



Health Care  
Compliance  
Association

# MACRA: What It Means For Your Organization

## Context and Tips for Compliance Professionals

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## Topics

- 1 **Post-election health care implications**
- 2 **Overview of Medicare Access & CHIP Reauthorization Act of 2015 (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**

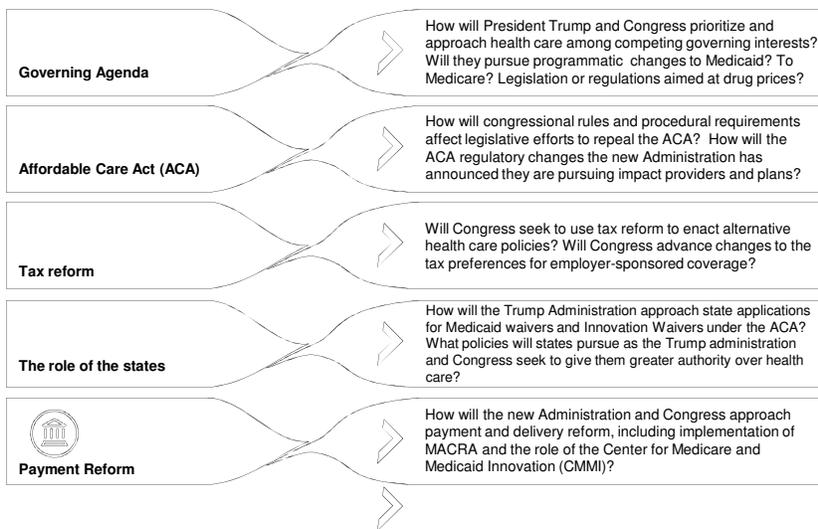
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# Post-election health care implications

## Critical health care issues on the horizon



### Drug Prices

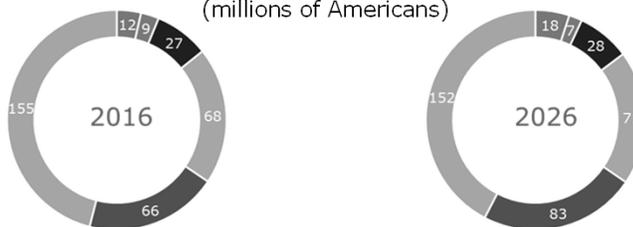
Source: Deloitte Risk and Financial Advisory Regulatory Services for Life Sciences and Health Care

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The world according to the Congressional Budget Office (CBO):  
Will the world actually look like this in 2026?

Projected Sources of Health Coverage Under the ACA,  
2016 vs. 2026

(millions of Americans)

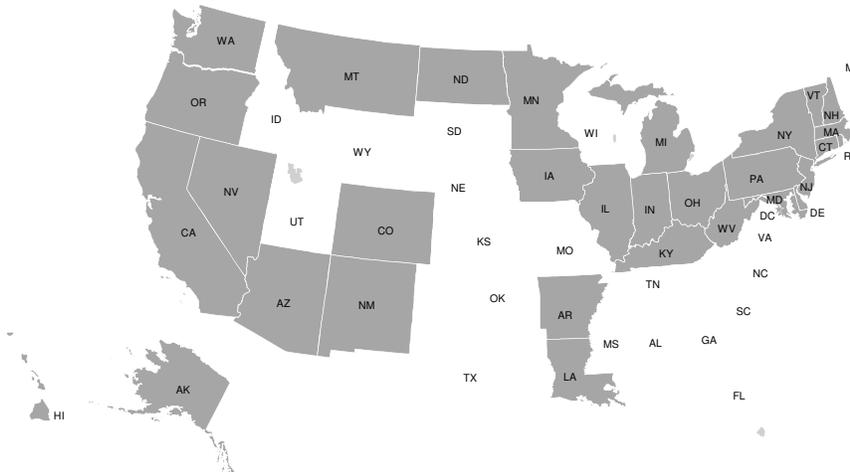


	Employer-Sponsored coverage	Medicare (Part A)	Medicaid and CHIP	Uninsured	Nongroup and other coverage	ACA Exchanges
2016 (Change in enrollment from the ACA)	155 (-2)	66 (N/A*)	68 (+13)	27 (-22)	9 (-2)	12 (+12)
2026 (Change in enrollment from the ACA)	152 (-9)	83 (N/A*)	71 (+19)	28 (-24)	7 (-4)	18 (+18)

\*Changes under the ACA are minimal for individuals under age 65 and numbers are included in "Nongroup and other coverage"  
Source: "Federal Subsidies for Health Insurance Coverage for People Under Age 65," Congressional Budget Office, March 24, 2016. "Medicare Baseline," Congressional Budget Office, March 24, 2016.

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To date, 31 states have expanded Medicaid under the ACA  
An additional 11 million people were eligible for Medicaid under the ACA in 2016

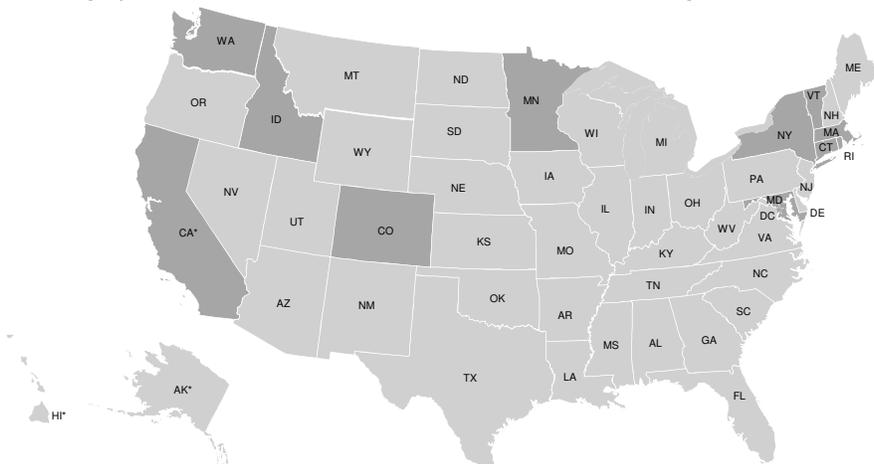


Adopted ACA Medicaid Expansion (32 states – including DC) [shaded box] Did not Adopt ACA Medicaid Expansion (19 states) [unshaded box]  
Source: Medicaid, "Coverage Expansion," July, 2016 <https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf>

