The Advisory Board Company

Health Policy

Understanding MACRA and Impact on Providers

Prepared for National Accountable Care Congress

November 16, 2015

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99	>1,000	165,000
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- Development and effectiveness of health information technology and data analytics
- Health care financing and revenue management, including technologies to administer risk-based payments
- Health care workforce, leadership development, and staffing strategies

1) Includes urban and rural health systems; academic medical centers and community hospitals; safety net hospitals; non-profit and for-profit hospitals; and the VA.

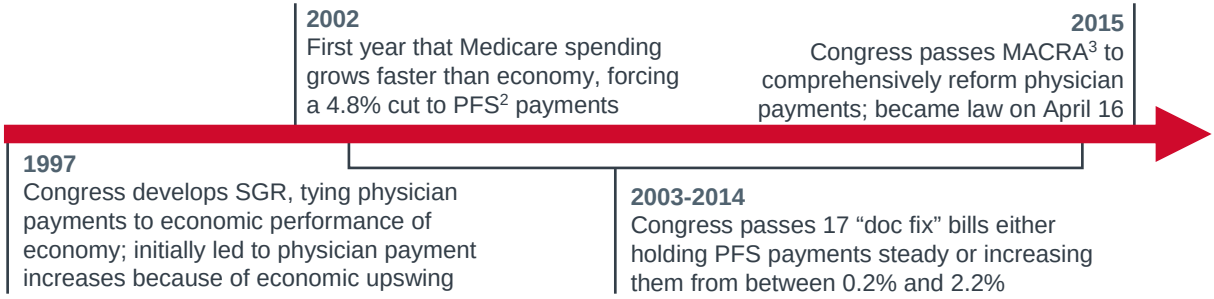
Source: The Advisory Board Company.

"…Putting an End to This Charade"[1]

Repeal of SGR Ends Long History of Looming Physician Payment Cuts

Sustainable Growth Rate (SGR) Timeline

(1997-2015)



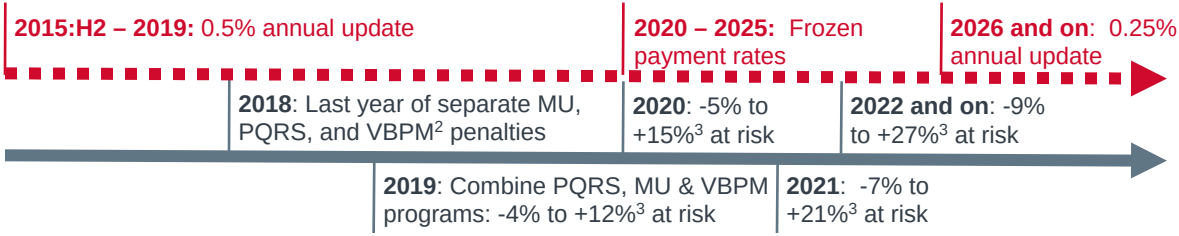
1) Excerpt of quote by John Rother, President of the National Coalition on Healthcare.
2) Physician Fee Schedule.
3) Medicare Access and CHIP Reauthorization Act of 2015.

Source: Congressional Research Service, The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions, March 21, 2014; Modern Healthcare, "'Doc Fix' Still On Track Despite Two Weeks to Lose Steam," April 9, 2015; Advisory Board analysis.

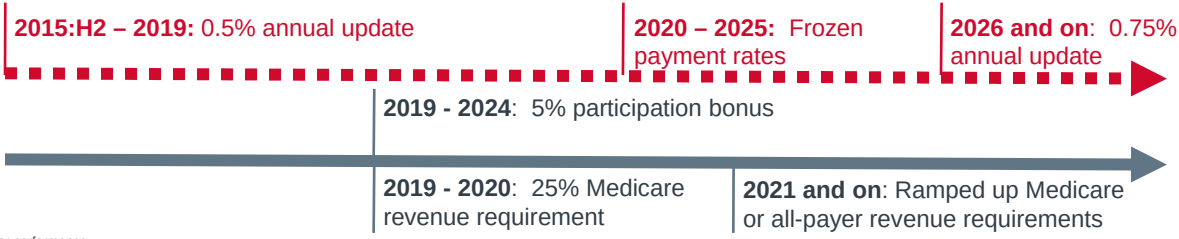
SGR Repeal Creates Two Tracks for Providers

