Making MACRA and Bundles Work Together

National Bundled Payment Summit Preconference

June 26, 2017

Nick Bluhm, MA, JD
Director, Strategy and Government Policy, Remedy Partners; Litigation Attorney/Health Insurance Specialist, US Department of Health and Human Services, New York, NY

Valinda Rutledge, MBA
Vice President, Public Payor Health Strategy, Care Coordination Institute, Greenville Health System; Former Group Director of Patient Care Model Group and BPCI Lead, Centers for Medicare and Medicaid Services, Greenville, SC

Lauren Seno, MS
Senior Consultant, Payment and Policy Intelligence Research, Sg2, Skokie, IL

Agenda

- **1:00-1:45** Review of MACRA (45 mins)
- **1:45-2:30** Review of MIPS Details (45 mins)
- **2:30-3:00** Break (30 mins)
- **3:00-3:45** MIPs APM, aAPMs and Bundles (45 mins)
- **3:45-4:15** Integrating MACRA Into Strategic Plan/Pop Health (30 min)
  4:15-4:45 Developing MACRA Action Plan (30 mins)
  - Small Group Exercises:
    - Segmenting Your Provider Network Worksheet
    - MACRA Shark Tank – Innovative Strategies for Partnership
- **4:45-5:00** Questions & Wrap-Up

Agenda

MACRA Review

MIPS Domains

MIPS APM, aAPM and Bundles

Strategic Plan Integration

Developing MACRA Action Plan

Surprise!

- 2018 MACRA Proposed Rule released 6/20
- We have incorporated updates from the proposed rule in this presentation, but please note that changes have not been finalized

MACRA Review

MACRA is Here to Stay, New Administration Will Adjust Program Rules

Vote Breakdown

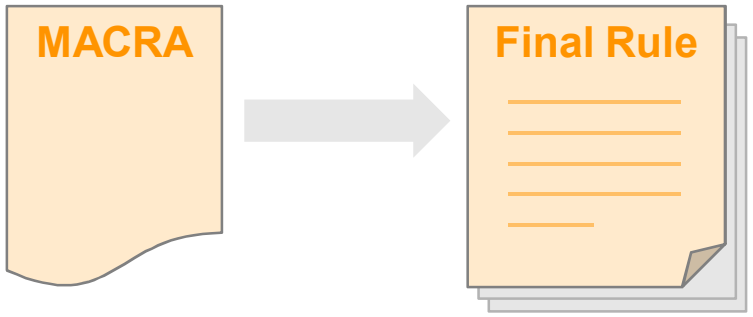
Senate: 92–8

House: 392–37

- Bipartisan supported law flattens fee updates for 10 years and establishes a 2-track system for earning positive adjustments
- Framework outlined by Congress, program details written by CMS

Congress:
House and Senate

Administration:
HHS and CMS



Program rules will be adjusted annually at discretion of HHS/CMS.

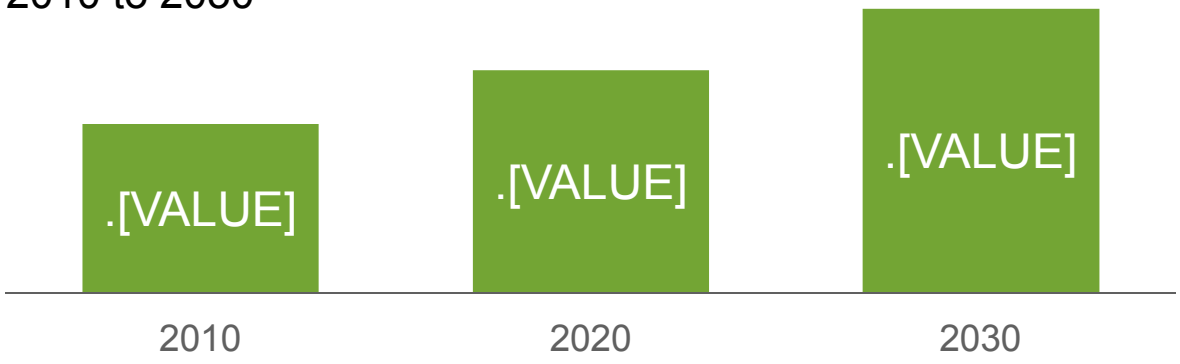
Without legislative action, CMS has very limited options to reduce or further delay impact of MACRA

HHS = Department of Health and Human Services.

Medicare Spending Reduction Driven by Necessity

- Aging population (65+) growth outpaces working population numbers
  - Smaller pool of eligible tax payers to finance Medicare expenditures

65+ Dependency Ratio
2010 to 2030



Regardless of policy context, 65+ population growth creates added financial pressure to reduce Medicare spending.

Working age population = ages 20 to 64; Dependency ratio = portion of the population over 65 compared to portion of the population of working age.
Source: US Census. Current Population Reports. June 2014.

What Is the **M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct of 2015?

- The **M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct of 2015 became a law on April 14, 2015.
- Final Rule outlining program details issued October 14, 2017.
- MACRA makes important changes to **how Medicare pays clinicians:**

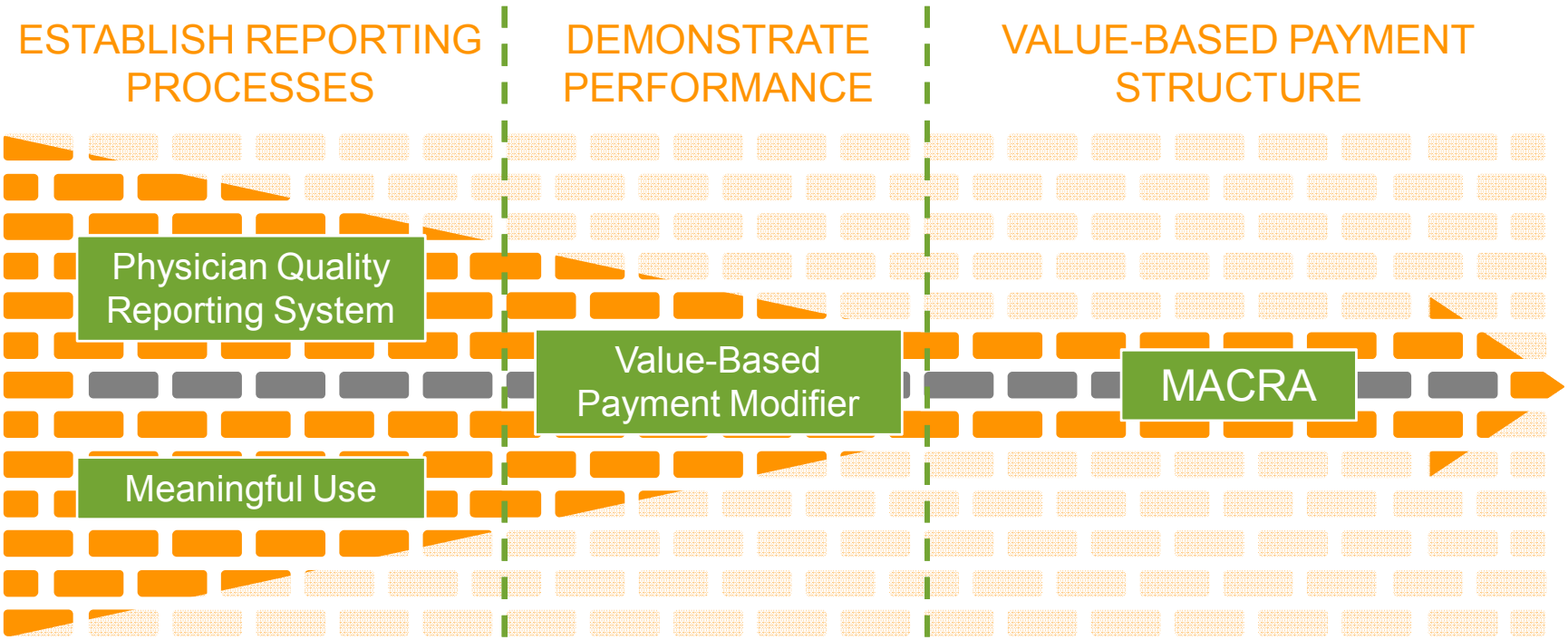
Ends Sustainable Growth Rate Formula

Ties Part B Payments for Items and Services to Performance

Note: Clinicians include physicians, dentists, physician assistants, nurse practitioners, clinical nurse specialists and certified RN anesthetists during the first 2 years of MIPS. From the third year, clinicians may also include other providers such as physical therapists, audiologists, nurse midwives, clinical psychologists, clinical social workers, etc. Impacts Part B items and services, including professional fees (no impact on facility fees)

Sources: CMS. Final Rule With Comment Period: 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 (PDF). October 14, 2016; Sg2 Analysis, 2016.

