MACRA: How the Final Rule Impacts Providers
October 28, 2016
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MACRA: How the Final Rule Impacts Providers
October 28, 2016
Today’s Presenters

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Practice Manager,  
Health Care Advisory Board
1. MACRA Context

2. Early Insights from the Final Rule

3. What to Do Next
Legislation in Brief

1. Medicare Access and CHIP Reauthorization Act (MACRA) passed in April 2015
2. Proposed rule issued April 27, 2016; final rule issued October 14, 2016
3. Repeals the Sustainable Growth Rate (SGR)
4. Locks Medicare Physician Fee Schedule reimbursement rates at near-zero growth:
   - 2016-2019: 0.5% annual increase
   - 2020-2025: 0% annual increase
   - 2026 and on: 0.25% annual increase or 0.75% increase, depending on payment track
5. Stipulates development of two new Medicare Part B payment tracks: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
6. Programs to be implemented on Jan. 1, 2019 based on annual performance period starting Jan. 1, 2017

The Quality Payment Program:
Two New Medicare Part B Payment Tracks Created by MACRA

1. Merit-Based Incentive Payment System (MIPS)
   - Rolls existing Medicare Physician Fee Schedule payment programs into one budget-neutral pay-for-performance program
   - Clinicians will be scored on quality, resource use, clinical practice improvement, and EHR use—and assigned a positive or negative payment adjustment accordingly

2. Advanced Alternative Payment Models (APM)
   - Requires significant share of patients and/or revenue in payment contracts with two-sided risk, quality measurement, and EHR requirements
   - APM track participants will be exempt from MIPS payment adjustments and qualify for a 5 percent incentive payment in 2019-2024


1) Meaningful Use, Value-Based Payment Modifier, and Physician Quality Reporting System.
2) Electronic Health Record.
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Resources Available for MACRA 101

Webconferences
- What You Need to Know Right Now About the Proposed Rule
- Strategic Implications for Provider Organizations from the Proposed Rule
- Operational Action Items from the Proposed Rule
- The No-Regrets Approach to MACRA

Tools
- MIPS Measures from the Proposed Rule
- Your questions about the MACRA proposed rule—answered

Education Materials
- Understanding the Merit-Based Incentive Payment System (MIPS) Reporting Requirements
- A Detailed Look at Provider Payment Under MACRA

For These and Forthcoming Resources on MACRA
https://www.advisory.com/macra

Sources: Advisory Board research and analysis.
First Performance Period Begins in Two Months

MACRA Implementation Timeline

- **April 16, 2015**: MACRA signed into law
- **April 27, 2016**: CMS released proposed rule with details for MIPS and APM tracks and call for comments
- **June 27, 2016**: Comment period on proposed rule closed
- **October 14, 2016**: CMS issues final rule with details for MIPS and APM tracks and call for comments
- **January 1, 2017**: First performance year begins
- **August 2017**: CMS begins to notify providers of qualification for APM Track
- **January 1, 2019**: First year of clinician payment adjustment under MIPS or APM

Broad Response, but Many Physicians Still Unaware

- **3,918**: Public comments submitted on CMS’ proposed rule
- **50%**: Percent of physicians unaware of MACRA

Source: CMS; Deloitte, “MACRA: Disrupting the health care system at every level,” available at: www2.deloitte.com; Advisory Board research and analysis.
Strong Bipartisan Support for MACRA Persists

Repeal or Perpetual Delays Unlikely—Safest Bet on Implementation

Legislation Enjoyed Bipartisan Support

Congress overwhelmingly passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) with the goal of moving towards a high-quality, value-based health care system…. [W]e are committed to the successful and timely implementation of the law while still providing practitioners time and opportunities to succeed.”

Bipartisan Leaders from House Energy and Commerce Committee and Ways and Means Committee

“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.”