Providers Must Choose Either PFP[1] or Risk-Based Pathway

Merit-Based Incentive Payment System (MIPS)



Advanced Alternative Payment Models[4]



1. Pay for performance.
2. Value-based payment modifier.
3. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
4. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis.

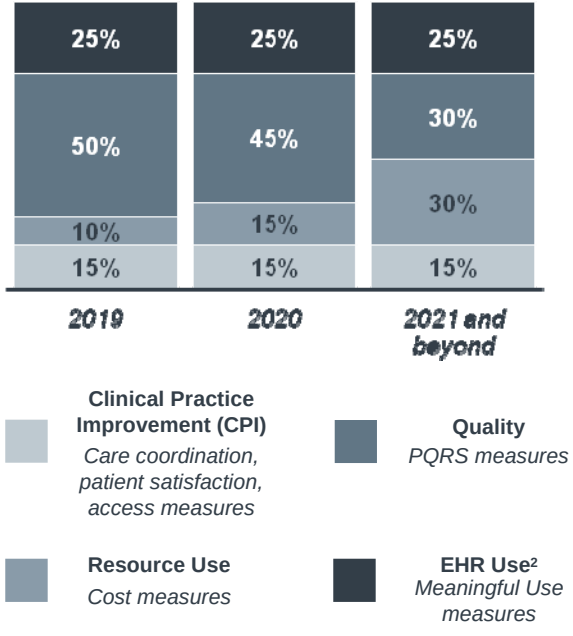
MIPS Track Moves Away from Volume Incentive

Seeks to Build Provider Accountability on FFS Foundation

Merit-Based Incentive Payment System Summary

- Sunsets current Meaningful Use, Value-Based Payment Modifier (VBPM), and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments under new budget-neutral methodology beginning in 2019 (based upon performance period starting in 2017)
- Applies to physicians, NPs[1], clinical nurse specialists, physician assistants, and certified RN anesthetists
- Includes improvement incentives for quality and resource use categories
- Continues public reporting on Physician Compare

MIPS Performance Category Weights



1)Nurse Practitioner.
2)The Secretary can weight EHR Use less if at least 75% of eligible providers are meaningful users, but cannot drop the weighting below 15%.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis.

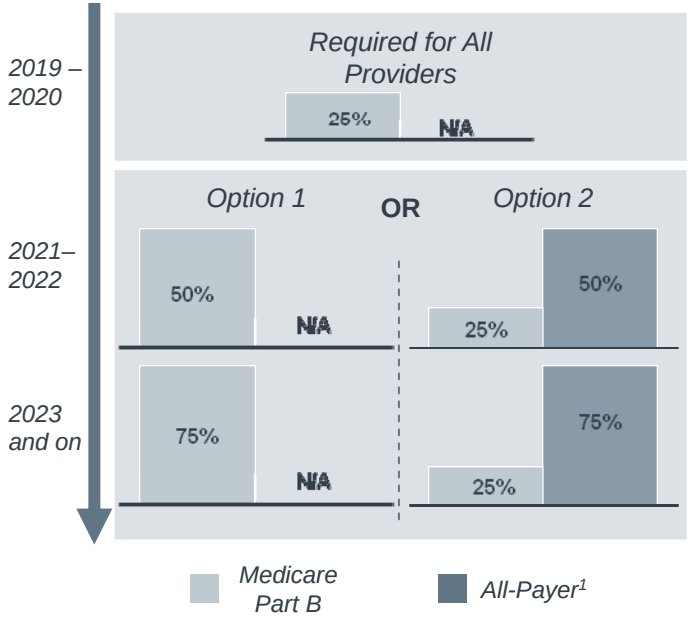
APM Track Designed to Reward Adoption of Risk