The Road to Pay for Performance

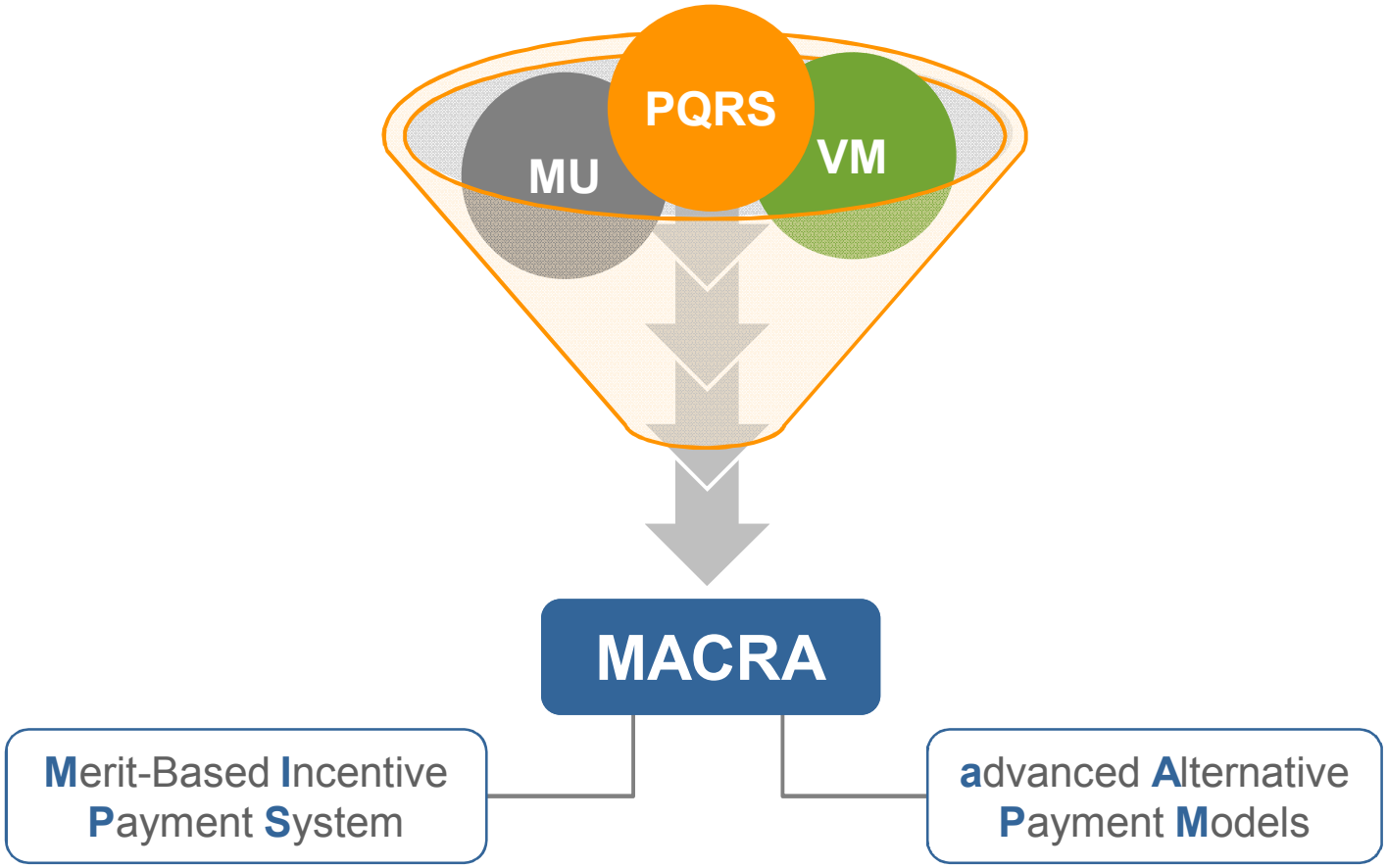


- **Can** you effectively report on quality measures?
- **Did** you adopt certified EHR?

- **Does** your practice perform well on cost and quality compared to peers?

- **How** do you perform as part of a team-based approach to population health?
- **How** are you using your EHR to improve patient outcomes?

MACRA's Quality Payment Program Establishes 2 Avenues for Clinicians



MU = meaningful use; PQRS = Physician Quality Reporting System; VM = Value-Based Payment Modifier.
Sources: CMS. Final Rule With Comment Period: 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 (PDF). October 14, 2016; Sg2 Analysis, 2016.

MACRA Has Already Started, 2019 Payment Impacted by 2017 Performance

- **Medicare Part B** items and services payment impacted by MACRA
  - This includes: professional fees, clinic and outpatient item costs
  - This does NOT include: facility fees, most drug payments, inpatient hospital claims (Part A)
- Data for all payers and all patients are subject to evaluation.

Sources: CMS. *Final Rule With Comment Period: 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.* November 4, 2016; Sg2 Analysis, 2016.

MACRA's Financial Impact Ramps Up Quickly

- Payment adjustment reflects past performance.
  - That is, 2017 performance determines 2019 payment adjustments.
- 83% to 90% of **nonexempt** clinicians in **MIPS** for 2017

	PAYMENT YEARS					
	2019	2020	2021	2022	2023	2024
Physician Fee Schedule	+0.5%	No Change				
MIPS Adjustments	–4% to 4x%	–5% to 5x%	–7% to 7x%	–9% to 9x%		
aAPM Incentives	Exempt from MIPS; +5% lump sum bonus					

Note: Physician Fee Schedule updates are the same across clinicians through 2025. From 2026, clinicians that qualify for aAPM Incentives will have a 0.75% update while other clinicians receive a 0.25% update; For MIPS positive adjustments, a scaling factor "x" of up to 3 can be applied by the HHS secretary to maintain budget neutrality. The performance threshold is 3 for 2019, but future years may set this threshold at the mean OR median of scores; An additional pool of $500M is available annually for 2019 to 2024 as an exceptional performance bonus. The additional performance threshold is 70 for 2019, but future years may set this threshold at a different level. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Who Is in the Quality Payment Program?

MIPS-Eligible clinicians include:

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

This list will grow as the years go on.

Medicare-enrolled clinicians who will be ***excluded*** from MIPS include:

Newly enrolled (≤1 year of Medicare billing experience)	≤$30,000 in allowed charges **OR** ≤100 Medicare patients	QPs and certain partial QPs in aAPMs

QP = Qualified Provider for advanced Alternative Payment Model. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Low Volume Exclusions for 2017

- $30,00 in Part B charges or 100 beneficiaries (increased from proposed rule)
- Medicare Advantage patients do not count in volume designations
- Determination is made at the group (TIN) level, not at individual (NPI) level
- Two time periods will be used to determine exemptions:
  - September 1, 2015 – August 31, 2016
  - September 1, 2016 – August 31, 2017
- CMS has informed clinicians that meet exemption criteria (letters sent May 2017)
  - Can also look up exemption status on QPP website: https://qpp.cms.gov/

TIN = Taxpayer Identification Number; NPI = National Provider Identifier; QPP = Quality Payment Program. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

The Major Components of MIPS in Plain English

Quality

Measures endorsed by national accreditation and governing bodies that assess quality performance

Cost

How much it costs to provide care for your patients compared to your peers

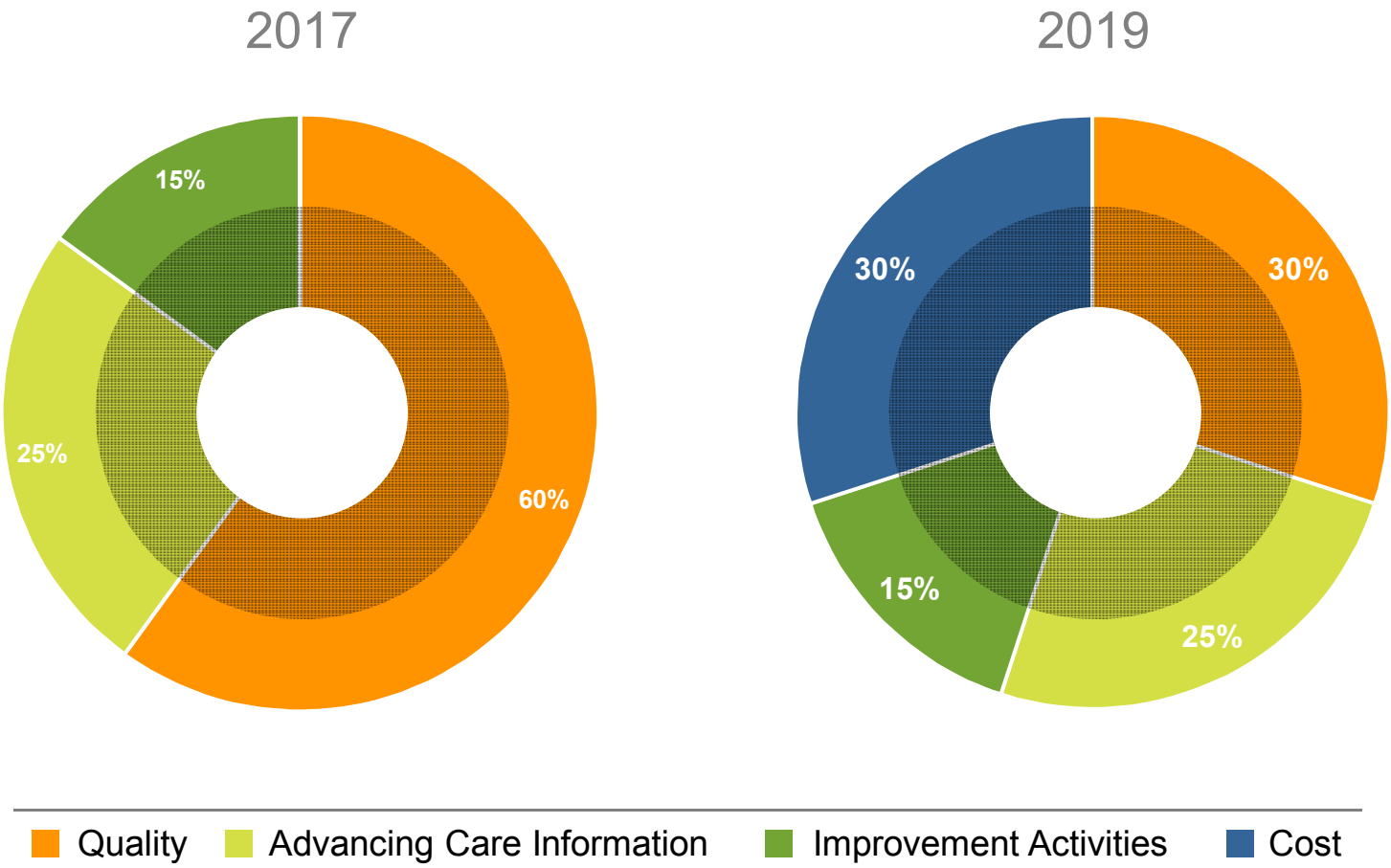
Improvement Activities

Clinical activities that demonstrate a commitment to practice transformation (medical home models, etc)

Advancing Care Information

Very similar to Meaningful Use, but without the all-or-nothing thresholds and less overall metrics to report on

