Session 53AB
Strategic and Operational Implications of the Medicare Access and CHIP Reauthorization Act

Presented by:
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Strategic and Operational Implications of the Medicare Access and CHIP Reauthorization Act (MACRA)

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Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

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Learning Objectives

- Review MACRA and its implications
- Discuss common challenges and capabilities needed to succeed
Agenda

1. Post Election Health Care Implications
2. Overview of MACRA
3. Overview of the Quality Payment Program (QPP)
4. MIPS (Merit-based Incentive Payment System)
5. APMs (Alternative Payment Models)
6. Perspectives and Next Steps

Post-election Health Care Implications
Critical health care issues on the horizon

Governing Agenda
How will President Trump and Congress prioritize and approach health care among competing governing interests? Will they pursue programmatic changes to Medicaid? To Medicare? Legislation or regulations aimed at drug prices?

Affordable Care Act (ACA)
How will congressional rules and procedural requirements affect legislative efforts to repeal the ACA? What regulatory changes to the ACA will the new Administration pursue?

Tax reform
Will Congress seek to use tax reform to enact alternative health care policies? Will Congress advance changes to the tax preferences for employer-sponsored coverage?

The role of the states
How will the Trump Administration approach state applications for Medicaid waivers and Innovation Waivers under the ACA? What policies will states pursue as the Trump administration and Congress seek to give them greater authority over health care?

Payment Reform
How will the new Administration and Congress approach payment and delivery reform, including implementation of MACRA and the role of the Center for Medicare and Medicaid Innovation (CMMI)?

Overview of MACRA

Source: Deloitte Advisory Regulatory Services for Life Sciences and Health Care
MACRA: Political context

MACRA is a bipartisan law that is poised to transform the future direction of health care

“We’re pleased to see the administration responded to many of our concerns and followed our recommendation to provide clinicians and practitioners more flexibility in the issuance of the final rule for MACRA ... This historic law has been a collaborative effort from the start. We are encouraged by this final rule and CMS’s commitment to ongoing collaboration with Congress and the health care community.”

Energy and Commerce Committee Chairman Fred Upton (R-MI), Ranking Member Frank Pallone, Jr. (D-NJ), House Ways and Means Committee Chairman Kevin Brady (R-TX), and Ranking Member Sander Levin (D-MI)

MACRA in the post-election environment

“I want to make sure people take the opportunity to plow ahead and not use anything that happened in the election as a distraction.” – Andrew Slavitt, CMS Acting Administrator

“The reality is, Medicare needs to be reformed,” Childs said. “So you need some mechanism to test and scale new models in fee-for-service Medicare. And so I think CMMI will in the end survive.” – Helen Darling, interim president and CEO of the National Quality Forum

“We don’t see that that (MACRA) is going to be repealed. It was bipartisan, nearly a unanimous vote.” – Anders Gilberg, senior vice president of government affairs for the Medical Group Management Association

“Last month, we applauded CMS for listening to physicians’ concerns when writing the regulations, and we look forward to engaging with the new administration and Congress on future implementation work. As MACRA is established law and goes into effect Jan. 1, the American Medical Association will continue to work with the incoming administration to ensure that physicians succeed under its implementation.” – Dr. Andrew Gurman, president of the American Medical Association

“MACRA was passed on a very strong bipartisan basis to move us towards value-based reimbursement and care delivery, so I fully anticipate that the foundational needs of healthcare with respect to the needs of health IT... those are still going to be priorities in any changes to overall healthcare policy.” – Tom Leary, vice president of government relations at the Healthcare Information and Management Systems Society (HIMSS)

Broad themes of MACRA

Providers now have dollars at stake
For the first time providers may see a reduction in their reimbursement and ultimately their pay due to performance on quality and cost metrics

Focus on Cost and Efficiency
Patients and payers have increased sensitivity to cost, especially avoidable cost. Providers that can be more efficient, while still maintaining high quality, will differentiate themselves

New Drivers of Patient Access
Availability of high quality care delivered in a cost-efficient manner will become a greater factor in referral patterns and access to patients overall

Data Transparency
Quality and cost data will become increasingly available to the public

Payment reform is not going away
The current system is unsustainable

MACRA: Disruptive by design

MACRA is a game changer…the law will drive the future of health care payment and delivery system reform for clinicians, providers, and plans across their payer mix

MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to move away from the traditional fee for service system