Bipartisan Leaders from House Energy and Commerce Committee and Ways and Means Committee

1. MACRA Context

2. Early Insights from the Final Rule

3. What to Do Next
Release of Final Rule Provides Clarity for 2017

Final Rule in Brief

• Issued October 14, 2016 to implement Quality Payment Program (QPP), including MIPS and Advanced APM
• 2,100 pages of regulation and responses to comments
• Comment period lasting 60 days after the date of filing for public inspection at OFR
• Final rule applies to 2017, with additional rulemaking to come in future years

Final Rule Highlights

• “Pick-your-Pace” in 2017
• MIPS measures reduced
• Fewer providers in MIPS
• APM Track requires downside risk
• Visibility into 2018 and beyond

2017 MACRA Final Rule Detailed Analysis

• Second webconference to cover final QPP parameters in greater detail
• Will be held on November 29 at 3:00pm ET and available on-demand
• To register, click here or visit: https://www.advisory.com/macra

Source: CMS, “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; Advisory Board interviews and analysis.
CMS Makes 2017 a MIPS Transition Year

Three Options For MIPS Participation in 2017

1. Minimal Reporting to Avoid Penalties
   • Submit any single metric under quality or clinical improvement or the required ACI measures
   • No minimum time period required
   • Will avoid a negative payment adjustment

2. Report Partial Data, Potential for Small Bonus
   • Submit more than one quality or clinical improvement metric or more than the required ACI measures
   • Must report for a full 90-day continuous reporting period
   • Possibility of qualifying for positive payment adjustment, but likely to be small

3. Report Full Data for Chance of Larger Bonus
   • Submit all required data in all categories
   • Must report for a full 90-day continuous reporting period
   • Potential for full payment adjustment
   • Highest performers still earn additional positive adjustment

What this Means for Eligible Clinicians

• Flexibility in MIPS participation in 2017, not all or nothing
• Clinicians will only see negative penalty if fail to report, but strong performers see reduced rewards
• Important: Providers should not slow MACRA preparations in light of new options

Despite Flexibility, MIPS Still A Zero-Sum Game

Annual Evaluation Likely to Create Volatility

**Payment Adjustment Determination**

1. Clinicians assigned score of 0-100 based on performance across four categories

2. Score compared to CMS-set performance threshold; non-reporting groups given lowest score

3. A score above performance threshold results in upward payment adjustment; a score below results in a downward adjustment²

**Maximum Clinician Penalties and Bonuses**

![Graph showing payment adjustment determination and maximum clinician penalties and bonuses](image)

Highest performers eligible for up to 10% additional incentive²

Budget neutrality adjustment: Scaling factor ranging from 0.0 to 3.0 may be applied to upward adjustment to ensure payout pool equals penalty pool

Non-reporting participants given lowest score

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1) Payment adjustment size corresponds with how far the score deviates from the PT.
2) High performers eligible for additional incentive of up to 10%.

Source: CMS, “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; Advisory Board interviews and analysis.

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Ease of Avoiding Penalties May Mean Light Bonuses

But Low Bar Rises Quickly After 2017

Hypothetical 2019 Payment Adjustments
Based on CMS Example of 2017 Provider Score Distribution

- Performance Threshold: Performance met or exceeded by reporting a single metric
- Additional Adjustment Threshold: Threshold met by full reporting, strong performance

2019 MIPS Payment Adjustment

- Base adjustment scaled down for budget neutrality

2017 MIPS Performance Score

- 0: 3%
- 70: 2.4%
- 100: 0%

$199M
Penalties anticipated from non-reporting ECs in 2017

$336
Estimated net upward base adjustment per clinician subject to MIPS

$500M
Additional funds to be distributed to ECs above Additional Adjustment Threshold

Source: CMS, “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; Advisory Board interviews and analysis.
CMS Simplifies Each of the MIPS Categories

**Quality**
- Removed two of three proposed population-based metrics
- Only requiring ACR\(^1\) measure for groups of more than 15 (instead of the proposed 10)
- Dialed back, phasing in data completeness requirements

**Cost**
- Reduced category weight to 0% in 2019, 10% in 2020
- Decreased number of episode-based measures from 41 to 10

**Improvement Activities**
- Total points possible is now 40, rather than 60
- Full credit through 4 medium-weighted or 2 high-weighted activities, instead of 6 medium-weighted or 3 high-weighted activities

**Advancing Care Information**
- Reduced number of required measures from 11 to 4 modified Stage 2-equivalent measures or 5 Stage 3-equivalent measures

Source: CMS, “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; Advisory Board interviews and analysis.