Option Signals Policymakers' High Expectations for Risk-Based Models

Advanced Alternative Payment Model (APM) Summary

- Requires significant share of provider revenue in APM with "two-sided" risk and quality measurement; possible future option for participation in CMS-certified PCMH model
- Provides financial incentive (5% annual bonus in 2019-2024) and exemption from MIPS requirements
- Does not change inherent rewards of an APM program
- Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS

Required Percentage of Revenue Under Risk-Based Payment Models



1) Risk-based contracts with Medicare Advantage plans count toward the all-payer requirement category.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis.

Early PQRS Focus on Reporting

Beginning This Year, Physicians Penalized for Failure to Report PQRS

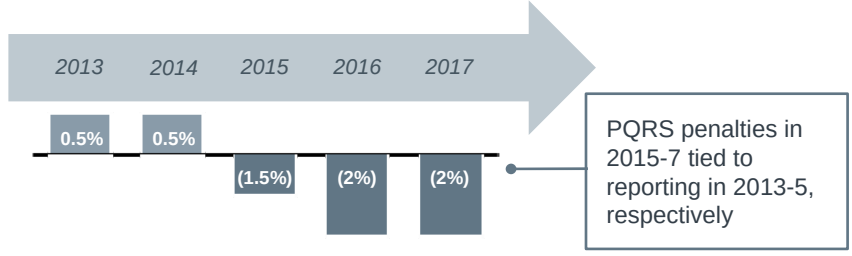
Program in Brief: Physician Quality Reporting System (PQRS)

- Starting in 2011, participating providers report at least nine quality metrics of their choice to CMS
- Incentives, penalties tied to quality metric reporting only – not outcomes
- Reported metrics used in other CMS programs, such as EHR Incentive Program, MSSP[1], and VBPM

Takeaways

- Overall reaction to the program has been muted
- Design of program incentives drives focus on reporting rather than on quality
- Payment adjustments often viewed as not significant enough to justify administrative burden
- Lag in timing of reward/penalty dilutes provider prioritization of this program

Current PQRS Incentives and Penalties



Source: CMS, "CY 2015 Physician Fee Schedule Final Rule," October 31, 2014, available at: www.federalregister.gov; Advisory Board interviews and analysis.

1) Medicare Shared Savings Program.

VBPM Participation Modest

Overhwlming majority of participating practices see no adjustment

Program in Brief: Value-Based Payment Modifier (VBPM)

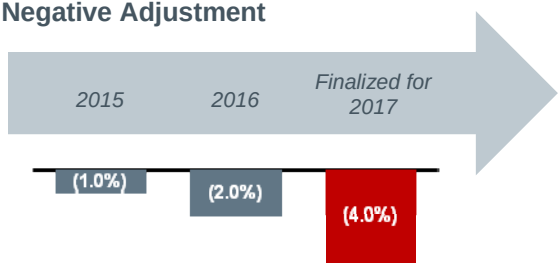
- Uses PQRS, CG-CAHPS[1], Medicare claims data to assign payment modifier to providers based on quality and efficiency performance
- Being gradually phased in
  - 2015 and 2016: Only applies to physicians groups of 100+
  - 2017: Applies to all physicians

Takeaways

- Participation—voluntary in 2015— was minimal (10%)
- Most participating groups reported average quality and cost metrics, but a handful will see upward or downward payment adjustments
- No groups performed well enough to be in top tier of both cost and quality
- Tiering would have been similar if participation had been mandatory

VBPM Maximum Negative Adjustment

Positive Adjustments calculated each year and based on the number of poor performers in order to be budget neutral. Payment adjustments in 2015-17 tied to reporting in 2013-15, respectively.



1) Clinician and Group Consumer Assessment of Healthcare Providers & Systems.

Source: CMS, "CY 2015 Physician Fee Schedule Final Rule," October 31, 2014, available at: www.federalregister.gov; Advisory Board interviews and analysis.