With the repeal of the Sustainable Growth Rate (SGR) formula, MACRA sets updates to the Medicare Physician Fee Schedule (PFS) for all years in the future

MACRA is poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare
Introduction to MIPS and APMs

MACRA establishes two paths for receiving payment adjustments in the future

**Merit-based Incentive Payment System (MIPS)**
- MIPS payment adjustments are percentage increases or decreases to the physician fee schedule
- Each clinician will receive an individual MIPS score, but may report as an individual or a group
- The MIPS score is compared to national averages to determine a payment adjustment
- MIPS scores will be shared publicly via Physician Compare

**Alternative Payment Models (APMs)**
- Providers who participate in APMs may receive a 5% lump sum incentive payment
- Only participation in certain APMs with sufficient downside risk will exclude providers from MIPS
- Includes programs such as Accountable Care Organizations
- At least 25% of Medicare revenue must come from an APM to be eligible for an incentive payment in 2017 and 2018

In 2017, approximately 85% of providers eligible for MACRA are expected to participate in MIPS

Payment updates, bonuses and adjustments under MACRA

MACRA creates two separate paths for payments in addition to the Physician Fee Schedule (PFS)

**PFS Updates**
- 2016: 0.5%
- 2017: 0.5%
- 2018: 0.5%
- 2019: 0%
- 2020: 0%
- 2021: 0%
- 2022: 0%
- 2023: 0%
- 2024: 0%
- 2025: 0%
- 2026+: 0.75%
- 2026+: 0.25%

**APM Incentive Payments**
- 2019: 5%
- 2020: 3%
- 2021: 3%
- 2022: 3%
- 2023: 3%
- 2024: 3%

**MIPS Payment Adjustments**
- 2019: +/-4%
- 2020: +/-5%
- 2021: +/-7%
- 2022 and subsequent years: +/-9%

**OR**

Source: 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, Department of Health and Human Services, November 4, 2016.

Source: Public Law 114-10 (April 16, 2015)

*For 2019 through 2024, the highest performing MIPS eligible clinicians who receive a positive payment adjustment will be eligible to share up to $500 million each year for "exceptional performance" payments. This upside is limited by the statute to +10% of Medicare charges.
Clinicians eligible to participate in Advanced APMs and MIPS

A narrower group of clinicians will initially be eligible for payment adjustments under MIPS than will be eligible to participate in the APM track.

**Advanced Alternative Payment Models (APMs)**
- Physicians*
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional
- Physical or occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist

*Physician, as defined under current law, includes: a doctor of medicine or osteopathy; a doctor of dental surgery or of dental medicine; a doctor of podiatric medicine; a doctor of optometry; and a chiropractor.

Source: Public Law 114-10 (April 16, 2015)

**Merit-based Incentive Payment System (MIPS), 2019–2020**
- Physicians*
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

Participation may be expanded to other professionals paid under the Physician Fee Schedule in subsequent years.

Source: 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, Department of Health and Human Services, November 4, 2016.
Implications of MACRA across health care organizations

The new MACRA law significantly impacts a number of key areas across health care provider organizations.

- **Financial**: Impacts future Medicare reimbursement for all clinicians paid under the Medicare HS.
- **Clinical**: Requires clinicians to change and increment workflow and assess and improve clinical quality outcomes.
- **Operational**: Requires organization-wide collaboration and coordination of eligibility, multiple moving parts, and regulatory requirements.
- **Technological**: Requires robust clinical data capabilities (data governance, capture, collection, validation, and reporting).
- **Reputational**: MIPS Composite Performance Score (CPS) results will be made public and transparency will expose the good and the bad.
- **Patient Engagement**: Smarter coordination of care and two-sided risk for health care providers will raise the stakes for health care providers to foster closer ties with patients and help them actively manage their health.

### Strategic activities timeline based on key regulatory dates

The new MACRA law significantly impacts a number of key areas across health care provider organizations.