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## Twelve states and D.C. run Exchanges in 2017

9.6 million people enrolled in coverage in 2016 in the 38 states using the federal Exchange platform, and 3 million enrolled via state-run Exchanges



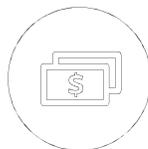
Source: Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2017," December, 2016 <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?activeTab=map&currentTimeframe=0&selectedDistributions=marketplace-type>  
 \*Alaska, California and Hawaii have submitted applications for State Innovation Waivers under Section 1332 of the ACA. CMS has approved Hawaii's waiver.

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## Post-election and compliance



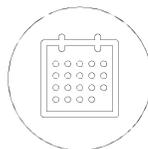
Government compliance scrutiny and initiatives not likely diminishing



Expect bipartisan support for efforts to control costs and government spending



Data will be more available, more complex and more powerful



Staying current and monitoring timeframes will be essential

# Overview of MACRA

## 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)

Source: <https://waysandmeans.house.gov/bipartisan-ways-and-means-energy-and-commerce-leaders-comment-on-final-macra-rule/>

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## 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."<sup>1</sup> — **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."<sup>2</sup> — **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."<sup>3</sup> — **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."<sup>4</sup> — **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."<sup>5</sup> — **Tom Leary, vice president of government relations at the Healthcare Information and Management Systems Society (HIMSS)**

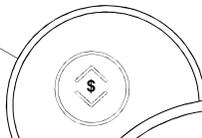
1. <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2016-11-15-min-connects-call-macra-transcript.pdf> 2. <http://www.modernhealthcare.com/article/20161111/MAGAZINE/161109907> 3. <http://www.healthcareitnews.com/news/aca-repeal-could-make-acos-macra-medicare-shared-savings-and-cms-cmmi-more-complicated-experts> 4. <http://www.forbes.com/sites/brucejansen/2016/11/13/trump-may-repeal-obamacare-but-he-wont-touch-obamas-other-major-health-law/#f0e50963079f> 5. <http://www.healthcare-informatics.com/article/payment/what-impact-will-trump-s-victory-have-value-based-healthcare/?page=2>

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## 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



**Payment reform is not going away**

The current system is unsustainable

### 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



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## 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

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 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**

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

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## 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



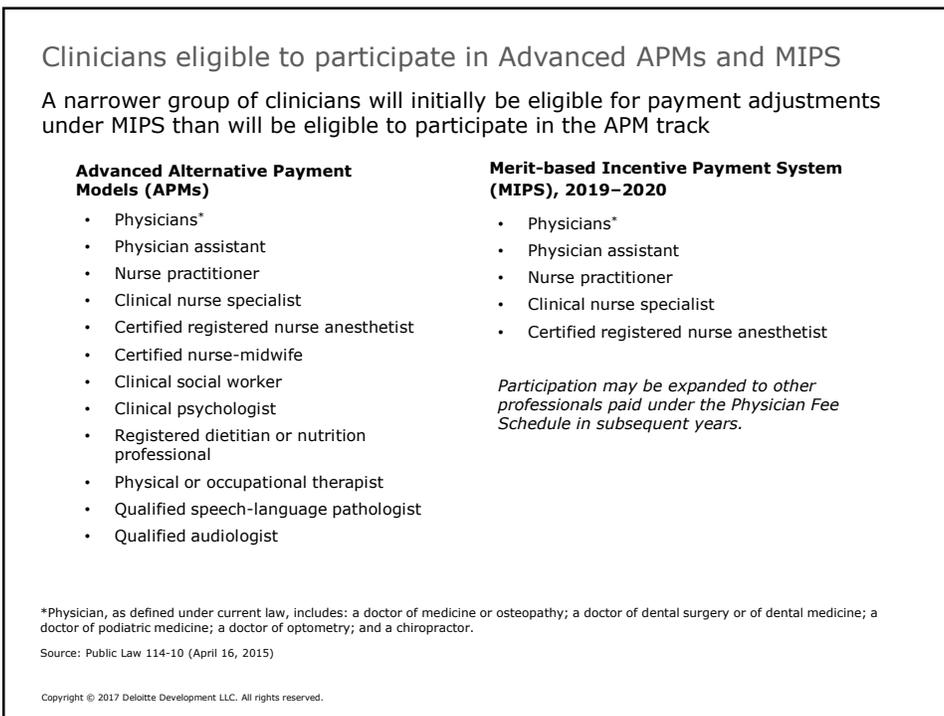
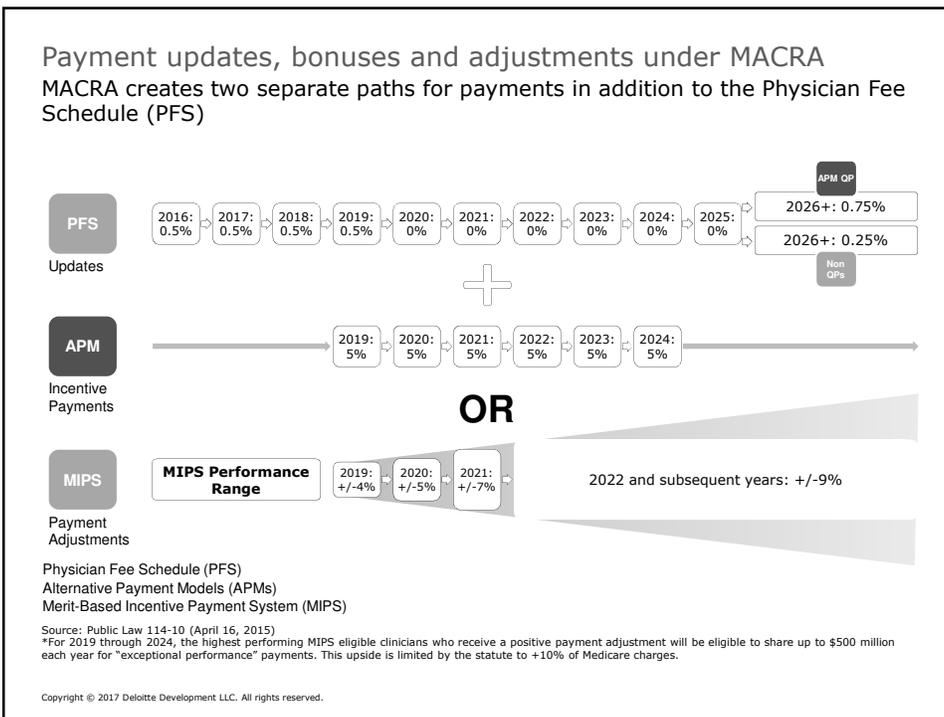
### Alternative Payment Models (APMs)