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1) All-Cause Readmissions.
Competition to Intensify with Smaller MIPS Track

Expanded Exemptions and APM Growth Reduce MIPS Participants

Distribution of Clinicians Billing Medicare in 2017

<table>
<thead>
<tr>
<th>Eligible Clinicians</th>
<th>Estimated Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineligible clinician type/newly enrolled</td>
<td>~284,000 (20%)</td>
</tr>
<tr>
<td>Below volume threshold</td>
<td>~384,000 (28%)</td>
</tr>
<tr>
<td>MIPS Track</td>
<td>~617,000 (45%)</td>
</tr>
<tr>
<td>APM Track</td>
<td>~95,000 (7%)</td>
</tr>
</tbody>
</table>

Low-Volume Threshold
Clinicians, groups with:
• ≤$30,000 in Medicare charges\(^2\)
• 100 or fewer Medicare patients

Final Rule Expands Low-Volume Exemptions, Reducing Number of ECs

Estimated Number of ECs\(^1\) Subject to MACRA

<table>
<thead>
<tr>
<th>Proposed Rule</th>
<th>Final Rule</th>
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</thead>
<tbody>
<tr>
<td>836,000</td>
<td>712,000</td>
</tr>
</tbody>
</table>

MIPS Expected to Shrink Further as APM Track Grows

25%
ECs projected to qualify for Advanced APM incentives in 2018

Source: “CMS announces additional opportunities for clinicians to join innovative care approaches under the Quality Payment Program,” Centers for Medicare & Medicaid Services, Oct. 25, 2016; CMS, “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; Advisory Board interviews and analysis.

1) Eligible Clinicians.
2) The Proposed Rule set the charge threshold at $10,000, but the amount was expanded to $30,000 in the Final Rule.
Financial Risk Criterion for Advanced APMs Changed

But Still Focus on Downside Risk Models

Final Advanced APM Criteria

- Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target) or
- Meet revenue-based standard (average of at least 8% of revenues at-risk for participating APMs)
- Certified EHR use
- Quality requirements comparable to MIPS

APM Entities Must Meet Percent of Payments or Patient Counts

- 2019: 25%, 20%
- 2020: 25%, 20%
- 2021: 50%, 35%
- 2022: 50%, 35%
- 2023: 75%, 50%
- 2024+: 75%, 50%

May Include Non-Medicare

Payments through Advanced APMs
Patients in Advanced APMs

Source: CMS, “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; Advisory Board interviews and analysis.
## APMs That Qualify Largely Unchanged—For Now

### Advanced APM-Ineligible Payment Models

- Bundled Payments for Care Improvement Initiative (BPCI)
- Comprehensive Care for Joint Replacement (CJR) Model\(^1\)
- Medicare Shared Savings Program (MSSP) Track 1 (50% sharing; upside only)

But participation in these models may positively affect MIPS payments

### Advanced APM-Eligible Payment Models

- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO Model
- Episode-Based Payment Model (currently a proposal; downside risk would begin in 2018)
- The Oncology Care Model Two-Sided Risk Arrangement
- Comprehensive ESRD\(^2\) Care Model (two-sided risk arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Certain commercial contracts with sufficient risk, including Medicare Advantage (starting in 2021)

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1. CMS has proposed updating CJR so that it would qualify as an Advanced APM if participating hospitals are using CEHRT, but has not yet finalized this proposal.
2. End stage renal disease.

Source: CMS, “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; Advisory Board interviews and analysis.