**Jan. 1, 2017**: Beginning of first performance period

**Jan. 1, 2018**: Beginning of first reporting period

**Jan. 1, 2019**: First payment adjustments under MIPS and APM; Beginning of All-Payer performance period

**Jan. 1, 2021**: All-Payer Model for APM thresholds under MACRA take effect

Source: Public Law 114-10 (April 16, 2015)
Key takeaways from the Final Rule

2017 as a Transition Year

- The final rule locks in January 1, 2017 as the beginning of the first performance period.
- CMS provided greater detail on changes intended to provide greater flexibility for clinicians to participate in MIPS at different levels in 2017.
- Clinicians who do not report any MIPS measures or activities will receive the full negative 4% payment adjustment.
- The final rule sets the MIPS performance threshold at three points for 2017. Clinicians who report at least one measure for Quality, Improvement Activities or Advancing Care Information (ACI) will not get a negative payment adjustment.
- CMS reduced the number of required measures for ACI and Improvement Activities to be submitted in order to be eligible for maximum positive adjustments. Quality reporting also was simplified.
- The final rule retains reporting advantages for clinicians who participate in MIPS APMs.
- The final rule weights Cost at 0% for the 2017 performance period. The weight will increase to 10% for 2018, and to 30% in 2019.

Organization of Clinical Networks

- Individual or Group reporting options remain unchanged from the proposed rule, reinforcing the emphasis on the organization of Tax Identification Numbers (TINs) for group MIPS reporting.

Updates to MIPS

- The final rule retains definitions from the proposed rule for AAM criteria related to financial risk.
- The list of anticipated Advanced APMs for 2017 remains the same as originally proposed.
- CMS declared its interest in creating a new Advanced APM (Medicare ACO Track 1+) to offer a pathway for existing MSSP Track 1 ACOs to achieve AAM status beginning in 2018.
- The Physician Focused-Payment Technical Advisory Committee (PTAC) is reviewing submissions from health care stakeholders for future AAMs. PTAC will make recommendations to CMS as to whether proposed models should be tested.

Advanced APMs

- The final rule sets the MIPS performance threshold at three points for 2017. Clinicians who report at least one measure for Quality, Improvement Activities or Advancing Care Information (ACI) will not get a negative payment adjustment.
- CMS reduced the number of required measures for ACI and Improvement Activities to be submitted in order to be eligible for maximum positive adjustments. Quality reporting also was simplified.
- The final rule retains reporting advantages for clinicians who participate in MIPS APMs.
- The final rule weights Cost at 0% for the 2017 performance period. The weight will increase to 10% for 2018, and to 30% in 2019.

The final rule aims to provide more options for provider organizations to participate in MACRA in 2017.

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Estimated MIPS exclusions for CY 2017 transition year

In the MACRA Final Rule, CMS increased the low-volume threshold for the first performance year to $30,000 in Part B allowed charges or 100 Medicare patients. Eligible clinicians who do not exceed the low-volume threshold have the option to participate voluntarily in MIPS, but would not be subject to payment adjustments.

The QPP by the numbers

CMS estimates that MIPS payment adjustments for 2019 will be +/- $199 million, while APM incentives will be between $333 million and $571 million.
MIPS and APMs: by the numbers

The Final Rule outlines the estimated impact of the QPP for 2019, both in the number of clinicians that fall under MIPS and APMs and the dollar amounts under each model.

<table>
<thead>
<tr>
<th></th>
<th>Estimated 70,000 - 120,000</th>
<th>Estimated 592,000 - 642,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Clinicians</td>
<td>Estimated $333 million - $571 million</td>
<td>+/- $199 million</td>
</tr>
</tbody>
</table>

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Overview of MIPS – including changes to the 2017 transition year

Components of MIPS Composite Performance Score (CPS)

<table>
<thead>
<tr>
<th>Performance Periods 2017-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
</tr>
<tr>
<td>60%</td>
</tr>
<tr>
<td>25%</td>
</tr>
<tr>
<td>15%</td>
</tr>
</tbody>
</table>

Overview of General MIPS Reporting Requirements for 2017 Performance Year

**Quality**
- Replaces the Physician Quality Reporting System (PQRS)
- Report up to six measures – including an outcome measure – for a minimum of 90 days

**Cost**
- Replaces Value-based Modifier
- Calculated from claims; no data submission required
- Counted in score beginning in 2018

**Advancing Care Information**
- Replaces Medicare Electronic Health Records (EHR Incentive Program for Providers (Meaningful Use)
- Report five required measures for a minimum of 90 days
- Submit up to nine measures for a minimum of 90 days for additional credit

**Improvement Activities**
- Attest to completion of up to four activities for a minimum of 90 days
- Special consideration for smaller practices, patient-centered medical homes and certain APMs