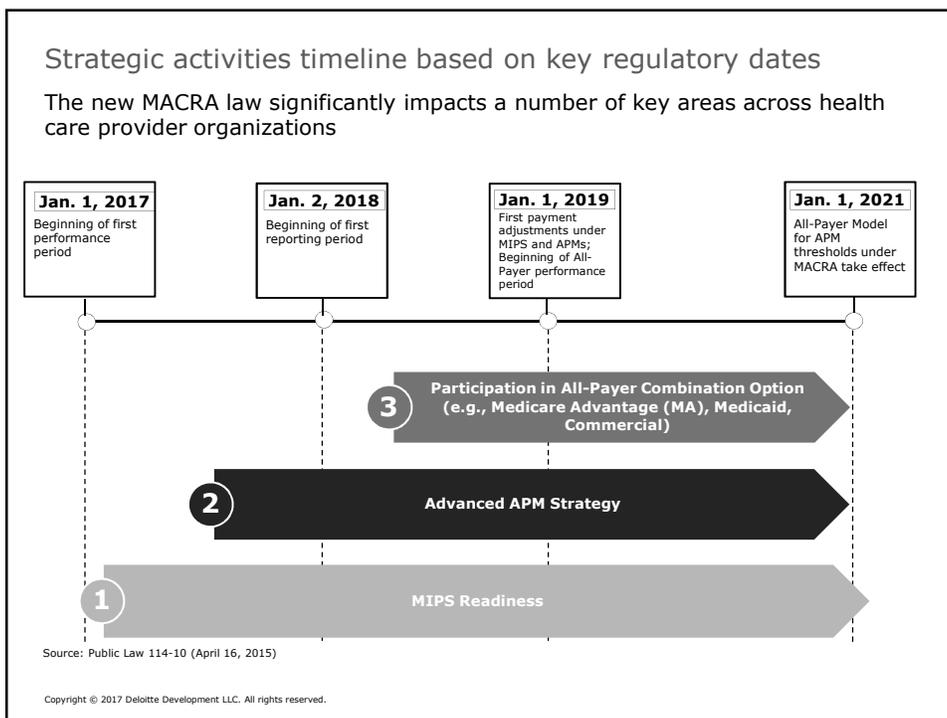
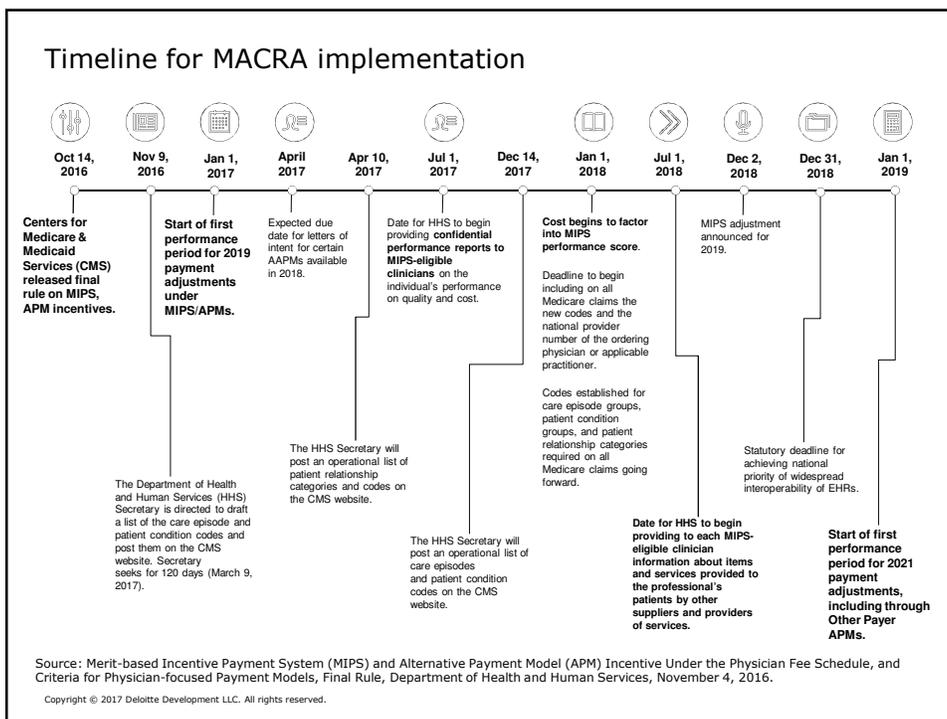
- Providers who participate in APMs may receive a 5% lump sum incentive payment
- Only participation in certain APMs with sufficient downside risk will exclude providers from MIPS
- Includes programs such as Accountable Care Organizations
- At least 25% of Medicare revenue must come from an APM to be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

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

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.