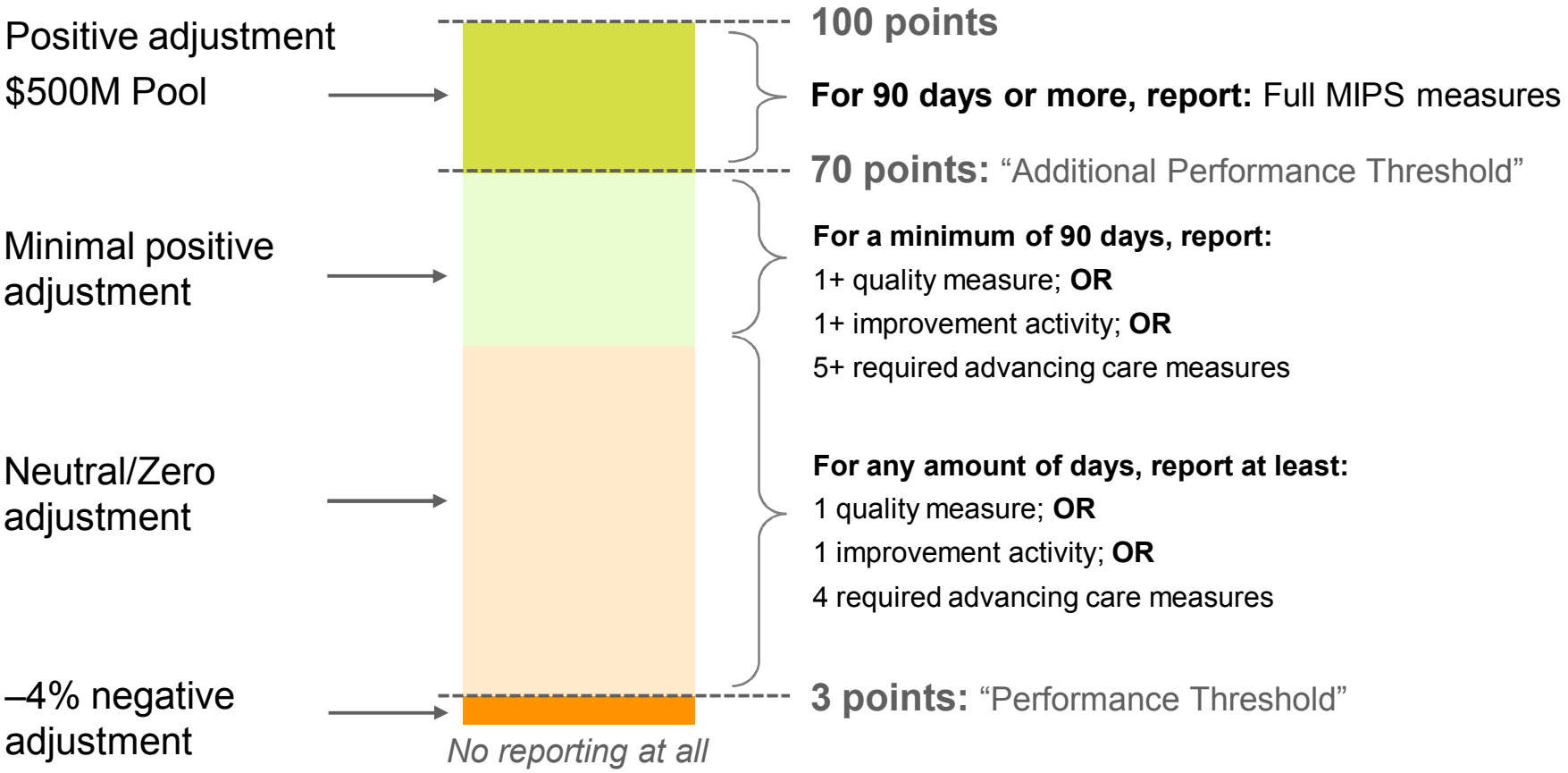
Cost Will Be Important in Future Years



Sources: CMS. *Final Rule With Comment Period: 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*. October 14, 2016; Sg2 Analysis, 2016.

Sg2 Position: Transition Year Buys You Time to Succeed in MACRA Over the Long-term

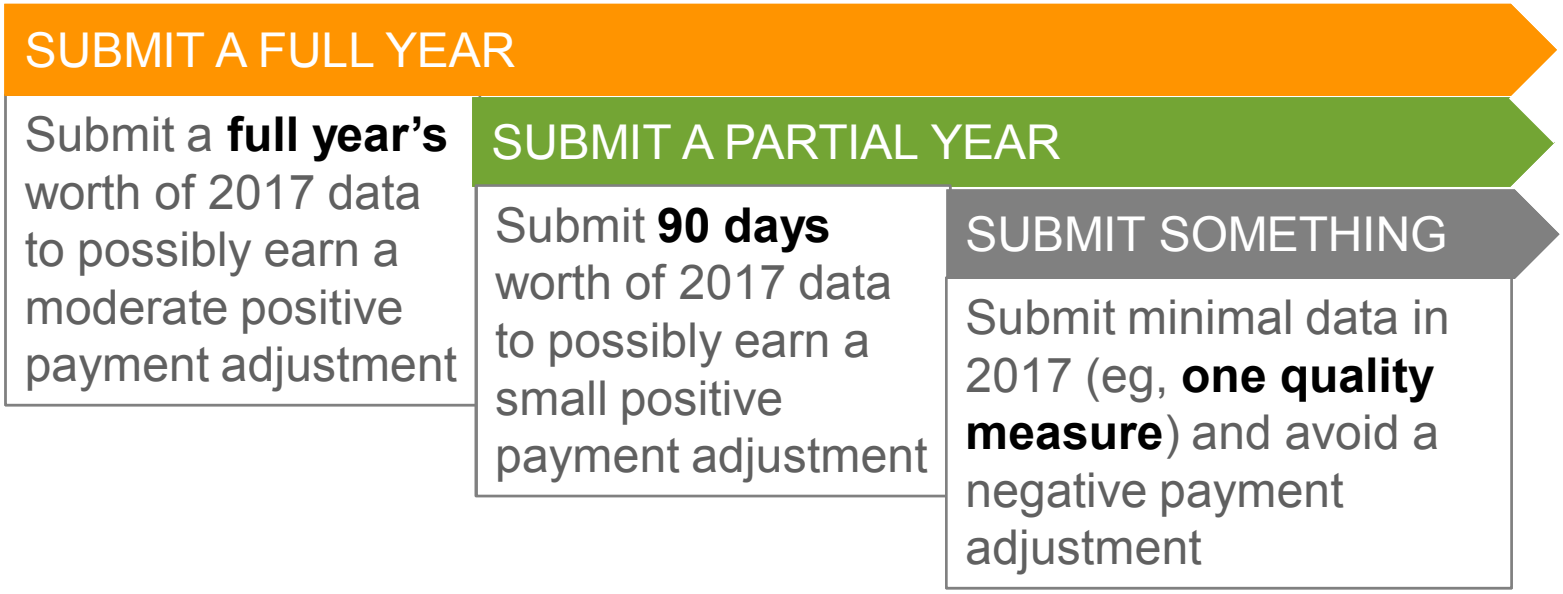
MIPS Transition Year 2017



Sources: CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Pick Your Pace Reporting Options for 2017

If you are in the MIPS track of the Quality Payment Program, you have 3 options.



Submit no data and receive a **negative 4%** payment adjustment

Sources: CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Agenda

MACRA Review

MIPS Domains

MIPS APM, aAPM and Bundles

Strategic Plan Integration

Developing MACRA Action Plan

What Measures Make Up the Quality Performance Score?

- Clinicians are required to report on up to **6 measures** annually with **1 outcome measure** or 1 specialty measure set.
  - If no outcome measures are available, a high-priority measure is required
- Reporting thresholds increase over time:
  - **In 2017, required to report on 50% of patients**
  - In 2018, required to report on 60% of patients
- **Bonus points awarded** for reporting quality measures through an EHR, qualified registry, QCDR or web-interface
- Groups, **including ACOs**, that use the CMS Web Interface must report all 14 measures
- Will use All-Cause Readmission claims data for groups **larger than 15**

Core Competency #1: Demonstrate quality and implement processes to drive improvement

Note: 90-day period can be the same or different for each of the 3 reporting domains required for full participation in performance year 2017. If fewer than 6 measures apply to the individual MIPS-eligible clinician or group, then the MIPS-eligible clinician or group will only be required to report on each measure that is applicable. QCDR = Qualified Clinical Data Registry. **Sources:** CMS. *Final Rule With Comment Period: 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*. October 14, 2016; Sg2 Analysis, 2016.

Strategic Selection of Measures Is Important

If you had to select 2 measures, which would you choose?

Example Hospital Data

Measure	Hospital Performance (Regional Ranking)
Chronic Kidney Disease—CKD Care in Stages I, II and III: Blood Pressure Control	90% (1 of 25)
Ischemic Vascular Disease: All-or-None Outcome Measure (Optimal Control)	60% (3 of 25)
Adult Screening for Tobacco Use	98% (8 of 28)

Sources: CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

If you had to select 2 measures, which would you choose?

A. The 2 with the highest percentage (Chronic Kidney Disease and Tobacco Screening).
B. The 2 with the highest relative ranking (Ischemic Vascular Disease and Chronic Kidney Disease).
C. The measures my docs complain about the least.
D. Not sure.

What Are the Components of the Advancing Care Information Score?

BASE—50%

- Protect Patient Health Information
- Electronic Prescribing
- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange

130 points available, but final category score cannot exceed 100

PERFORMANCE—80%

- Patient Access
- Patient-Specific Education
- View, Download, Transmit
- Secure Messaging
- Patient-Generated Health Data
- Patient Care Record Exchange
- Request/Accept Patient Care Record
- Clinical Information Reconciliation

Core Competency #2: Leverage technology investments to enhance patient engagement and safety

Sources: CMS. *Final Rule With Comment Period: 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*. October 14, 2016; Sg2 Analysis, 2016.

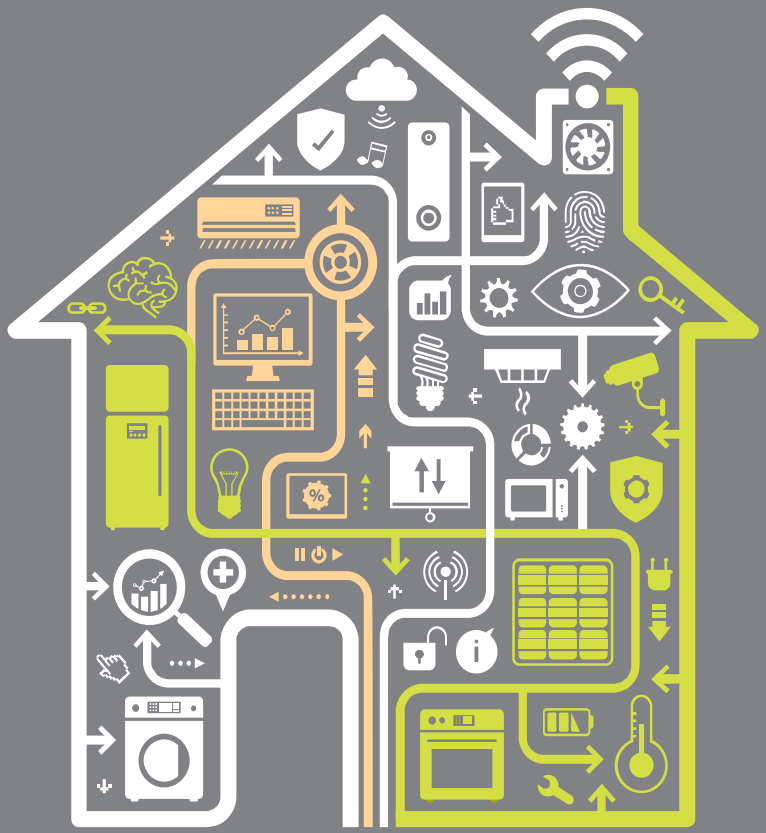
What Are the Improvement Activities?