Sample MIPS Measures

**QUALITY**
- **Outcome:** Diabetes: HbA1c Poor Control (> 9%): % of pts 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
- **Cross-cutting:** Controlling: High Blood Pressure: % of pts 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period
- **Process:** Preoperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin: % of surgical patients aged 18 years & older undergoing procedures with the indications for a 1st OR 2nd generation cephalosporin prophylactic antibiotic, who had an order for a 1st OR 2nd generation cephalosporin for antimicrobial prophylaxis

**COST**
- **Cost:** Breast: Mastectomy for Breast Cancer: episode is triggered by a patient’s claim with any of the interventions assigned as Mastectomy trigger codes
- **Cardiovascular:** Acute Myocardial Infarction (AMI) without PCI/CABG: episode is triggered by an inpatient hospital claim with a principal diagnosis of any AMI trigger code

**ADVANCING CARE INFORMATION**
- **Neurology:** Parkinson Disease: episode is triggered by two (2) Evaluation & Management codes (E&M) with a principal or secondary diagnosis of any Parkinsons trigger code occurring within 30 calendar days

**IMPROVEMENT ACTIVITIES**
- **Protect Patient Health Information:** Attest yes that a security risk analysis has been conducted during the performance period
- **Electronic Prescribing:** % of prescribed medications that queried a drug formulary and were electronically transmitted during the performance period
- **Provide Patient Access:** % of patients provided access to view, download or transmit their health information online

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Clinicians eligible to participate in MIPS

Any affected clinicians are termed as "MIPS eligible clinicians" and will participate in MIPS.

**2019–2020**

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

**2021 and Beyond**

- Physical or occupational therapists
- Clinical social workers
- Speech-language pathologists
- Audiologists
- Nurse midwives
- Clinical psychologists
- Dietitians/Nutritional professionals

The statute provides flexibility to specify additional MIPS eligible clinicians in the 3rd and subsequent years.

Any clinician who is not eligible for MIPS has the option to volunteer to report on applicable measures and activities under MIPS; however, these clinicians will not receive a MIPS payment adjustment.

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016).

Who is eligible to participate in MIPS?

Unless they meet one of the following criteria:

1. New Medicare-enrolled eligible clinicians
   - Newly enrolled in Medicare during the performance period
   - Did not previously submit Medicare claims as an individual, an entity, part of a physician group or under a different Taxpayer Identification Number (TIN)

2. Qualifying (QP) & Partial Qualifying (Partial QP) APM Participants
   - Partial QPs can elect to report under MIPS or not, which determines whether or not they will be subject to MIPS adjustments
   - These participants are in advanced APMs

3. Low-volume threshold
   - Individual MIPS eligible clinicians or groups who:
     a. Have Medicare billing charges less than or equal to $30,000; or
     b. Provide care for 100 or fewer Part B-enrolled Medicare beneficiaries

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016).
MIPS exclusions: Low-volume threshold

The MIPS low-volume threshold exclusion is applied the same regardless of whether an Eligible Clinician (EC) reports as a group or an individual.

<table>
<thead>
<tr>
<th>MIPS Low Volume Thresholds (Must Meet One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30,000 Medicare Charges</td>
</tr>
</tbody>
</table>

**Illustrative Example**

TIN 12345 includes 100 clinicians who had $500,000 in aggregate Medicare charges and saw 6,000 patients during the measurement period.

- 40 ECs meet one of the low volume thresholds
- 60 ECs do not meet either low volume threshold

Reporting Options:

**Group Reporting**
- Aggregate data is submitted for ALL 100 ECs in the TIN, including those who individually meet the exclusion
- All ECs receive the same MIPS score and payment adjustment

**Individual Reporting**
- Submit 60 individual sets of data for the ECs who are not excluded from MIPS
- The 60 ECs will receive a unique MIPS score and payment adjustment
- The 40 excluded ECs do not receive a MIPS score or payment adjustment

*2017 low volume thresholds are calculated from September 1, 2015 to August 31, 2016 and from September 1, 2016 to August 31, 2017. ECs/Groups who are below the threshold in either time period are excluded.

**Source:** Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016).

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**Group reporting / scoring under MIPS**

Providers who report as a group will have an “individual” score on Physician Compare, but that score will be their group score based on aggregate reporting.