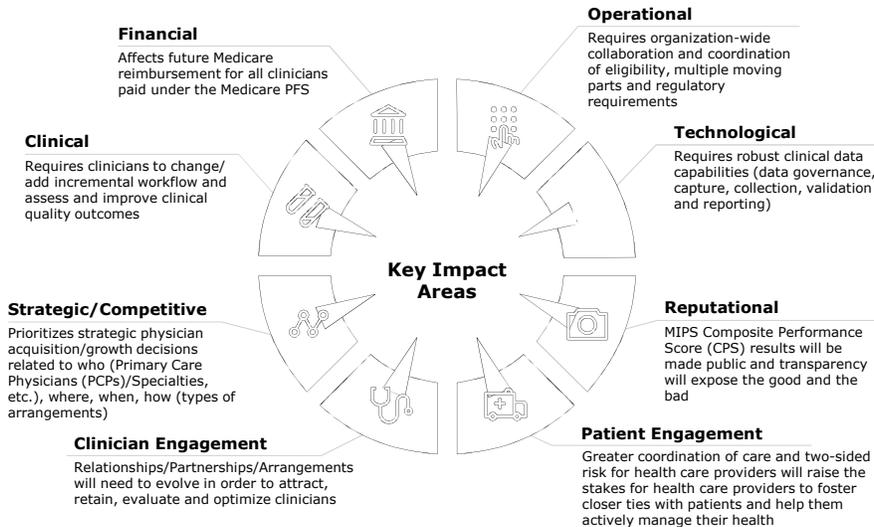
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## Implications of MACRA across health care organizations

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



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## Compliance: Danger in incentives



What gets measured, gets reported



Watch for sudden dramatic changes in practice patterns



Audit original records to assure proper reporting



PHI now a revenue source



Help physician behavior adjust for the right reasons for all patients

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# Overview of the Quality Payment Program (QPP)

## 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.



### Updates to MIPS

- 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.



### Advanced APMs

- The final rule retains definitions from the proposed rule for AAPM 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 AAPM status beginning in 2018.
- The Physician Focused-Payment Technical Advisory Committee (PTAC) is reviewing submissions from health care stakeholders for future AAPMs. PTAC will make recommendations to CMS as to whether proposed models should be tested.

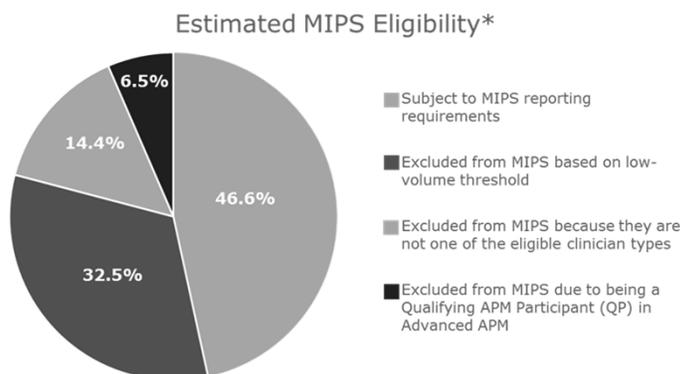
**The Final Rule aims to provide more options for provider organizations to participate in MACRA in 2017.**

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

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## 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



\*CMS estimates that nearly 200,000 clinicians (14.4%) will not be considered an eligible type of clinician, 380,000 (32.5%) to be exempted based on the low-volume threshold, and between 70,000 and 120,000 clinicians (approximately 5-8 percent) due to participation in an Advanced APM. For the purposes of the chart above, we averaged 5 and 8 to get our APM exemption percentage.

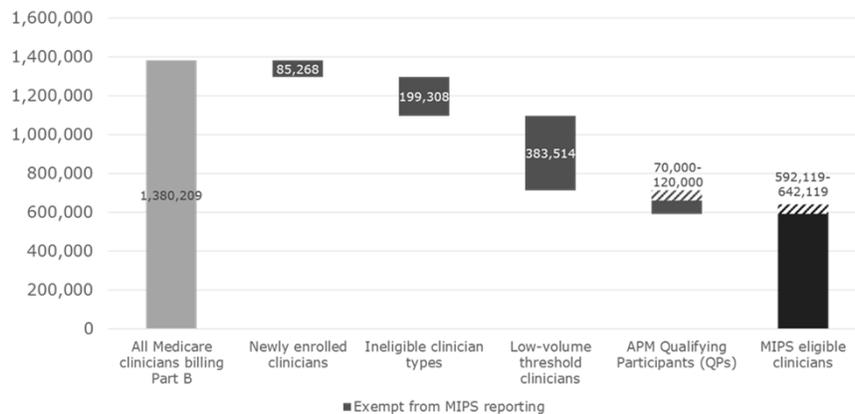
Source: Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-focused Payment Models, Final Rule, Department of Health and Human Services, November 4, 2016.

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### 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

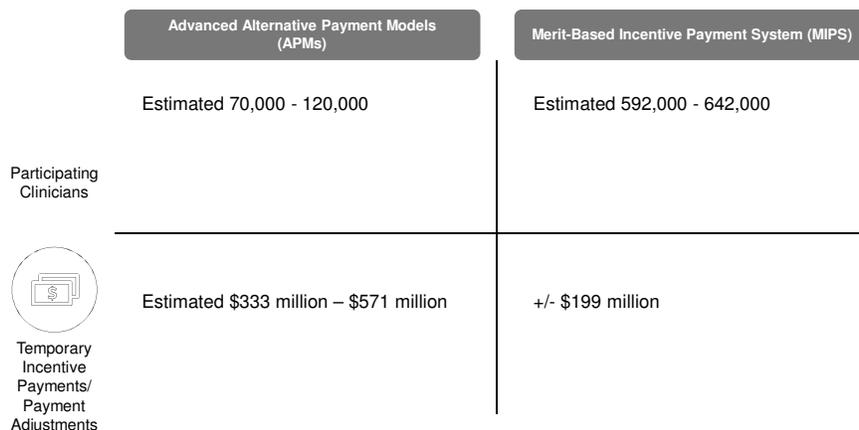
Projected participation in the QPP for the 2017 performance year



Note: CMS counts clinicians as unique combinations of Tax Identification Number (TIN) and National Provider Identifier (NPI).  
 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.  
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### MIPS and Advanced APMs: by the numbers

The Final Rule outlines the estimated impact of the Quality Payment Program for 2019: Both in the number of clinicians that fall under MIPS and APMs and the dollar amounts under each model