Meeting MU Requirements Remains a Challenge

Program in Brief: EHR[1] Incentive Program

- Financial incentives for "meaningful use" (MU) of EHRs
- CMS established core objectives within each stage to gauge compliance
- Rolling out in three stages of increasing requirements: Currently in Stage 2 and Stage 3 scheduled to start in 2018

Meaningful Use Incentive Payments As of June 2015

	Medicare	Medicaid
Eligible Hospitals	$12.6B	$5.9B
Eligible Professionals	$8.2B	$3.9B

Takeaways

- Program driving EHR adoption but significant workflow and interoperability challenges persist
- Eligible providers face some difficulties meeting requirements in first two stages
- Stage 2 challenges:
  - Implementing upgraded 2014 EMRs successfully to meet MU this year
  - Meeting measures for patient portals/personal health record use and sending summaries of care
- CMS moved to simplify the program and make requirements more achievable; most recent rule reduces the number of objectives, provides flexibility in demonstrating MU, and delays the Stage 3 transition to 2018
- CMS startng to issue regulations that bridge the EHR Incentive Program with MIPS

1) Electronic Health Record.

Sources: CMS, Medicare & Medicaid EHR Incentive Programs, HIT Policy Committee, February 10, 2015; Advisory Board research and analysis.

Details Yet To Come for Clinical Improvement Category

Performance Category in Brief

- Category measures activities that improve clinical practice or care delivery
- Providers will not have to participate in all activities in order to get the highest score
- Eligible providers practicing in a certified PCMH[1] will automatically score the highest potential score in this category
- Eligible providers participating in an APM will automatically receive half of the highest potential score in this category

Clinical Practice Improvement Activity Categories

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an alternative payment model

1) Patient Centered Medical Home.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis.

Medicare Utilizing Range of APMs

Similar models seen in Medicaid, commercial plans

Continuum of Medicare Risk Models





Pay-for-Performance	Bundled Payments	Shared Savings	Shared Risk	Full Risk
• Hospital VBP Program • Hospital Readmissions Reduction Program • HAC Reduction Program • Merit-Based Incentive Payment System	• Bundled Payments for Care Improvement Initiative (BPCI) • Comprehensive Care for Joint Replacement (CCJR) Model	• MSSP Track 1 (50% sharing)	• MSSP Track 2 (60% sharing) • MSSP Track 3 (up to 75% sharing) • Next Generation ACO Model (80-85% shared savings option)	• Next Generation ACO Model (full risk option) • Medicare Advantage (provider-sponsored)

Increasing Financial Risk

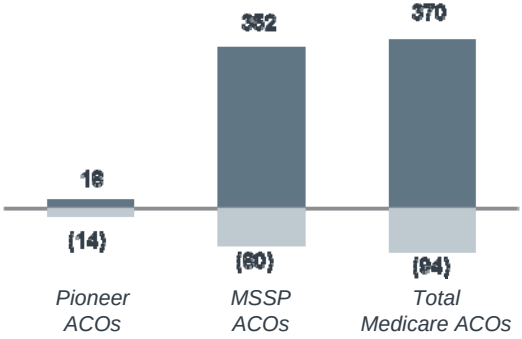
Source: Health Care Advisory Board interviews and analysis.

MSSP[1] Continues to Grow Despite Mixed Results

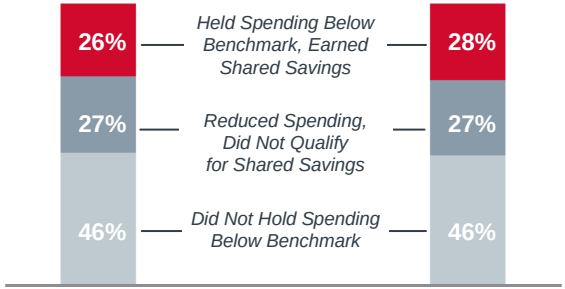
89 ACOs Join in 2015, But Few Generating Shared Savings