- Choose from **90+ activities** that use a patient-centered approach to improve health outcomes.
- Weighted activities as **"medium"** (10 points) or **"high"** (20 points)
- **Favorable scoring** for PCMHs, some APM participants and CMS study participants
- **Reduced requirements** for small groups (consisting of 15 clinicians or fewer), clinicians located in rural areas, geographic HPSAs or non–patient-facing clinicians

Core competency #3: Establish culture of care coordination and continuous improvement

CPIA = Clinical Practice Improvement Activity; HPSA = health professional shortage area; PCMH = Patient-Centered Medical Home.
Sources: CMS. *Final Rule With Comment Period: 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*. October 14, 2016; Sg2 Analysis, 2016.

Improvement Activity Categories



Expanded Access

Population Management

Care Coordination

Emergency Response

Behavioral Health Integration

Patient Safety

Health Equity

Beneficiary Engagement

What Measures Will Be Used to Determine My Cost Score in 2017?

- **Three types of measures:**
  - Total per capita cost
  - Medicare Spend per Beneficiary (MSPB)
  - Episode-based measures (in development)
- **Minimum threshold** of 35 cases for MSPB and 20 cases for other measures
- Medicare Part B **claims–based measures**
- CMS is developing patient condition groups and patient relationship codes to assist with attribution beginning in 2018
- **<u>Will NOT be utilized in 2017 and 2018*</u>**
  - Feedback reports expected Summer 2017
  - Measure weight increases to 30% in 2019

Core competency #4: Effectively manage resources while delivering high-value care to patients

The MACRA 2018 proposed rule indicates the cost category weighting = 0%, but is subject to change pending the final rule. **Sources**: CMS. *Final Rule With Comment Period: 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*. October 14, 2016; Sg2 Analysis, 2016.

CMS Episode-Based Cost Measures

2017	2018	2019
Claims-Based Feedback Only Mastectomy Aortic/Mitrial Valve Surgery CABG Hip/Femur Fracture Cholecystectomy Colonoscopy Transurethral Resection of the Prostate Lens and Cataract Procedures Hip Replacement or Repair Knee Arthroplasty Medicare Spending per Beneficiary Measure	Claims-Based Feedback Only Measures developed based on Episode Grouper for Medicare 2017 Measures Phased-Out	30% of MIPS Composite Performance Score Second Performance Period for 2017 Measures Possible Condition Measures AMI Asthma/COPD Atrial Fibrillation Cellulitis GI Hemorrhage Heart Failure Ischemic Stroke UTI Pneumonia

Episode-Based Cost Measures in Development

- **What is CMS focused on?**
  - Aligning cost measures with quality measures (analogous to standardized quality measures in CJR and Cardiac Episode Payment Models)
  - Cost measures should deliver “actionable information”
  - Physicians should be held accountable only for patient outcomes that are within the scope of their clinical role
  - Attribution of episodes should be clear at the time of service

MIPS Reporting Options

- Individual
  - Report by NPI for all 4 categories
  - Payment at TIN
- Group
  - Report at TIN with one score in all 4 categories
  - Payment at TIN
  - All small groups are defined as less than 15 clinicians
  - Virtual Groups defined in final rule
- APM Entity – Medicare ACO
  - Report at APM entity, except ACI
  - Payment at TIN for APM entity

TIN = Taxpayer Identification Number; NPI = National Provider Identifier; QPP = Quality Payment Program; APM = Advanced Payment Model; ACO = Accountable Care Organization; ACI = Advancing Care Information. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Agenda

MACRA Review

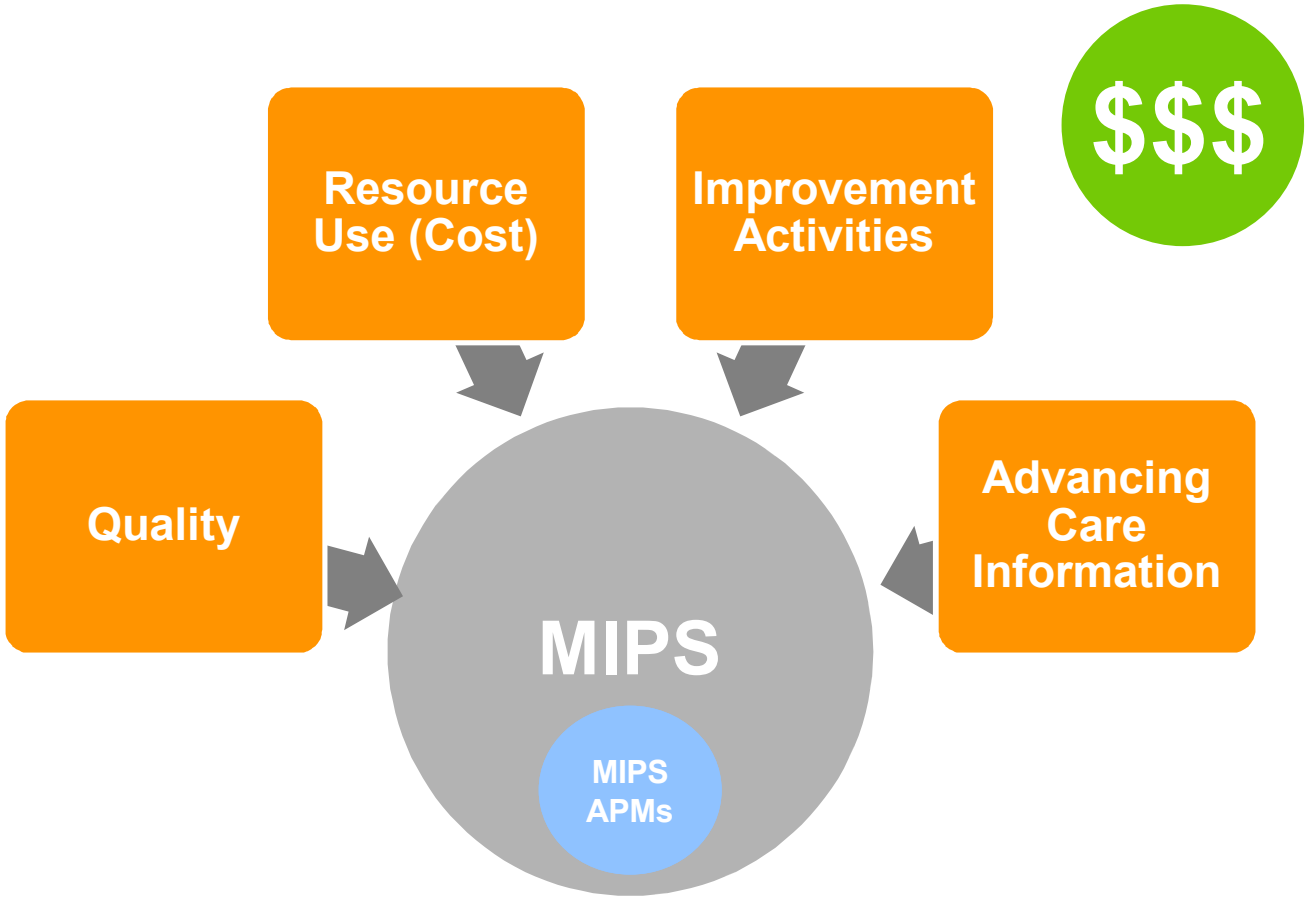
MIPS Domains

MIPS APM, aAPM and Bundles

Strategic Plan Integration

MACRA Action Plan

Merit-Based Incentive Payment System (MIPS) APMs



QPP & Bundled Payments

MIPS

- Cost Measures (including Episode-based)
  - 30% of Score in 2019 (0% in 2018)
  - Based on the Episode Grouper for Medicare (EGM)
  - Assessed at the NPI level
- Focus: Avoiding Penalty
- **Open QPP Policy Questions:**
  - May clinicians select which episodes to be measured (similar to picking quality measures)?
  - Proposed **0%** of MIPS Composite Performance Score in 2018 Performance Period (soliciting comment on including at **10%** of composite score)

Advanced APM

- BPCI Advanced
  - Beginning in 2018
  - Based on the EGM?
  - Assessed at the APM Entity level; QP status determined at NPI level
- Focus: Managing Technical Risk
- **Open QPP Policy Questions:**
  - Will CMS change the definition of "attribution-eligible beneficiary" for BPCI Advanced participants?

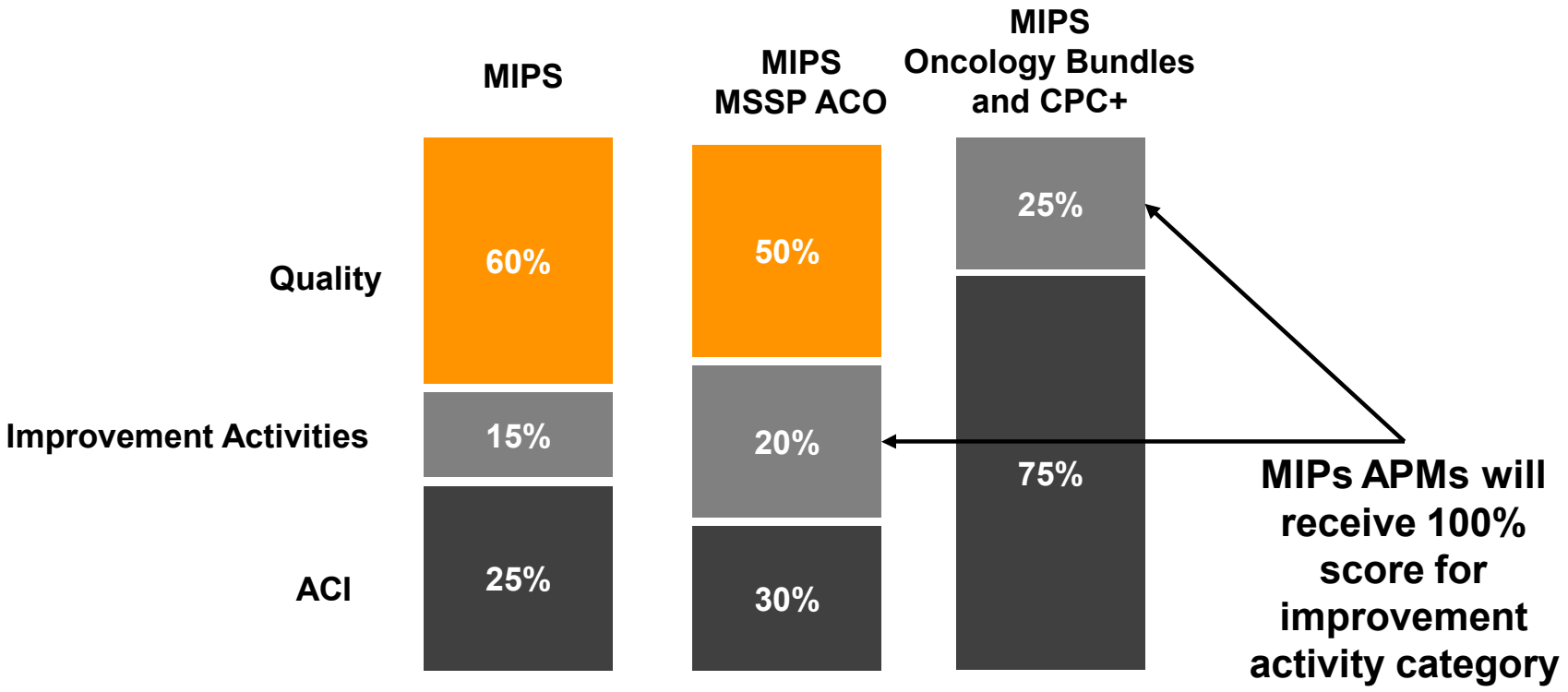
Observations from QPP Proposed Rule (2018)