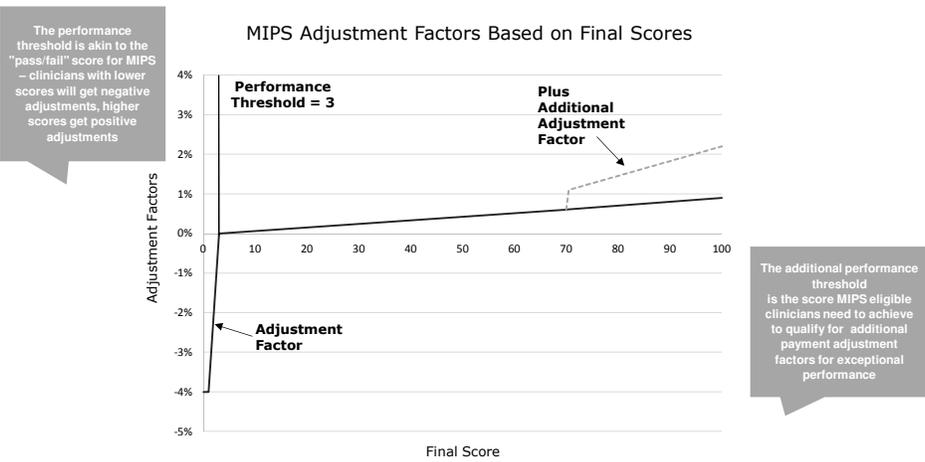


Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)

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# MIPS

## CMS Illustrative example: how the payment adjustment will work

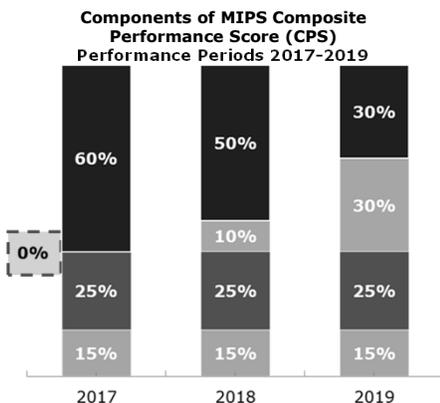


Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)

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## Overview of MIPS – including changes to the 2017 transition year

The Final Rule weights cost at 0% for the initial 2017 performance period. Centers for Medicare & Medicaid Services (CMS) reduced the number of required measures for Advancing Care Information (ACI) and Improvement Activities to be submitted in order to be eligible for the maximum positive adjustments. Quality reporting was also simplified for the transition year



### 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

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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## 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 1<sup>st</sup> OR 2<sup>nd</sup> generation cephalosporin prophylactic antibiotic, who had an order for a 1<sup>st</sup> OR 2<sup>nd</sup> generation cephalosporin for antimicrobial prophylaxis

### 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
- Cerebrovascular: Ischemic Stroke:** episode is triggered by an inpatient hospital claim with a principal diagnosis of any Stroke trigger codes
- Neurology: Parkinson Disease:** episode is triggered by two (2) Evaluation & Management codes (E&Ms) with a principal or secondary diagnosis of any Parkinsons trigger code occurring within 30 calendar days

### ADVANCING CARE INFORMATION

- 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

### IMPROVEMENT ACTIVITIES

- Expanded Practice Access:** Provide 24/7 access to MIPS Eligible Clinicians (ECs), groups, or care teams for advice about urgent & emergent care
- Population Management:** Use of a qualified clinical data registry (QCDR) to generate regular feedback reports that summarize local practice patterns & treatment outcomes
- Care Coordination:** Participation in the CMS Transforming Clinical Practice Initiative

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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## Cost – the components of the performance score

Monitoring cost across Part A and B – and potentially Part D – and in particular episodes of care will require new processes and controls

### Value modifier cost measures

#### Total Costs per Capita

- Includes payments under both Part A and Part B, but **not Part D**
- Attributed at the physician group and solo practicing level using the Medicare-enrolled billing TIN under a two-step attribution methodology
- **Risk-adjusted** and **payment-standardized**
- Focuses on delivery of **primary care** services

#### Medicare Spending per Beneficiary

- Attributed to the TIN that provides the **plurality of Part B** claims during the index inpatient hospitalization
- Assigned differently for individuals than for groups
- Assess performance as part of the episode-based measures for a variety of conditions

### Episodes of care

#### Breast

- Mastectomy

#### Cardiovascular

- Aortic/Mitral Valve Surgery
- Coronary Artery Bypass Graft (CABG)

#### Gastrointestinal

- Cholecystectomy and common duct exploration
- Colonoscopy and biopsy

#### Genitourinary

- Transurethral resection of the prostate (TURP) for benign prostatic hyperplasia

#### Musculoskeletal

- Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based
- Hip Replacement or Repair
- Knee Arthroplasty (Replacement)

#### Ophthalmologic

- Lens and cataract procedures

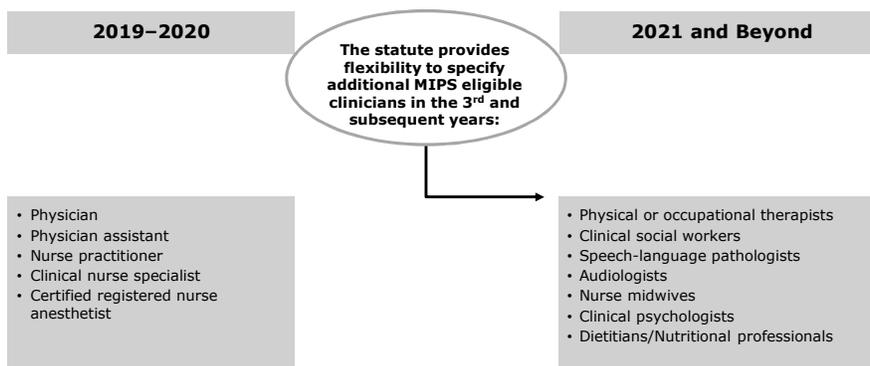
Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)

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## Clinicians eligible to participate in MIPS

Any affected clinicians are termed as “**MIPS eligible clinicians**” and will participate in MIPS.