**Illustrative Example**

TIN 12345 Includes 4 Clinicians:

<table>
<thead>
<tr>
<th>Dr. A</th>
<th>Dr. B</th>
<th>Dr. C</th>
<th>Dr. D</th>
</tr>
</thead>
</table>

Dr. A 65 Dr. B 65 Dr. C 65 Dr. D 65

Scores are Posted Individually On Physician Compare, but all providers in TIN 123 receive same score

Group reporting requires data to be aggregated (i.e., TIN numerator and TIN denominator) for all performance categories

- Quality Measure 1: 400/550
- Quality Measure 2: 332/480
- Quality Measure 3: 120/130
- Quality Measure 4: 535/600
- Quality Measure 5: 225/300
- Quality Measure 6: 100/110

Data is converted to a group composite score

65

**Source:** Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016).
MIPS Performance Category Measures and Activities

Data submission mechanisms for MIPS eligible clinicians reporting individually and as a group

<table>
<thead>
<tr>
<th>Quality</th>
<th>Clinical Practice Improvement Activity (CPIA)</th>
<th>Advancing Care Information</th>
<th>Resource Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>🔴</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

- Claims
- Qualified clinical data registry (QCDR)
- Qualified registry
- EHR
- Administrative Claims*

- Attestation
- QCDR
- Qualified registry
- EHR
- Administrative Claims*

- Attestation
- QCDR
- Qualified registry
- EHR

- Calculated using administrative claims data
- No submission required

Individual Reporting Mechanisms

- QCDR
- Qualified registry
- EHR
- CMS Web Interface (groups of 25 or more)
- CMS approved survey vendor for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS (must be reported in conjunction with another data submission mechanism)
- Administrative Claims*

- Attestation
- QCDR
- Qualified registry
- EHR
- CMS Web Interface (groups of 25 or more)
- Administrative Claims*

- Attestation
- QCDR
- Qualified registry
- EHR

- Calculated using administrative claims data
- No submission required

Group Reporting Mechanisms

* No data submission requirements for certain measures performance on the quality performance category and for certain activities in the CPIA performance category. CMS will use administrative claims data to calculate performance on this subset of the MIPS quality and CPIA performance categories

Source: Public Law 114-10 (April 16, 2015)

Pick your pace for Performance Year 1

MIPS Adjustment

**Negative 4% payment adjustment**
No MIPS performance data submitted to MIPS

**Neutral to small positive adjustment**
Low overall performance in the categories on which they choose to report for at least a 90 day period may receive a final score at or slightly above the performance threshold

**Higher positive adjustment**
Average to high overall performance across the three categories for at least a 90-day period; MIPS eligible clinicians who receive a final score at or above the additional performance threshold will receive an additional adjustment

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Key Highlights: Advanced APMs

### Available for 2017

1. MSSP Track 2
2. MSSP Track 3
3. Next Generation Accountable Care Organization (ACO) Model
4. Comprehensive Primary Care Plus (CPC+)
5. Comprehensive End-Stage Renal Disease (ESRD) Care (CQC) Model – two-sided risk arrangement
6. Oncology Care Model (OCM) two-sided risk arrangement
7. Comprehensive Care for Joint Replacement (CJR)* Bundle
8. Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

### Anticipated Available Beginning 2018

1. Medicare ACO Track 1+
2. Acute Myocardial Infarction (AMI)* Bundle
3. Coronary Artery Bypass Graft (CABG)* Bundle
4. Surgical Hip/Femur Fracture Treatment (SHFFT)* Bundle
5. New Future Episode Payment Model based on Bundled Payment for Care Improvement (BPCI)*

### Key Considerations

**Enrollment:** Application cycle for 2017 is closed.

**Timing:** Next application cycle for MSSP will begin in April 2017 for 2018. Next Generation ACO and CPC+ applications to reopen in 2017 for 2018.

**Additional Options:** The Physician-Focused Payment Technical Advisory Committee (PTAC) opened the proposal process December 1, 2016.

*To qualify as an Advanced APM, participants must opt into Track 1 of each bundled payment model, requiring the use of Certified Electronic Health Record Technology.

Source: CMS, Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) (July 2016), CMS, 2016 Fact Sheet: The Quality Payment Program (October 25, 2016)
In order to achieve Qualifying Participant (QP) status through an Advanced APM, the APM entity must meet the specified payment amount thresholds for Medicare Part B claims through an Advanced APM.

* CMS also allows for APM Entities to achieve QP Status through an Advanced APM using the patient count method.