- BPCI Advanced not listed
  - CMS has a policy of designating models as Advanced APMs when they are announced (but not before then)
- Clinicians may qualify for MACRA bonuses in 2018 Performance Period even if BPCI Advanced starts later
  - CMS proposes to change its regulations to not assess physicians for the months in 2018 during which an Advanced APM (like BPCI Advanced) is not active
- The definition of "attribution-eligible beneficiaries" needs to be aligned with the type of model in which a clinician is participating
  - "Attribution-eligible" for ACOs is not the same as that for EPMs

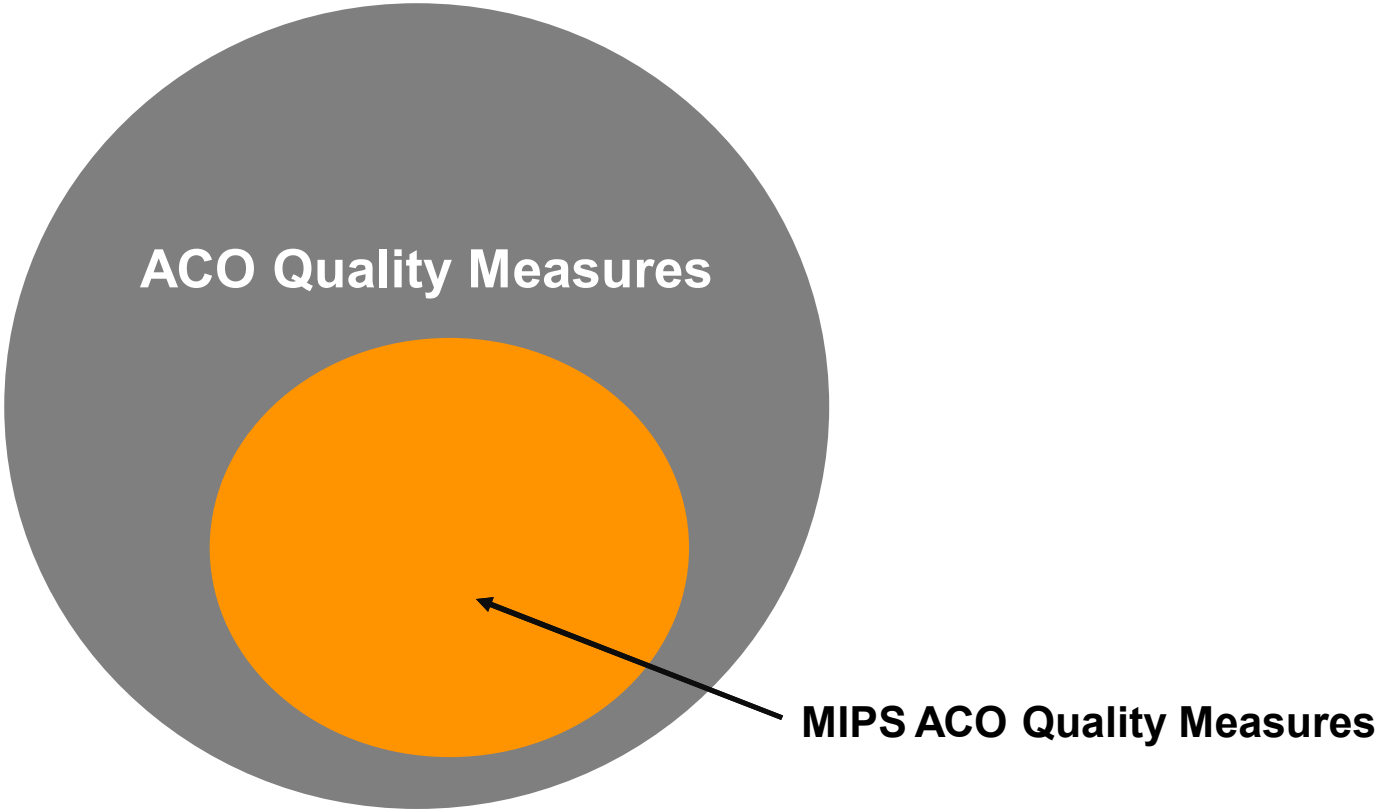
Key Questions Surrounding MIPS APMs

- What is the designation?
  - What is the purposed of designation?
- Which APMs are included?
- What is the difference between MIPS APM and non-APMs?
- What are the scoring differences?

Comparison of MIPS APM and MIPS Scoring



Interaction of ACO Quality Measures and MIPS ACO Measures



2017 ACO MIPs Scoring Standard

	Reporting	Performance Score	Weight
Quality	ACOs will submit as an entity through Web interface	Compared to national benchmarks (non ACOs)	50%
Cost	In 2017, clinicians will not be assessed	N/A	0%
Improvement	No reporting necessary	2017 CMS will assign 100% score to participants in ACO	20%
Advancing Care	Each TIN reports separately through one of the group Mechanisms.	ACO TIN scores will be aggregated, weighted, and averaged to get one score	30%

Advanced Alternative Payment Models (aAPM)

Key Characteristics of aAPMs:

- Must use certified EHR technology
- Base payment on quality measures comparable to MIPS
- "More than nominal" financial risk

Qualifying aAPM Participants (QPs) receive a **5% lump sum bonus.**

- Participation alone isn't enough to be considered a QP.
  - Must exceed revenue or patient count thresholds
  - For **2017**: 25% Medicare Part B payments or 20% Medicare Part B patients in aAPM
    - 2021: 50% payments or 35% patients
    - 2023: 75% payments or 50% patients

Notes: For 2017, QP thresholds are 25% Medicare Part B payments or 20% Medicare Part B patients in aAPMs. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Growing Number of CMS Pilots Qualify as an aAPM

INELIGIBLE

- Medicare Shared Saving Program (MSSP) Track 1
- Oncology Care Model (1-Sided Risk)
- Bundled Payments for Care Improvement (BPCI)

ELIGIBLE IN 2017

- MSSP Track 2 and 3
- Oncology Care Model (Double-Sided Risk)
- Comprehensive Primary Care Plus (CPC+)
- Next-Generation ACO
- Comprehensive ESRD Care Model (Large Dialysis Organization Arrangement)

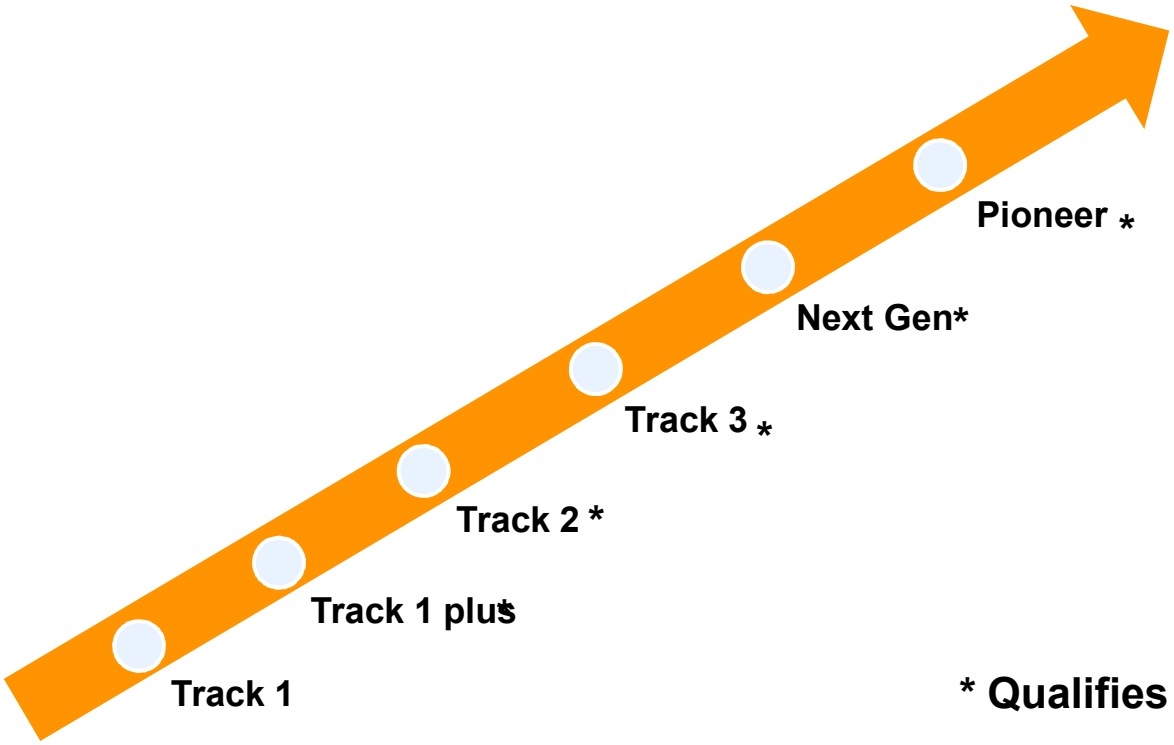
PROPOSED for 2018

- Medicare ACO Track 1+
- Comprehensive Care for Joint Replacement Model (CEHRT track)
- New voluntary bundled payment model
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)

CMS will finalize and update list annually by January 1.

ACO = accountable care organization; CEHRT = certified electronic health record technology; ESRD = end stage renal disease. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; CMS. CMS announces additional opportunities for clinicians under the Quality Payment Program. December 2016; Sg2 Analysis, 2016.