**Note:** All Medicare Part B clinicians will report through MIPS during the first performance year.



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

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## 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).

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## 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

MIPS Low Volume Thresholds (Must Meet One)	
\$30,000 Medicare Charges	100 Medicare Patients

### 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

**OR**

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).

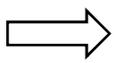
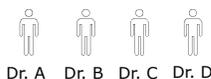
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### Group Reporting / Scoring Under MIPS

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

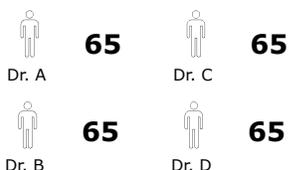
TIN 12345 Includes 4 Clinicians:



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

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



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).

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### MIPS Performance Category Measures and Activities

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

	Quality	Clinical Practice Improvement Activity (CPIA)	Advancing Care Information	Resource Use
Submission Requirement	* ✓	* ✓	✓	✗
Individual Reporting Mechanisms	<ul style="list-style-type: none"> <li>• Claims</li> <li>• Qualified clinical data registry (QCDR)</li> <li>• Qualified registry</li> <li>• EHR</li> <li>• Administrative Claims*</li> </ul>	<ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified registry</li> <li>• EHR</li> <li>• Administrative Claims*</li> </ul>	<ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified registry</li> <li>• EHR</li> </ul>	<ul style="list-style-type: none"> <li>• Calculated using administrative claims data</li> <li>• No submission required</li> </ul>
Group Reporting Mechanisms	<ul style="list-style-type: none"> <li>• QCDR</li> <li>• Qualified registry</li> <li>• EHR</li> <li>• CMS Web Interface (groups of 25 or more)</li> <li>• 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)</li> <li>• Administrative Claims*</li> </ul>	<ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified registry</li> <li>• EHR</li> <li>• CMS Web Interface (groups of 25 or more)</li> <li>• Administrative Claims*</li> </ul>	<ul style="list-style-type: none"> <li>• Attestation</li> <li>• QCDR</li> <li>• Qualified registry</li> <li>• EHR</li> <li>• CMS Web Interface (groups of 25 or more)</li> </ul>	<ul style="list-style-type: none"> <li>• Calculated using administrative claims data</li> <li>• No submission required</li> </ul>

\* 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).  
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### Pick your pace for Performance Year 1

CMS announced new options for participation in MIPS that are intended to give clinicians more flexibility for reporting in the QPP in 2017 with payment adjustments in 2019

#### MIPS Adjustment

##### Negative 4% payment adjustment

No MIPS performance data submitted to MIPS

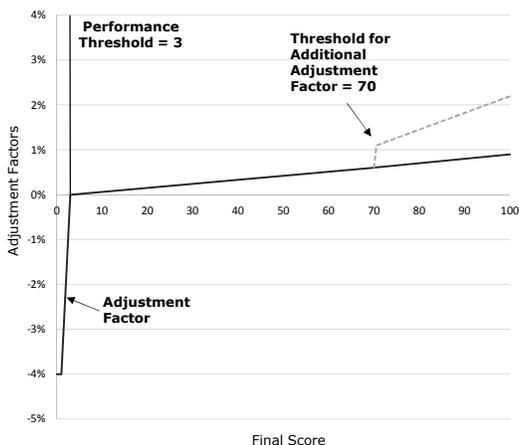
##### Neutral to small positive adjustment

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

#### MIPS Adjustment Factors Based on Final Scores



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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## Compliance: Devil in the details

### QUALITY

- Develop quality checklist
- Assess system capability for accurately capturing data on the 16 possible quality measures
- Consider which 6 of the 15 quality measures can best be accurately captured and are suitable and beneficial for the practice
- Be sure Sharing Savings Track 1 APM, Oncology Care Model One-sided risk APM report quality through APM and not MIPS
- Verify data before reporting
- Retain secure copy of data reported
- Develop new audit systems

### IMPROVEMENT ACTIVITIES

- Medical Home Models and existing Shared Savings Program Track 1 participants automatically earn full credit
- If one practice under the TIN has Medical Home Model recognition, the entire TIN qualifies
- Most participants must attest to completing 2 high-weighted or 4 medium-weighted improvement activities from a list of > 90 for a minimum of 90 days
- If in rural or health professional shortage area, only need to attest to 2 improvement activities
- Decide who will sign attestation
- Maintain documentation that supports attestation

### ADVANCING CARE INFORMATION

- Be sure EHR is properly certified and have documentation of certification or no credit
- Match reporting categories with edition of certified EHR technology
- Can submit up to 9 additional measures for extra credit
- Can earn bonus credit for reporting public health and clinical data registry reporting measures
- Decide who will sign attestation
- Maintain secure documentation that supports attestation
- Have system for addressing clinicians who change TIN

### Accomplish all for minimum of 90 days

#### PHI Access and Security now Revenue Source

- Security Risk Analysis
- E-Prescribing
- Patient Access to her EHR
- Send summary of care to patient and other providers
- Request/accept summary of care from other providers



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# APMs

## Key highlights: Advanced APMs

### Requirements for 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 (CEC) 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)\*
6. Comprehensive Care for Joint Replacement (CJR)\* Bundle

### 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

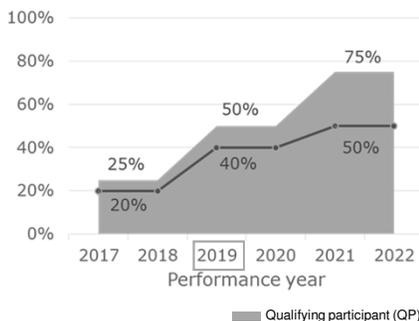
Source: CMS, Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMS); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) (July 2016), CMS, 2016 Fact Sheet: The Quality Payment Program (October 25, 2016)

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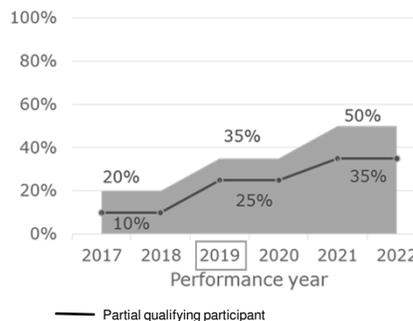
## Getting into the advanced APM track – and staying there

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**



**QP Patient Count Thresholds**



**The Other Payer Option:** Under Other Payer Advanced APMs, at least 25% of Medicare payments for covered professional services must be through CMS approved Advanced APMs. Overall, the sum of combined Medicare payments and all other payments regardless of payer through Advanced APMs and Other Payer Advanced APMs must meet the specified threshold.