Source: Public Law 114-10 (April 16, 2015)

Impact of APM Participation

Thresholds in 2019 and 2020

APM participation is not an all or nothing proposition. Eligible Clinicians who do not meet QP thresholds may still be excluded from MIPS or receive bonus points or additional benefits within MIPS.

*MIPS Eligible Clinicians who participate in APMs may not be subject to quality and resource use scoring categories, resulting in an adjustment of their MIPS weighting.

Source: Public Law 114-10 (April 16, 2015)
Getting into the advanced APM track – and staying there

The threshold for QP status in advanced APMs increases dramatically in just five years. Many organizations are looking to the Other Payer Advanced APM option beginning in the 2019 performance year.

**QP Payment Amount Thresholds**

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifying participant (QP)</td>
<td>20%</td>
<td>50%</td>
<td>75%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial qualifying participant</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**QP Patient Count Thresholds**

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<td></td>
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<td>25%</td>
<td>35%</td>
<td>50%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Source:** Public Law 114-10 (April 16, 2015)

**Advanced APM QP Determination Snapshots**

Eligible clinicians on the participant list at one of three determination points throughout a performance period will be considered a Qualifying Participant (QP) in an APM Entity Group.

2017 QP Performance Period

**NOTE:** A QP determined from a Snapshot earlier in the performance year will remain a QP even if they are no longer on the participant list in a later snapshot.

**Source:** Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Advanced APM nominal risk standard
The Final Rule generally reduced the level of overall risk required to be considered an Advanced APM and outlined two distinct approaches to determining whether payment arrangements satisfy the nominal risk standard.

**Revenue-based standard**
- 8% of average estimated total Part A and B revenue of participating APM entities
- No marginal risk or minimum loss ratio
- Available for performance years 2017 and 2018; will increase for the third and subsequent performance years

**Benchmark-based standard**
- 3% of all expenditures for which an APM entity is responsible
- Available for all performance years

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)

Bundled Payment Models to qualify as Advanced APMs
CMS's Proposed Rule on Bundled Payment Models for High-Quality, Coordinated Cardiac and Hip Fracture Care would create a track for each of the five proposed models with the potential to qualify as Advanced APMs.

1. **Certified EHR Users**
   - Acute Myocardial Infarction (AMI)
   - Coronary Artery Bypass Graft (CABG)
   - Surgical Hip/Femur Fracture Treatment (SHFFT)
   - New Future Episode Payment Model based on Bundled Payment for Care Improvement (BPCI)
   - Comprehensive Joint Replacement (CJR)

2. **Non-Certified EHR Users**
   - Acute Myocardial Infarction (AMI)
   - Coronary Artery Bypass Graft (CABG)
   - Surgical Hip/Femur Fracture Treatment (SHFFT)
   - New Future Episode Payment Model based on Bundled Payment for Care Improvement (BPCI)
   - Comprehensive Joint Replacement (CJR)

Source: CMS, Proposed Rule: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)
Arrangement of Clinicians in Advanced APMs

Advanced APMs meet the three requirements: 1) require use of a certified EHR; 2) tie payment for covered services to quality measures similar to those under MIPS; 3) be a Medicare Home or bear more than nominal risk for monetary losses. Clinicians who meet thresholds for revenue or patients through an Advanced APM qualify for APM Incentive Payments.

Advanced APM Entities are groups of clinicians that meet the required Advanced APM thresholds. One health system may have multiple Advanced APM Entities depending on the arrangements in which their clinicians participate. One Advanced APM entity may include physicians that participate in multiple Advanced APMs.

Clinicians who meet revenue or patient attribution thresholds through one or more Advanced APMs are excluded from MIPS and qualify for Advanced APM Incentive Payments. Qualifying participants can participate in one or more Advanced APMs through one or more Advanced APM entities.

MSSP Track 1+ Eligibility

CMS established a number of pathways for ACOs to participate in the Track 1+ model beginning in 2018 and will align the application process with the other tracks. CMS limits participation in Track 1+ to one full 3-year agreement period.

**Mid-Agreement Transfer**
ACOs currently in a Track 1 agreement can apply to participate in the model for the remainder of their current agreement period.

**New ACO**
New ACOs can move straight into Track 1+, bypassing MSSP Track 1.

**Renewing ACO**
Track 1 ACOs that complete their agreement period under the Track 1+ model can renew for one additional agreement period in 2019 or 2020.