ACO Program Growth Continues

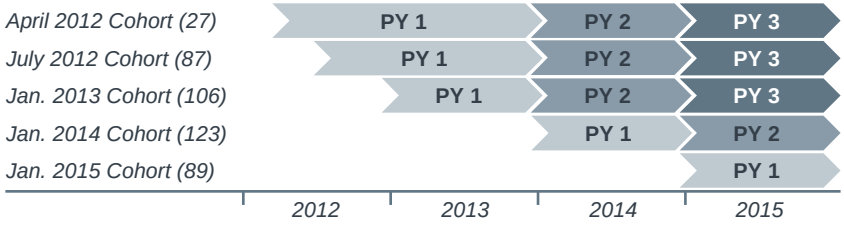
As of October 2015



One-Quarter of MSSP ACOs Share in Savings



Early MSSP Participants Completing Third Performance Year (PY)



1) Medicare Shared Savings Program.
2) 2012 cohorts had performance periods of 18 and 21 months; percentages may not add to 100 due to rounding.
3) Percentages may not add to 100 due to rounding.

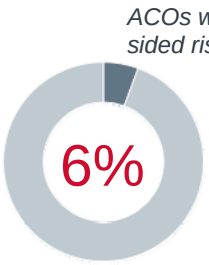
Source: Spitalnic P, "Certification of Pioneer Model Savings," CMS, April 10, 2015; available at www.cms.gov; "Shared Savings Program Fast Facts," CMS, April 2015, available at: www.cms.gov; CMS, "Fact Sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth," September 16, 2014, available at www.cms.gov; McClellan M et al., "Changes Needed to Fulfill the Potential of Medicare's ACO Program," Health Affairs Blog, April 8, 2015, available at www.healthaffairs.org/blog; "Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014," August 25, 2015, available at: www.cms.gov; Health Care Advisory Board interviews and analysis.

Downside Risk Models May Grow in Future

MACRA Criteria Require "More than Nominal Financial Risk" for APM Track

Participation in Two-Sided Risk ACOs

Includes Pioneer and MSSP Track 2 Participants
n=370



Two-Sided Risk Seemingly Required

"Eligible alternative payment entity … means … an entity that … bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount."

Medicare Access and CHIP Reauthorization Act of 2015

CMS Launching New Two-Sided Models

MSSP Track 3

- Prospective attribution
- Maximum shared savings rate of 75%
- Three MSR/MLR[1] options
- SNF three-day regulatory waivers

Next Generation ACO Model

- Prospective attribution
- Maximum shared savings rate options of 80% or 100%
- No MSR/MLR[1]
- Telehealth, home health, and SNF three-day regulatory waivers
- Option to provide beneficiaries a reward for seeing providers in ACO

1) Minimum savings and loss rates.

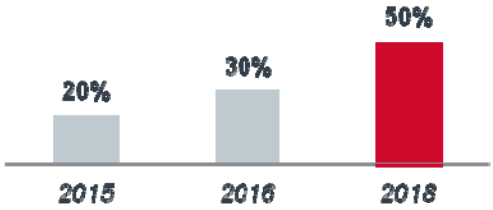
Source: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board research and analysis.

Legislation Complements Existing HHS Risk Goals

Both Payment Tracks Strengthen Ties to Value-Based Payments

Aggressive Targets for Alternative Payment Models

Percent of Medicare Payments Tied to Risk Models

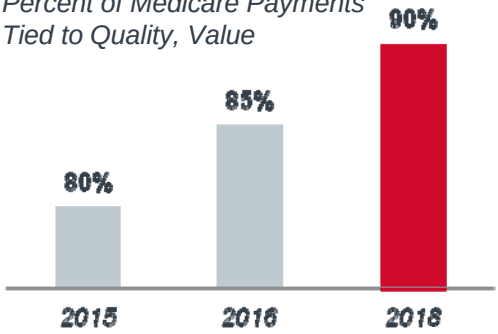


Examples of Qualifying Risk Models

- Medicare Shared Savings Program
- Bundled Payments for Care Initiative
- Patient-Centered Medical Home

Most Remaining FFS Payments Linked to Quality, Value

Percent of Medicare Payments Tied to Quality, Value



Examples of Quality/ Value Programs

- Hospital-Acquired Condition Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital Readmissions Reduction Program
- Merit-Based Incentive Payment System

Source: HHS, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," available at: http://www.hhs.gov/, accessed February 2015; Advisory Board analysis.