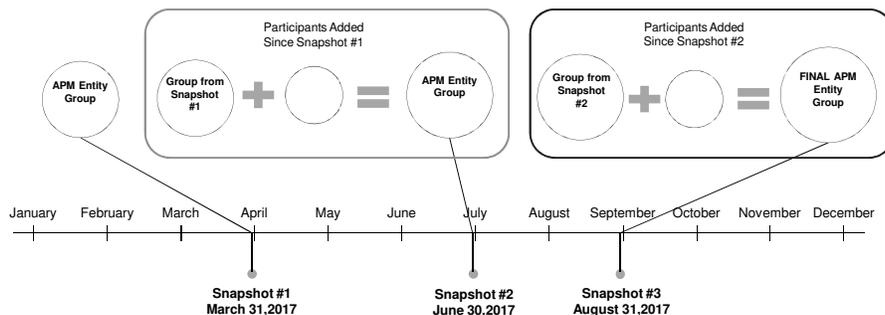
Source: Public Law 114-10 (April 16, 2015)

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### 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 QP in an APM Entity Group

2017 QP Performance Period



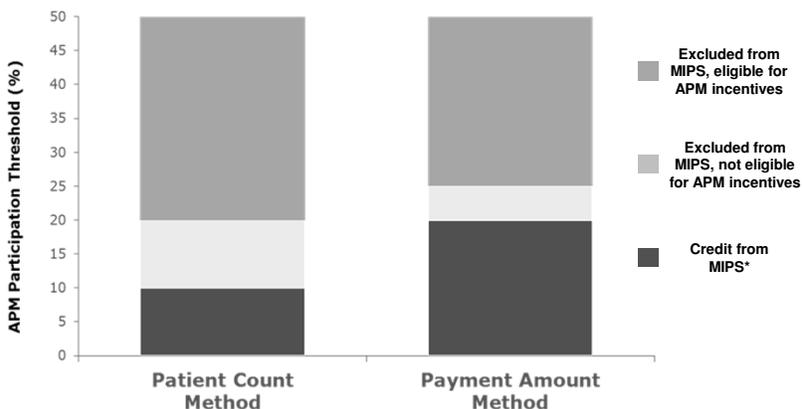
**NOTE:** A QP determined from a Snapshot earlier in the performance year will remain a QP even if they are no longer on the participant list in a later snapshot

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

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### Impact of APM participation thresholds in 2019 and 2020

APM participation is not an all or nothing proposition. ECs 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 CPS weighting

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

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### 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)

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### Bundled Payment Models to qualify as Advanced APMs in 2018

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)

APM

2

#### Non-Certified EHR Users

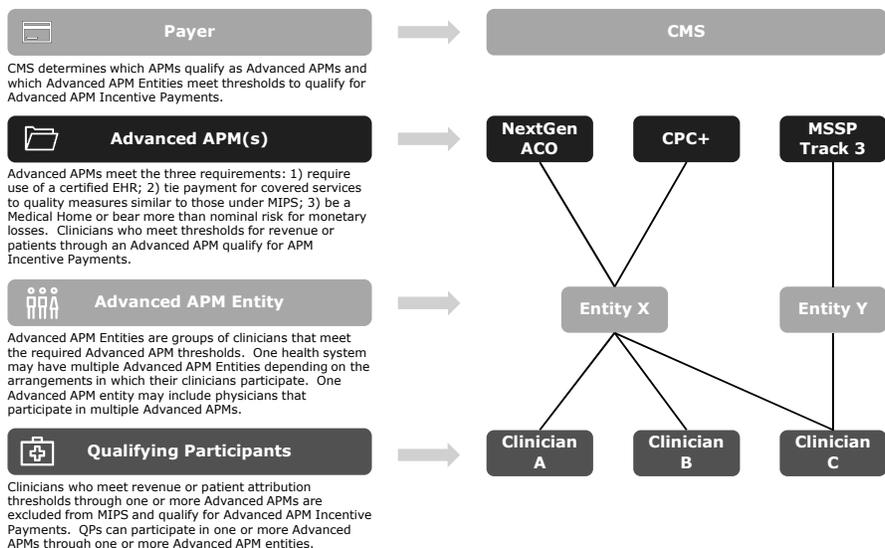
- Acute Myocardial Infarction (AMI)
- Coronary Artery Bypass Graft (CABG)
- Surgical Hip/Femur Fracture Treatment (SHFFT)
- New Future Episode Payment Model based on Bundled Payment for Care Improvement (BPCI)
- Comprehensive Joint Replacement (CJR)

MIPS

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)

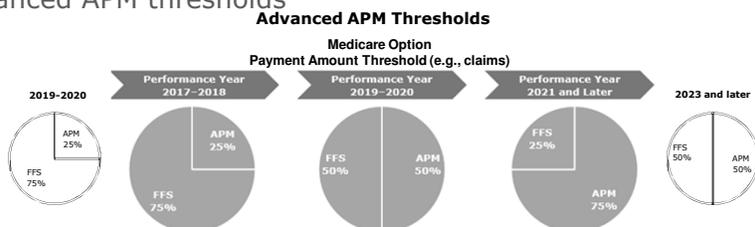
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### Arrangement of Clinicians in Advanced APMs

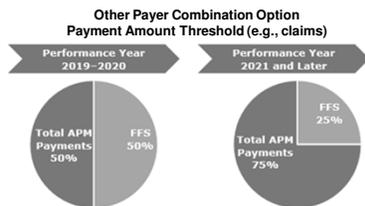


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### Advanced APM thresholds



In order to achieve 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.\*



Under Other Payer Advanced APMs, the sum of combined Medicare payments and all other payments regardless of payer through Advanced APMs and Other Payer Advanced APMs must meet the specified threshold. Importantly, at least 25% of Medicare payments for covered professional services must be through CMS approved Advanced APMs.