**Track 1 Transition**
Track 1 ACOs can choose to move to Track 1+ at the start of their new agreement period.

**NOTE:** ACOs currently participating in Track 2 or Track 3 and ACOs owned or operated by a health plan cannot participate in the MSSP Track 1+ model.

Source: CMS, "New Accountable Care Organization Model Opportunity: Medicare ACO Track 1+ Model" January 2017
Track 1+ ACO

The Track 1+ ACO, which qualifies as an advanced APM, is based on the Track 1 model but allows providers to take on more limited downside risk as they transition to the Track 2 or Track 3 model.

**Increasing downside risk**

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 1+</th>
<th>Track 2</th>
<th>Track 3</th>
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<tbody>
<tr>
<td>• Up to 50 percent shared savings rate based on quality performance</td>
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<td>• Fixed 30 percent loss sharing rate</td>
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<td>• Prospective beneficiary assignment</td>
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<td>• Option to request SNF 3-Day Rule waiver</td>
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<td>• Benchmarks are rebased at the start of each agreement period</td>
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<td>• Use of regional growth rates to trend and update benchmarks in 2017 and subsequent years</td>
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<tr>
<td>• Benchmarks risk-adjusted using CMS-HCC risk scores</td>
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<td>• Payment amounts and benchmarks calculated using total Medicare Parts A and B expenditures</td>
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**Common features across all models**

**Track 1+ ACO – Two potential risk arrangements**

Track 1+ ACOs will enter one of two risk arrangements depending on whether or not the ACO meets certain criteria.

The ACO includes:

1. A participant that is an IPPS hospital, cancer center, or a rural hospital with more than 100 beds;
2. An ACO participant that is owned or operated by a rural hospital with 100 or fewer beds that is not itself an ACO participant; OR
3. An ACO participant rural hospital with 100 or fewer beds that is owned or operated by a health system

**Benchmark-based loss sharing limit**

- Loss sharing limit will be 4 percent of the ACO’s updated historical benchmark
- The loss sharing limit would be determined by CMS near the start of the ACO’s agreement period
- Regional benchmark adjustments phased in

**Revenue-based loss sharing limit**

- Loss sharing limit equal to 8 percent of ACO participant Medicare (Parts A and B) fee-for-service revenue in year 1
- In years 2 and 3, Track 1+ ACOs can accept higher loss sharing limit if needed for Advanced APM qualification

Potential of the Other Payer Combination Option

The Other Payer Combination Option is poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare.

2021

Beginning in 2021, health care professionals can also qualify for APM Incentive Payments through Other Payer Advanced APM thresholds.

2022

In order to qualify in 2021 and 2022, Qualifying APM Participants (QPs) must receive at least 50% of the sum of payments by Medicare and other payers through Advanced APMs and Other Payer Advanced APMs.

2023

For 2023 and subsequent years, QPs must receive at least 75% of payments through Advanced APMs and Other Payer Advanced APMs.

Under Other Payer Advanced APMs, at least 25% of Medicare payments for covered professional services must be through Advanced APMs.

Source: Public Law 114-10 (April 16, 2015)

The QPP & Medicare Advantage (MA)

Implications of the Final Rule on MIPS and APM Incentives for MA

Advanced APMs
The Final Rule reiterates that MA and other private plans paid to act as insurers on Medicare’s behalf are not Medicare Advanced APMs in their current form.

Quality Rating Systems
CMS relies on the Five-Star Quality Rating System to hold Medicare Advantage Organization (MAOs) accountable for health care outcomes; MIPS measures, on the other hand, are tied directly to individual and groups of providers. Both measurement systems need to be examined for future alignment.

MA “Capitation” as Financial Risk
Where we currently stand (i.e., the Medicare-only option), MA capitation does not count as an advanced APM in part because CMS is not directly paying providers -- the MAO is.

All-Payer Combination Options
A provider can qualify for the APM incentive payment established by MACRA through, in part, participation in an Advanced APM with MAOs. “In essence, the “All-Payers Combination Option” creates a new incentive for providers to engage with MAOs in establishing certain types of value-based arrangements.”

Legislative changes would be needed for CMS to require MAOs to adopt the use of APMs in payment arrangements.