CMS Seeking Input on MACRA Implementation

MIPS-Related Questions in RFI[1]

- Should the same or similar reporting criteria be maintained under MIPS as under PQRS? What is the appropriate number of Quality measures? Should a minimum number be outcomes-based? Should additional specialty specific measures be created?
- What measures should CMS use to assess Resource Use? What role should episode-based costs play in calculating a score in this category? What peer groups or benchmarks should be used?
- What Clinical Practice Improvement subcategories and measures should be used? What information should be reported to ensure completion?
- Should the Meaningful Use performance score be based solely on full achievement of objectives and measures? Should the scoring be tiered/variable in some way?

APM-Related Questions in RFI

- To be considered an eligible APM, what is the appropriate type of "financial risk"? What is the appropriate level of financial risk "in excess of a nominal amount"?
- How should "financial risk" and "in excess of a nominal amount" be calculated with non-Medicare payers?
- What criteria could be considered when determining "comparability" to MIPS of quality measures used to identify an eligible APM?
- What are the core health IT functions that providers need to manage patient populations coordinate care, engage patients, and monitor and report quality?

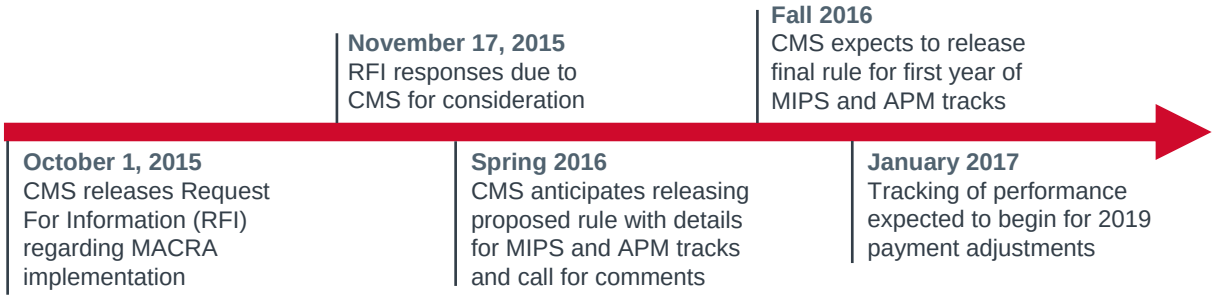
Source: CMS, "Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models"; Advisory Board analysis.

1. Request for Information.

MACRA Details to be Hashed out Over Next Year

MACRA Implementation Timeline

(Fall 2015 – Winter 2017)



Source: CMS; Advisory Board analysis.

MACRA Shows Faith in Value-Based Payments

Looking to Shift Away from FFS as Answer to Cost, Quality Problems

Overall Takeaways

1. Providers poised to see dramatic increase in link of payment to performance; which is defined more broadly with IT and efficiency considerations

2. MACRA is a clear indicator of Congress' bipartisan commitment to payment transformation; risk-based payment emerging as dominant approach

3. Substantial implementation questions will be answered over next year but likely that beginning phase of program will be bumpy transition

4. Complex decision for providers to decide between two tracks:
   - MIPS minimizes disruption to business model but involves potentially complex administrative requirements and zero-sum game
   - APM may offer greater incentives but also requires substantial risk in emerging models and PCMH option unpredictable

5. Unclear how well CMS will be able to align requirements in the two tracks and how easy it will be to transition between them

Source: Advisory Board research and analysis.

Questions?

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