MACRA and Medicare Advantage Risk

The Case for a Level Playing Field

KEY POINTS

- MACRA overlooks the critical role of Medicare Advantage in moving the healthcare delivery system from volume to value.
- Some physicians take risk in Medicare Advantage agreements with health plans, but much more can be done to move the needle toward risk-bearing arrangements across all of Medicare.
- MACRA places unequal emphasis on APMs in traditional Medicare compared to APMs in Medicare Advantage. Both are necessary to achieve the goals of better quality and lower cost.
- Action is required by Congress to introduce legislation that would level the playing field for MA APMs – affording physicians taking risk in MA the same treatment as those taking risk in traditional Medicare.

CAPG
The Voice of Accountable Physician Groups
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Treatment of Risk: The Case for a Level Playing Field

The Medicare Access and CHIP Reauthorization Act (MACRA) creates a two-tracked system of physician payment in Traditional Medicare beginning for the 2019 payment year. The two options are the Merit-Based Incentive Payment System (MIPS) and the advanced Alternative Payment Model (APM) path.

In the APM path, physicians and physician groups may qualify for a 5% bonus on their traditional Medicare Part B covered professional services for 2019 through 2024. Only certain types of APMs are eligible for the bonus (e.g., the Medicare Shared Savings Program [MSSP] and other Innovation Center initiatives). Eligible APMs must also participate in quality programs comparable to those in MIPS; use certified electronic health records (EHR) technology, bear "more than nominal financial risk," or be a qualifying medical home.

In addition, APM participating physicians must have a certain threshold of their Part B covered professional services furnished through the APM entity to qualify. In 2019 and 2020, the 25% of Medicare Part B payments must be attributed to the APM to qualify as a bonus eligible APM.[i] The threshold increases over time.

THE PROBLEM

The risk undertaken by physicians seeking to qualify as an advanced APM under MACRA is treated disparately between Medicare Advantage and traditional Medicare.

Today physicians cannot use their MA relationships to qualify as APMs under MACRA – instead they must participate in a specific Part B model (i.e., MSSP) in order to become eligible for a payment bonus in traditional Medicare.

To be considered an advanced APM, a certain threshold of a physician's Part B covered professional services must be furnished through the APM entity. An APM entity must (1) participate in quality programs comparable to MIPS, (2) operate a qualified EHR, and (3) demonstrate a certain percentage of "more than nominal risk" on their books.

The Centers for Medicare and Medicaid Services (CMS) has interpreted[ii] that services delivered through the APM entity which count toward its threshold may only reflect risk assumed on behalf of patients who are enrolled in traditional Medicare, not MA, in the first two years of the law.

Payment Year	Revenue Threshold
2019-2020	25%
2021-2022	50%
2023 and Beyond	75%

Beginning in 2021 physicians may begin to get credit for APM activities through MA toward the threshold to qualify as an APM as part of MACRA's "combination all payer Medicare threshold option." However, once MA risk is incorporated its value is counted for less than risk taken through traditional Medicare for the same activities. In the all-payer years, physicians are still required to

have a certain threshold of their Part B revenue or patients in an APM in traditional Medicare.

Nationwide, more than one third of eligible Medicare beneficiaries choose to receive their benefits through MA. In some regions of the country more than half of the Medicare patients treated by some physicians may be enrolled in MA.[iii] Without corrective action, physicians that see higher levels of MA patients may be disadvantaged in their eligibility toward becoming an advanced APM.

Even more troubling, a physician participating in a risk-bearing APM in Medicare Advantage may be treated as though he or she is not participating in an APM at all. In some cases, this may create a backwards incentive – leading more sophisticated providers who have demonstrated experience and success in taking higher levels of risk through MA to adopt a Medicare Part B model designed to support physicians who are only beginning to venture into risk-based payment arrangements.

WHAT THIS MEANS FOR PHYSICIANS IN MA

Across the country, physician organizations are experimenting with risk across the entire Medicare program, including both traditional Medicare and Medicare Advantage. Yet, the increasing levels of risk-bearing behavior in MA are largely ignored by current efforts at delivery system reform.

This means that a physician participating in a risk-bearing ACO contract with an MA plan is treated as though he or she is not participating in any delivery system reform but a physician participating in a risk-bearing ACO in traditional Medicare is being paid 105% of fee-for-service.

THE SOLUTION

Creating a Level Playing Field between Risk in MA and Traditional Medicare

CAPG recommends legislation that would create equal treatment for comparable risk-based payment arrangements in MA and traditional Medicare.

This solution would retain the escalating MACRA thresholds outlined above. It would also require that physicians take "more than nominal" financial risk in MA relationships with health plans – the same standard used in traditional Medicare under MACRA – in order for their activities to be counted toward the advanced APM threshold. Notably, this solution would only create a bonus on a physician's Part B revenue, not their Medicare Advantage revenue.

This change would enable physician organizations to get credit for their experience with risk relationships through MA to meet the revenue or patient thresholds under MACRA to qualify as an advanced APM - looking at a physicians' total Medicare risk, rather than just their Part B risk.

CONCLUSION

Treating comparable risk-based arrangements in traditional Medicare and MA, with equal weight toward

MACRA's advanced APM threshold would enable physician groups to qualify based on the merits of their behavior, not the type of coverage obtained by their patients.

[i] There is also a patient count option that similarly relies only on Medicare Part B.
[ii] https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/Report-to-Congress-APMs-and-Medicare-Advantage.pdf
[iii] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html

CAPG is the leading national association representing physician organizations practicing capitated, coordinated care. Our membership currently comprises more than 250 multispecialty medical groups and independent practice associations (IPAs) across 40 states, the District of Columbia, and Puerto Rico.

CAPG members provide comprehensive healthcare through coordinated and accountable physician group practices. We strongly believe that patient-centered, coordinated, and accountable care offers the highest quality, most efficient delivery mechanism, and greatest value for patients. CAPG members have successfully operated under this budget-responsible model for more than two decades.

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