Medicare ACOs in Terms of Risk



*** Qualifies as aAPM**

Agenda

MACRA Review

MIPS Domains

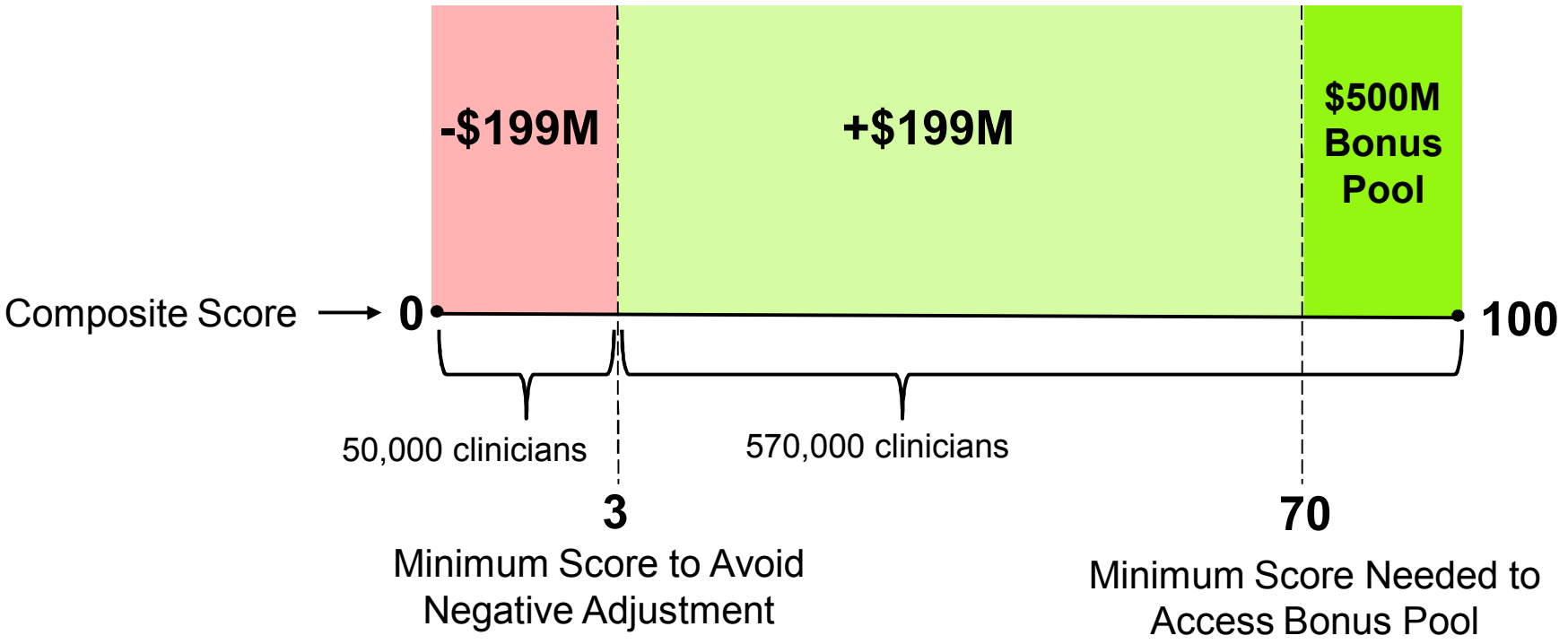
MIPS APM, aAPM and Bundles

Strategic Plan Integration

MACRA Action Plan

2017 Performance Year Payment Distribution

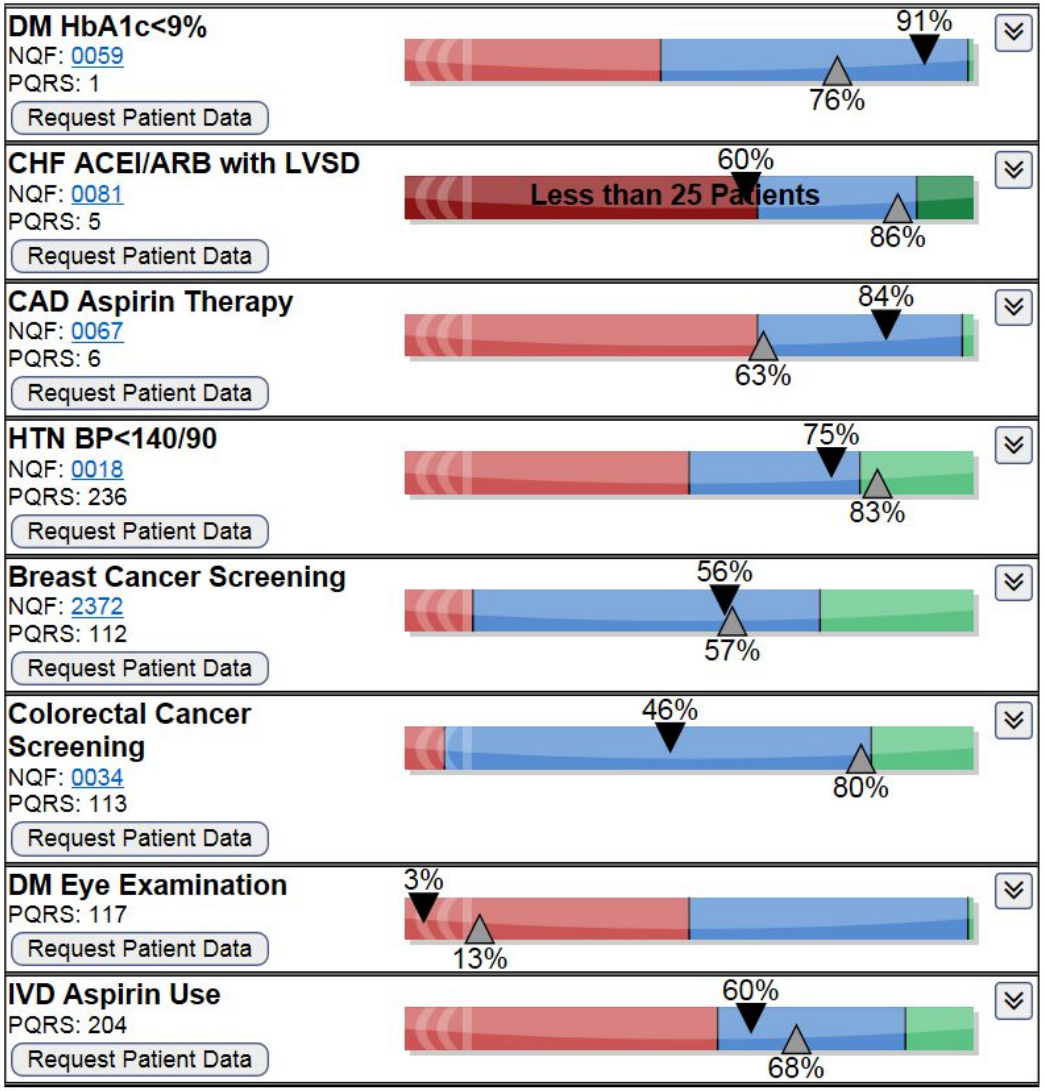
- Payments designed to be **budget neutral**
- MIPS is a zero-sum game



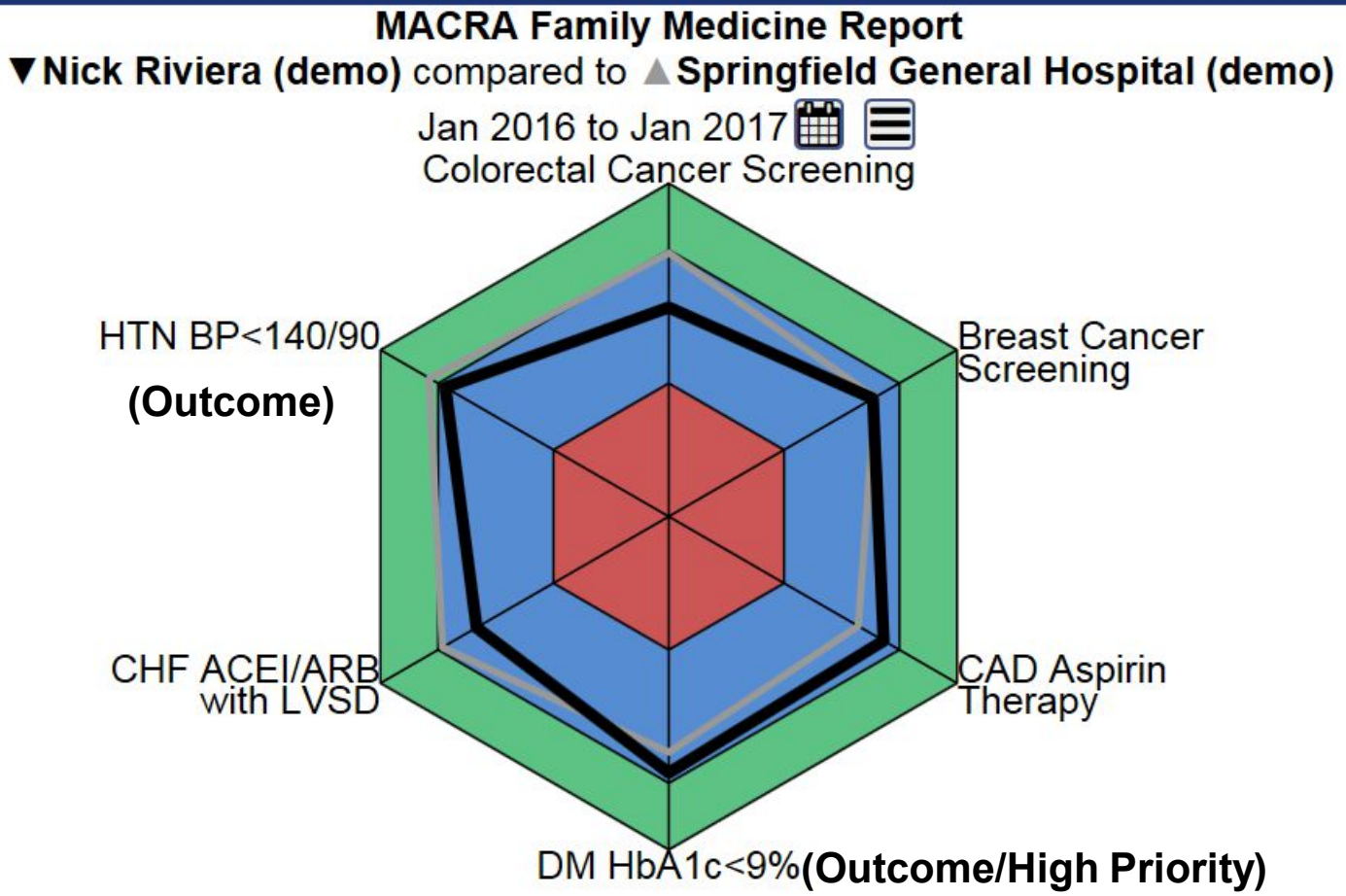
MACRA Family Medicine Report

▼Nick Riviera (demo) compared to **▲Springfield General Hospital (demo)**

Jan 2016 to Jan 2017



Example Data Radar Report

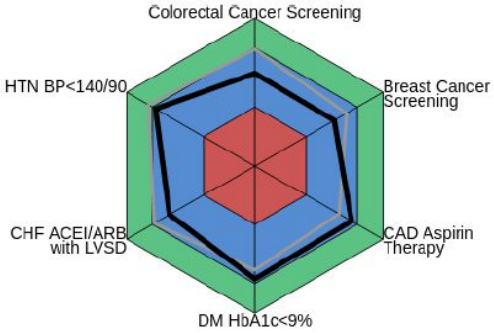


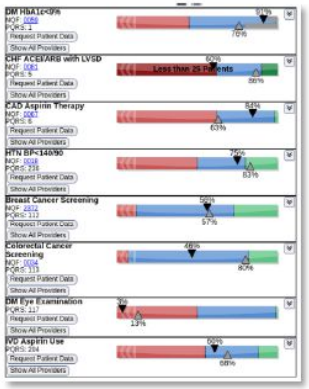
MACRA PHASE I WORKSHEET

INSTRUCTIONS: Use the four square to select a metric to work based on knowledge and controllability.

