

Advanced APMs: Criteria and Qualifying Models

Under MACRA, clinicians who participate in certain Medicare alternative payment models (APMs) – known as advanced APMs – may earn incentive payments and be exempted from Merit-based Incentive Payment System (MIPS) reporting and potential payment adjustments. Generally, eligible Medicare models include the Medicare Shared Savings Program (MSSP) and Center for Medicare and Medicaid Innovation demonstrations. In addition, to be an advanced APM, a model must:

- Require participants to use certified electronic health record (EHR) technology;
- Tie payment to quality; and
- Require downside financial risk.

More information on each of these requirement and models that qualify as advanced APMs follows.

Use of Certified EHR Technology

An advanced APM must require at least 50 percent of Medicare-enrolled clinicians participating in the model (or each hospital if the hospital is the APM participant) to use certified EHR functions to document and communicate clinical care with patients and other health care professionals. For 2017, clinicians will be able to use either the 2014 edition or 2015 edition certified EHR technology to satisfy this requirement; for 2018, clinicians must use 2015 edition certified EHRs.

Tying Payment to Quality Measures

To meet the requirement, the model must base at least some amount of payment on at least one measure that is evidence-based, reliable and valid. In addition, at least one measure must be an outcome measure, unless no applicable measure exists when the APM is developed. These quality measures must include at least one of the following types of measures:

- Any MIPS quality measure
- Measures that are endorsed by a consensus-based entity
- Measures developed under CMS's authority to develop new measures
- Measures submitted in response to the MIPS call for quality measures
- Other measures determined by CMS to be evidence-based, reliable and valid

National Quality Forum measures meet these criteria.

Downside Financial Risk

Advanced APMs must require that participating entities incur some of the financial loss when actual expenditures exceed projected expenditures – commonly referred to as downside risk. The loss could occur through withheld payments for services, reduced payment rates or required repayment to CMS. The agency has set two alternative standards for how much financial risk an entity must potentially repay:

- **Benchmark standard:** If the APM entity's actual spending exceeds expected spending, it must repay is at least 3 percent of expected spending.
- **Revenue standard:** The potential payback is based on total Parts A & B revenue of the APM entity. For 2017 and 2018, CMS has set this amount at 8 percent of total Parts A & B revenues.

CMS set a different financial risk standard for medical homes, which typically do not take on downside risk. For medical home models, the risk requirement would be met if repayment is required when there is *either* excess spending or failure to meet performance requirements. The total amount that the APM entity potentially owes must be at least a certain percentage of the entity's total Parts A & B revenue; this percentage will be 2.5 percent in 2017, 3 percent in 2018, 4 percent in 2019, and 5 percent in 2020 and beyond.

Currently, the medical home standard only applies to the Comprehensive Primary Care Plus (CPC+) program. For 2017, the first year of CPC+, all organizations in this model can qualify under this standard. However, beginning in 2018, CMS will limit the standard to organizations with fewer than 50 clinicians. This will likely exclude most hospital-employed physicians from receiving advanced APM credit for participation.

Fully capitated arrangements will meet the risk requirements.

Qualifying Advanced APMs

CMS has announced which existing Medicare APMs meet the above criteria for 2017, in addition to those that have been created or modified to meet the advanced APM criteria for future years. These models are listed below; each link offers more information. A comprehensive list of Medicare APMs – including which ones qualify as advanced APMs – is available on CMS's QPP [website](#).

2017 Advanced APMs

- [MSSP Tracks 2 and 3](#)
- [Next Generation ACO](#)
- [Comprehensive ESRD Care Model](#): Large dialysis organizations arrangement and two-sided risk track
- [Oncology Care Model](#): Two-sided risk track
- [Comprehensive Primary Care Plus](#) (qualifies as a medical home)
- [Comprehensive Care for Joint Replacement](#) (Track 1 with Certified EHR Technology)

Future Advanced APMs

- [MSSP Track 1+](#) (2018)
- [Surgical Hip and Femur Fracture Treatment \(SHFFT\) Model](#) (start TBD)*
- [Coronary Artery Bypass Graft \(CABG\) Model](#) (start TBD)*
- [Acute Myocardial Infarction \(AMI\) Model](#) (start TBD)*

***Note:** In an Aug. 15, 2017 Notice of Proposed Rulemaking, CMS proposed to cancel these models. A final rule is expected in late 2017.

Other Payer Options

Beginning in performance year 2019, there will be an option to qualify as an advanced APM based on participation in APMs with payers other than Medicare. Other payers include Medicare Advantage, Medicaid and private payers. To determine whether an arrangement qualifies as an “other payer advanced APM,” CMS will apply criteria parallel to the Medicare advanced APM criteria. In general, this means that arrangements with other payers will need to incorporate the certified EHR technology requirement, quality measurement and financial risk similar to the aforementioned Medicare advanced APM requirements.