Fee For Service (FFS)

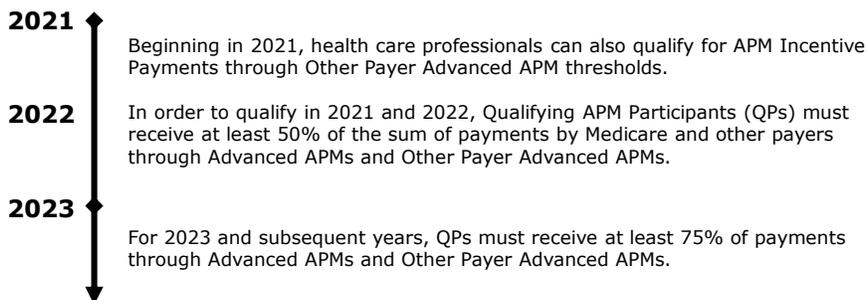
\* CMS also allows for APM Entities to achieve QP Status through an Advanced APM using the patient count method.

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

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### 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



**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)

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### The QPP and 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.**

Source: CMS, "Report to Congress: Alternative Payment Models & Medicare Advantage" July 2016

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# Perspectives and next steps

## 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?**

**How should our physician compensation and incentives change, if at all?**

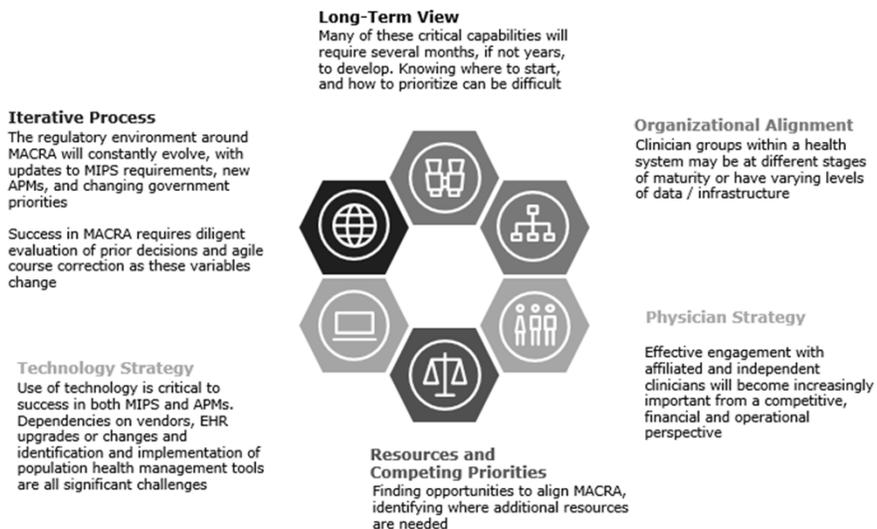
**Do we need to re-examine all of our joint ventures?**

**Into which Advanced APMs should we move and in which performance year?**

**What does this mean for our MA business?**

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## Challenges exist in developing and maturing MACRA capabilities



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## Journey for Health Systems

MACRA accelerates the directional journey 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, reduce utilization, and manage financial risk is one of the highest operational priorities

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## Next steps to consider

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

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



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

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

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## Next steps to consider on compliance

Develop a compliance education plan on MACRA requirements and practical functioning of each payment model

Design a system to verify the key representations associated with the types of claims under each model such as clinician and practice eligibility and elections, quality measures, improvement activities and advancing care information



Collaborate to designate responsibility for attestation to satisfaction of the payment model requirements and who will monitor and maintain documentation to demonstrate compliance

Establish a system of appropriate claim edits and an audit plan to catch mistakes, respond to any notices of deficiencies from payers and re-educate clinicians and billing staff as needed



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### Managing Director | Deloitte Risk and Financial Advisory

#### Profile

Claudia Douglass is a Managing Director in the Advisory Life Sciences and Health Care Practice of Deloitte & Touche LLP, and has over 20 years of experience in the healthcare industry in both consulting and with large health systems in senior leadership roles in the areas of strategic planning, operations and financial management. Claudia's 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. She has presented on the topics of customer relationship management and leadership at professional conferences. Claudia is a Fellow in the American College of Healthcare Executives and certified in project management as a Project Management Professional. She holds a B.B.A. in Finance and Marketing from the University of Miami and a Master of Health Services Administration degree from the University of Michigan.

#### Education

- B.B.A., Finance and Marketing - University of Miami
- Master of Health Services Administration - University of Michigan

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## Maureen Demarest Murray

### Partner and Health Care Group Leader Smith Moore Leatherwood LLP

#### Profile

Maureen is the health care practice leader at Smith Moore Leatherwood LLP, which has offices located throughout the Southeast. With over 35 years of experience, Maureen has defended providers in fraud and abuse investigations, OCR and OIG investigations and inquiries, billing and regulatory compliance, patient billing class actions, privacy, risk management, patient care, professional licensing and privileging matters, EMTALA and acquisitions. She has also handled varied health care business transactions and agreements. Maureen has spoken on compliance matters at the American Health Lawyers Association, NC Hospital Association Trustee Institute and HCCA Regional meeting in Charlotte. Maureen was ranked as a leading individual in health care in U.S. Chambers from 2014 through 2016. She has been listed in health care in North Carolina Super Lawyers since 2006 and as one of the top 50 women attorneys in North Carolina in multiple years including 2016. She has been listed in health care law for more than 25 years in the Best Lawyers in America and in Benchmark Litigation, as a North Carolina Litigation Star in 2016. She is a fellow in the American College of Trial Lawyers.

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- B.A., magna cum laude – Duke University
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Health Care  
Compliance  
Association

# QUESTIONS?

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