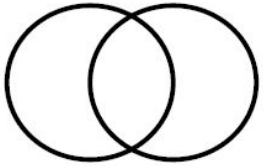
Choose one metric to improve.

Examples:

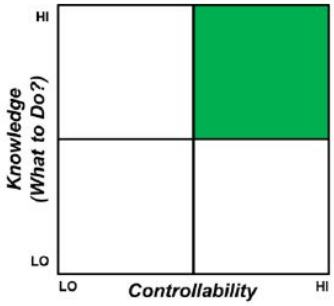




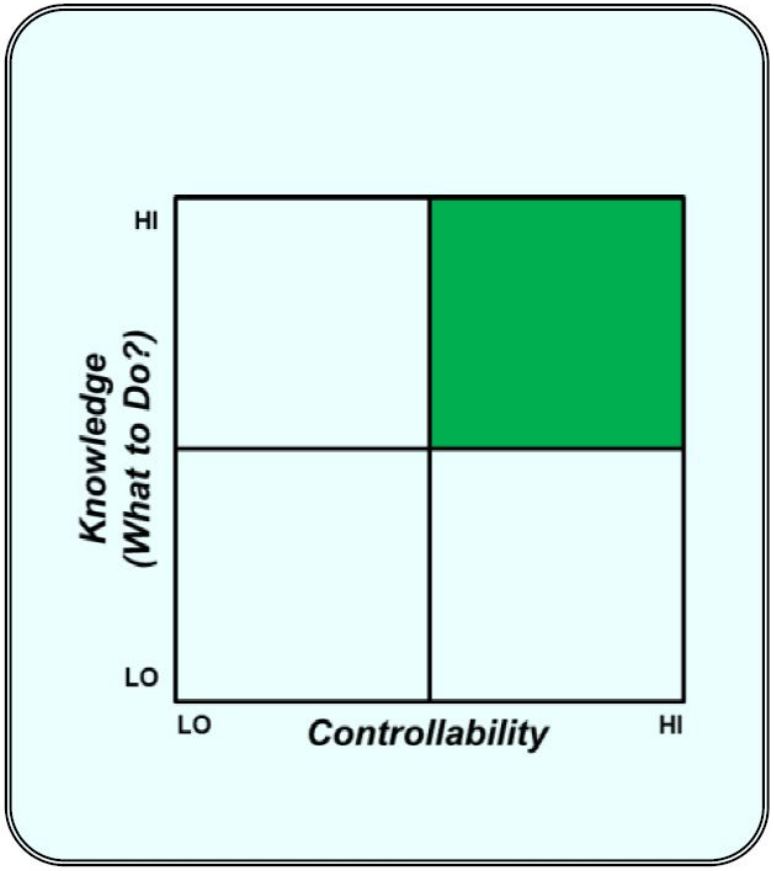
- ✓ **Controllable?**
- ✓ **Do we know what to do?**



Venn Diagrams



4-Square



MACRA PHASE II WORKSHEET

2

INSTRUCTIONS: Generate and priorotize ideas using brainstorming and a 4-square.

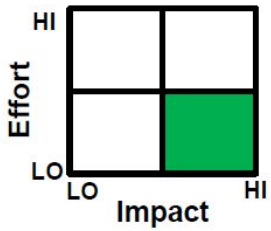
Select the best ideas for action.

Examples (Idea Generation):

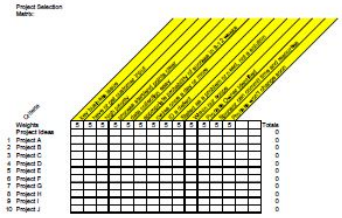
- ✓ Brainstorming / Brain Writing
- ✓ Mind Mapping
- ✓ Affinity Diagram
- ✓ Benchmark Others / Research
- ✓ Experimentation
- ✓ Obvious Quick Wins
- ✓ Etc.

Examples (Prioritize):

- ✓ Impact?
- ✓ Effort?
- ✓ Other Criteria (Time, $, Resources, etc.)



4-Square



Selection Matrix

Brainstorming

Use MACRA to Develop 4 Core Competencies of Value-Based Care Delivery

#1: Demonstrate quality and implement processes to drive improvement

#2: Leverage technology investments to enhance patient engagement and safety

#3: Establish culture of care coordination and commitment to continuous improvement

#4: Effectively manage resources while delivering high-value care to patients

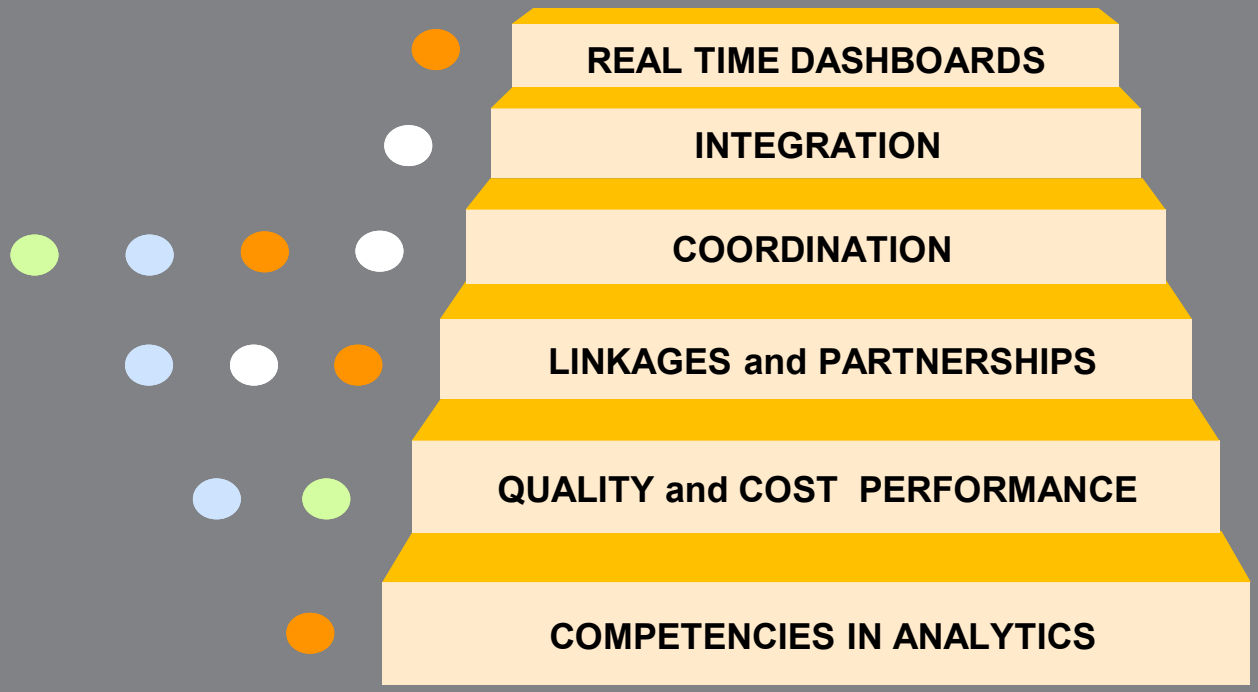
Critical Success Factors for Value-Based Contracts

