawrence Frank, MD, FAAPMR a physiatrist in Elmhurst, IL, says, "In the future, I do see a greater role for PM&R locally as the ACO experiment evolves to include more downside risk. Our hospital system is already participating in orthopedic and other bundled contracts, so they are slowly beginning to understand and manage downside risk. Although PM&R is not a currently a player in these contracts, my system fortunately does see a role for PM&R in the management of their spine population. They also understand that the future of payment will increasingly include risk-based contracts and that they need to be ready once these are eventually implemented."

Moreover, PM&R specialists could likewise benefit from ACO participation. Gregory Park, MD, FAAPMR, physiatrist with Pioneer Spine and Sports in Western Massachusetts, participates in several ACOs and notes that his experience has been largely positive for several reasons, including the role of ACOs in serving as referral sources, the availability of shared savings payments (which he says "has already been more lucrative than MIPS bonuses, since MIPS does not begin paying for quality until 2019"), and the availability of data shared by the ACOs that give his practice "opportunities to make improvements both from the standpoint of business practices as well as medical practices." He cautions, however, that not everything has been

positive, and that it can take added effort to make the relationship with the ACO work.

As an additional benefit, Dr. Park also notes that ACO participation makes it much easier to qualify for incentive payments under the Advanced APM physician payment track. This may be particularly valuable given the lack of opportunities to participate in Advanced APMs that specifically focus on physical medicine and rehabilitation and limited physiatrist participation in the Advanced APM track to date. Based on estimates reported by CMS, less than 1% of PM&R specialists were expected to qualify for the Advanced APM track based on performance in 2017.¹⁴ And while CMS did not provide comparable specialty-specific estimates for 2018, it estimated that between 185,000 and 250,000 eligible clinicians overall would qualify for payment updates based on Advanced APM participation in the 2018 performance year,¹⁵ which still only represents between about 12 and 17% of physicians participating in Medicare.

Absent new models that provide a role for PM&R specialists, ACOs may offer a potential window for physiatrists to achieve the benefits of QP status. Physiatrists who believe they are affiliated with a Medicare ACO should verify whether they are listed as participating practitioners in the ACO and which track the ACO has selected to know whether they qualify for the Advanced APM track.

Conclusion

In future years, it is expected that there will be a greater number of Advanced APM participation options, and it's possible that some will be designed to be more directly relevant to the care provided in the field of physical medicine. Until that time, however, it is likely that participation in ACOs will be a potential PM&R opportunity for those practicing at sites of care that have enrolled in the program. As ACOs seek to provide care more efficiently for their attributed population of patients, the value that PM&R professionals bring to their patients could align with the goals that have been set up for ACOs while also offering the opportunity for physiatrists to qualify for the Advanced APM track and eliminate the reporting requirements under MIPS. ❖

References

- 1 Pub. L. 111-148. 124 Stat. 119. 23 March 2010.
- 2 Pub. L. 111-148. 124 Stat. 119. 23 March 2010.
- 3 Centers for Medicare and Medicaid Services (CMS) Accountable Care Organizations Web page, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html> (accessed August 19, 2018).
- 4 CMS classifies this model as an MSSP ACO, though notes: "The Track 1+ Model is a time-limited CMS Innovation Center model. An ACO must concurrently participate in Track 1 of the Shared Savings Program in order to be eligible to participate in the Track 1+ Model." (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html>; accessed August 19, 2018)
- 5 A comparison of the four MSSP tracks can be found in the appendix of CMS' fact sheet on the ACO Track 1+ model (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf#page=8>; accessed August 19, 2018).
- 6 On August 17, 2018, CMS published the proposed rule "Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations Pathways to Success." (83 Fed Reg. 41786) In this rule, among other changes, CMS proposes to overhaul the MSSP, such that the 4 MSSP tracks detailed above would be retired or, in the case of Track 3, renamed. In their place, CMS proposes a BASIC track and an ENHANCED track. Additional details can be found in the proposed rule. Final policies will be promulgated in future rulemaking.
- 7 ACO quality measures and specifications for 2018 can be found in the CMS manual here: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf>; accessed August 19, 2018).
- 8 <https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/> (accessed August 19, 2018).
- 9 <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/> (accessed August 19, 2018).
- 10 <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/> (accessed August 19, 2018).
- 11 Centers for Medicare and Medicaid Services, <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf> (accessed August 13, 2018).
- 12 Centers for Medicare and Medicaid Services (January 2018). Medicare Shared Savings Program: Accountable Care Organization (ACO) 2018 Quality Measures, Narrative Specifications Document. Downloaded from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf> on August 13.
- 13 Medicare Payment Advisory Commission, (March 2018). Moving beyond the Merit-based Incentive Payment System. In Report to the Congress: Medicare Payment Policy (p. 465). Retrieved June 5, 2018 from Medicare Payment Advisory Commission Web site: <http://www.medpac.gov>.
- 14 Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final rule with comment period, 81 Fed. Reg. 77519 (November 4, 2016).
- 15 Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, Final rule with comment period and interim final rule with comment period, 82 Fed. Reg. 53571 (November 16, 2017).