What we are hearing from health systems and health plans

- In order to be successful, we'll need access to real-time claims data.
- Which physicians are likely to perform well under risk-based contracts and MIPS?
- What does the future provider-plan relationship look like?
- How do we change our care delivery model to better deliver better outcomes more efficiently?
- Into which Advanced APMs should we move and in which performance year?
- How should our physician compensation and incentives change, if at all?
- What does this mean for our MA business?
- Do we need to re-examine all of our joint ventures?
Challenges exist in developing and maturing MACRA capabilities

Iterative Process
The regulatory environment around MACRA will constantly evolve, with updates to MIPS requirements, new MIPS, and changing government priorities. Success in MACRA requires diligent evaluation of prior decisions and agile course correction as these variables change.

Technology Strategy
Use of technology is critical to success in both MIPS and APMs. Dependence on vendors, EMR upgrades or changes and identification and implementation of population health management tools are all significant challenges.

Organizational Alignment
Clinician groups within a health system may be at different stages of maturity or have varying levels of data infrastructure.

Physician Strategy
Effective engagement with affiliated and independent clinicians is becoming increasingly important from a competitive, financial and operational perspective.

Resources and Competing Priorities
Finding opportunities to align MACRA, identifying where additional resources are needed.

Journey for health systems
MACRA accelerates the directional journey we are on from volume to value

- Assisting clinicians to manage reimbursement and reputation risk is critical to future success, and ultimately, is the link to brand enhancement and patient engagement.
- Moving from volume-driven reimbursement to risk-based payment models requires clinical and financial integration across the entire health system enterprise, within your delivery models, and across your local payer mix.
- Aligning provider networks (both employed and non-employed clinicians) with new payment models is imperative to your growth strategy and risk management.
- Access to real time and accurate data to improve performance, may reduce utilization, and manage financial risk is one of the highest operational priorities.
Next steps to consider

1. Begin internal discussions with key enterprise stakeholders (including potentially the board of directors) on forthcoming MACRA impacts.

2. Perform a thorough impact assessment to understand how MACRA will impact Strategic, Financial, Clinical, Technological, Operational, and Organizational priorities as well as exploration of strategies to gain access to higher percentage of the premium dollar.

3. Plan and prepare for tactical changes and/or enhancements associated with MIPS readiness, particularly given the Performance Range began January 1, 2017.

4. Make informed, strategic choices around moving in a swift and responsible manner toward Advanced APMs and Other Payer Advanced APMs.

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Claudia Douglass
Managing Director | Deloitte & Touche LLP

Profile
Claudia Douglass is a managing director in Deloitte Risk and Financial Advisory Life Sciences and Health Care Practice of Deloitte & Touche LLP, specializing in health care strategy, regulatory and operations for both the provider and health plan sectors. Claudia has over twenty five (25) years of experience in the health care industry in both consulting and with large health systems in senior leadership roles in the areas of strategic planning, operations and financial management. Her experiences include a focus on developing and leading complex strategic initiatives across multiple business units, primarily in the areas of quality and patient experience, population health, and cost management.

Claudia helps clients with the planning, preparation and implementation of changes as a result of regulatory disruptors, most recently the implications of MACRA. She has also presented on the topics of customer relationship management and leadership at professional conferences.

Claudia is a Fellow in the American College of Healthcare Executives (FACHE) and certified in project management with the Project Management Institute (PMI) as a Project Management Professional (PMP).

Education
- B.B.A., Finance and Marketing - University of Miami
- Master of Health Services Administration - University of Michigan
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Vickie Monteith
Managing Director | Deloitte & Touche LLP

Profile
Vickie Monteith, RN, MBA, is a managing director at Deloitte & Touche LLP and is the national leader for the ICD-10 solution. She also assists in leading the Clinical Documentation Excellence (CDE) solution at Deloitte and is one of Deloitte’s national MACRA leaders. Vickie has more than 30 years of experience in the healthcare industry in the areas of scheduling, patient access, medical necessity processing, utilization management, case management, medical records, patient accounting, billing compliance, charge integrity, chart-to-bill audits, CDE, charge description master (CDM) reviews and standardization, compliance risk assessments, compliance effectiveness reviews, compliance program development, internal control reviews, Recovery Audit Contractor (RAC) readiness, Medicare compliance, ICD-10, MACRA, nursing and supply chain. Vickie’s extensive provider experience includes academic medical centers, ambulatory surgery centers, physician practices, home health agencies, and post-acute care.

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• B.S., Nursing - University of North Carolina at Charlotte
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Interoperability of health IT
Office of National Coordinator HHS Interoperability Metrics
Questions?

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Please remember to complete your evaluation!
Thank you!