Quality

Cost

Advancing Care Information

Improvement Activities



Agenda

MACRA Review

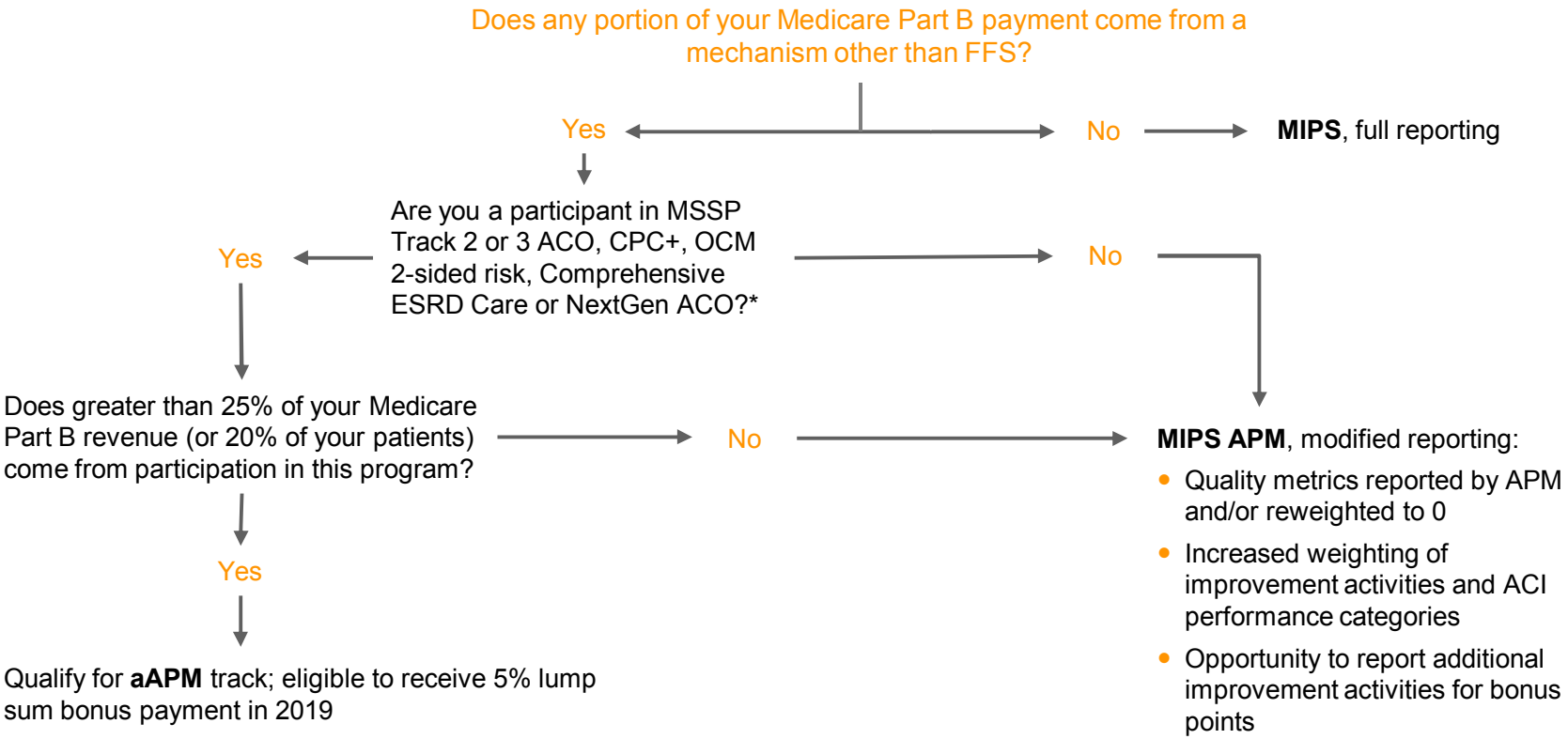
MIPS Domains

MIPS APM, aAPM and Bundles

Strategic Plan Integration

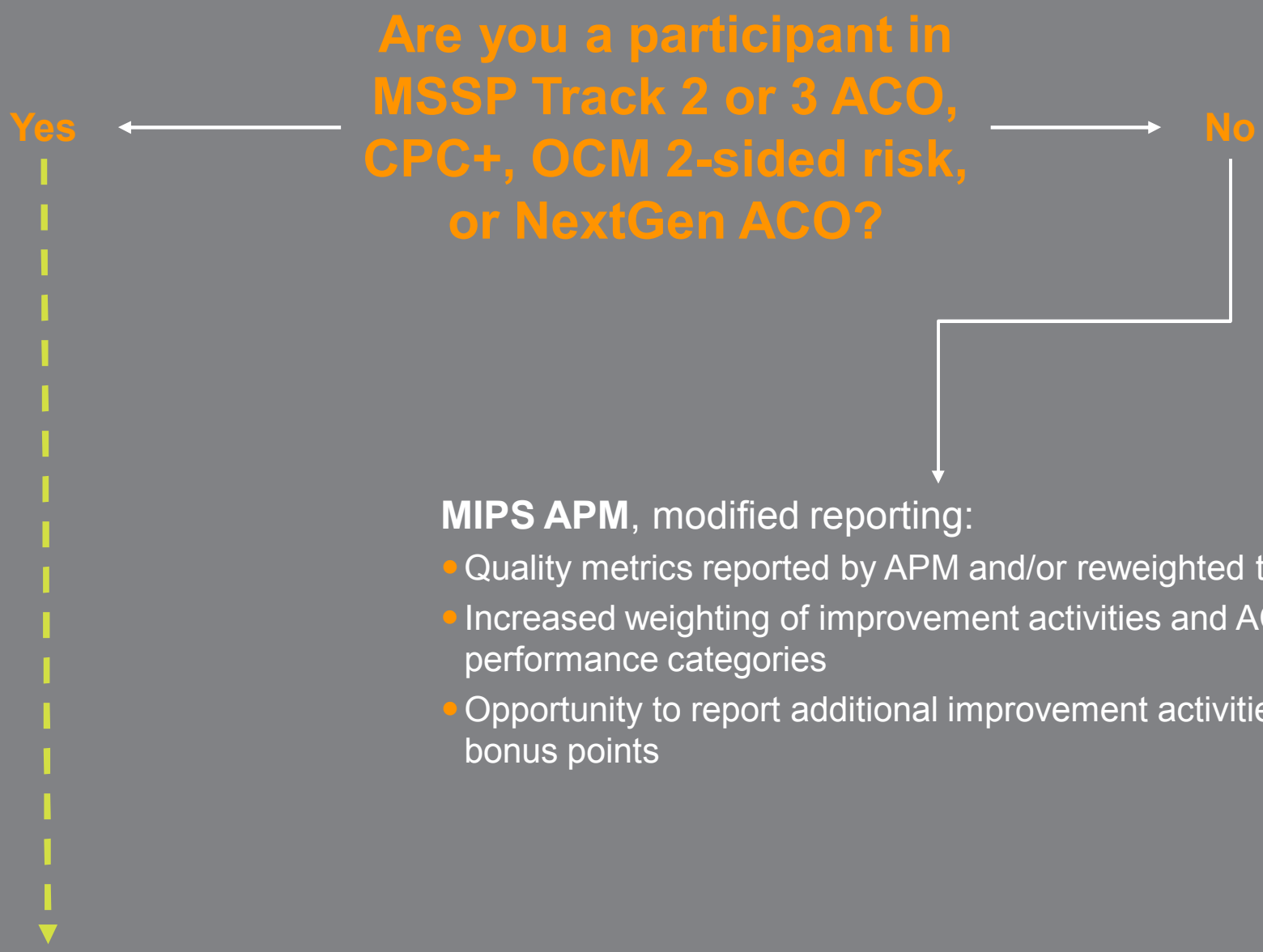
MACRA Action Plan

You Don't Choose MACRA. It Chooses You.



*Beginning in Performance Year 2018, MSSP ACO Track 1+ will qualify for aAPM incentives. Notice of Intent to Apply due May 2017. **Note:** Threshold ramps up to 50%/35% in 2021 and 75%/50% in 2023. ACI = Advancing Care Information; APM = Alternative Payment Model; FFS = fee-for-service; OCM = Oncology Care Model. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Does any portion of your Medicare Part B payment come from a mechanism other than FFS?


Are you a participant in MSSP Track 2 or 3 ACO, CPC+, OCM 2-sided risk, or NextGen ACO?
Yes
No
MIPS APM, modified reporting:
Quality metrics reported by APM and/or reweighted to 0
Increased weighting of improvement activities and ACI performance categories
Opportunity to report additional improvement activities for bonus points

Does greater than 25% of your Medicare Part B revenue (or 20% of your patients) come from participation in this program?

No

MIPS APM

Yes

Qualify for **aAPM** track; eligible to receive 5% lump sum bonus payment in 2019

Using the Assessment Criteria—Example

317 Member Multispecialty Group Practice
2016 Medicare Part B Revenue = $72,828,748.08

Does any portion of their Medicare Part B payment come from a mechanism other than FFS?

- No → **MIPS**, full reporting
- Yes → Are you a participant in MSSP Track 2 or 3 ACO, CPC+, OCM 2-sided risk, Comprehensive ESRD care or NextGen ACO?*
  - No → **MIPS APM**, modified reporting:
    - Quality metrics reported by APM and/or reweighted to 0
    - Increased weighting of improvement activities and ACI performance categories
    - Opportunity to report additional improvement activities for bonus points
  - Yes → Does greater than 25% of your Medicare Part B revenue (or 20% of your patients) come from participation in this program?
    - No → **MIPS APM**, modified reporting:
      - Quality metrics reported by APM and/or reweighted to 0
      - Increased weighting of improvement activities and ACI performance categories
      - Opportunity to report additional improvement activities for bonus points
    - Yes → Qualify for **aAPM** track; eligible to receive 5% lump sum bonus payment in 2019

Projected 2017 aAPM Revenue: **15%**

Projected 2017 aAPM Patients: **25%**

*Beginning in Performance Year 2018, MSSP ACO Track 1+ will qualify for aAPM incentives. Notice of Intent to Apply due May 2017. **Note:** Threshold ramps up to 50%/35% in 2021 and 75%/50% in 2023. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2016.

Your Task: Identify the Appropriate Reporting Path

Action Steps:

- As a group, review the worksheet and use the MACRA decision tree to determine which reporting path—MIPS, MIPS APM, aAPM—is most appropriate for each practice.

Key Questions:

- Does the practice meet low-volume exclusion criteria?
  - ≤$30,000 in Medicare Part B allowed charges ***OR*** ≤100 Medicare patients
- Does the practice include clinicians participating in APMs? If so, are they participating in MIPS APMs or aAPMs?
- At the practice-level (TIN-level), does it qualify for aAPM incentives?
  - ≥25% of Medicare allowed charges OR ≥20% Medicare patients
- Are a significant proportion of APM participants specialists or hospital-based physicians?

TIN = tax identification number. **Sources:** CMS. *Final Rule With Comment Period: 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*. November 4, 2016; Sg2 Analysis, 2017.

Answer Key

Practice Group	Answer
A	aAPM
B	Exempt
C	MIPS
D	MIPS APM
E	aAPM
F	MIPS

CASE STUDY | Devising a Partnership Strategy Between Hospital System and Provider Groups

Your Situation

- You are a member of the strategy leadership team with a regional IDN responsible for developing a long-term MACRA strategy.
- Your IDN currently participates in MSSP ACO Track 1 and are considering a move to Track 1+ next year. You are also participating in CJR and a BPCI CABG bundle.
- Your focus is to strengthen physician relationships by helping area providers optimize their MACRA performance, while growing your market relevance.

Exercise: Devise a Partnership Strategy

Your Task

- Your table will be given a specific situation whereby a provider group approached you for help to optimize their MACRA strategy.
- As a group, discuss the provider group's relative strengths and/or weaknesses when it comes to MACRA performance.
- Use the worksheet to:
  - Identify opportunities for the IDN to support the provider group.
  - Pitch your partnership approach to your hospital's board of directors. To win them over, you will need to answer the following key questions:
    1. What's the main issue?
    2. How will you help them improve?
    3. How much will it cost?

Closing Thoughts

1. Most clinicians will be under MIPS during the initial years.
2. MIPS forces the development of critical success factors required to take on risk in aAPMs.
   - Don't remain paralyzed at MIPS.
   - Do consider aAPMs the next step of the value-based care evolution.
3. Participation in APMs expected to grow in future years.
   - CMS will provide more opportunities to participate (eg, physician-focused bundled payment models, Medicare ACO Track 1+).
   - 5% aAPM bonus will provide known ROI for participating in qualifying APMs.
   - Growth will enhance adoption of APMs by commercial payers.

MACRA Drives Practice Transformation Through Changes in Payment

Sg2, a Vizient company, is the health care industry's premier authority on health care trends, insights and market analytics.

Our analytics and expertise help hospitals and health systems achieve sustainable growth and ensure ongoing market relevance through the development of an effective System of CARE.

Sg2.com 847.779.5300