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MIPS APM Standard Finalized

Preferential Scoring for ECs Without QP Status or in MIPS APMs

Comparison Between MIPS CPS Weighting and Scoring Standard for MIPS APMs in 2017

MIPS APM Scoring Standard
- Quality
- Cost
- Improvement Activities (IAs)
- Advancing Care Information (ACI)

Applies to Two MIPS Scenarios

Below QP Volume Threshold in Advanced APM

Any Volume in MIPS APM

Below QP Volume Threshold in Advanced

Medicare Advanced APMs
- Comprehensive ESRD Care two-sided risk arrangement
- MSSP Track 2 and Track 3
- Next Generation ACO
- Oncology Care Model Two-Sided Risk

Other APMs

MSSP
- Comprehensive ESRD Care one-sided risk arrangement
- MSSP Track 1
- Oncology Care Model One-Sided Risk

MIPS APMs

60% 50% 50% 25%
15% 20% 20% 75%
25% 30% 30%
Flat Trajectory for Baseline Physician Payments

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

1. MIPS Bonuses/Penalties

- +/-4%: Maximum annual adjustment, 2019
- +/-9%: Maximum annual adjustment, 2022
- $500M: Additional bonus pool for high performers

2. APM Bonuses/Penalties

- 5%: Annual lump-sum bonus from 2019-2024

(plus any bonuses/penalties from Advanced Payment Models themselves)


Baseline payment updates:

- 2015 – 2019: 0.5% annual update (both tracks)
- 2020 – 2025: Payment rates frozen (both tracks)
- 2026 onward: 0.25% annual update (MIPS track) 0.75% annual update (Advanced APM track)

1) Clinicians with a threshold final score of 70 or higher eligible for additional bonus.
2) Relative to 2015 payment

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MIPS to Rapidly Become More Challenging

Full-Year Reporting, Weighting for Cost Category, Outcomes Metrics Loom

Weights of MIPS Score Components in Final Rule

<table>
<thead>
<tr>
<th>Component</th>
<th>2017</th>
<th>2018</th>
<th>2019+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>15%</td>
<td>10%</td>
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<tr>
<td>Advancing Care Information</td>
<td>25%</td>
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</tr>
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Key MACRA Reporting Trends Looking Forward

**Resource Use Measurement Intensifies Post-Transition Year**
Resource use reporting not considered for 2017 performance year, but still increased to 30% by 2019; CMS expects to add more episode-based measures over time.

**Quality Scoring to Center on Outcomes Metrics**
To keep the emphasis on such measures in the statute, we plan to increase the requirements for reporting outcome measures over the next several years through future rulemaking, as more outcome measures become available.

*Centers for Medicare and Medicaid Services*

Source: CMS, “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; Advisory Board interviews and analysis.
More Opportunity to Participate in Advanced APMs

CMS to Expand List of Qualifying Programs in 2018 and Beyond

Anticipated Additions to Advanced APM List for 2018 Program Year

**Creation of Qualifying New Models**

- **MSSP¹ Track 1+**
  Two-sided risk track with less upside reward but also less downside risk than Track 2 and Track 3, expected to begin in 2018

- **Voluntary Bundled Payment Model**
  CMMI² considering a new voluntary bundled payment model for 2018; would build on BPCI³

**Inclusion of Existing Models**

- **CJR⁴ Payment Model (CEHRT⁵ Track)**
  Proposed rule allows for qualification as an Advanced APM if participating hospitals are using CEHRT

- **EPM⁶ Track 1 (CEHRT Track)**
  Proposed rule creates two tracks; participants required to use CEHRT in Track 1 of each EPM to qualify as Advanced APM

- **Vermont Medicare ACO Initiative**
  CMS expects the Vermont Medicare ACO program (part of Vermont’s new All-Payer ACO Model) to be an Advanced APM

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1) Medicare Shared Savings Program.
2) Center for Medicare and Medicaid Innovation.
3) Bundled Payments for Care Improvement.
4) Comprehensive Care for Joint Replacement.
5) Certified electronic health record technology.
6) Episode Payment Model.

Source: CMS, “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; Advisory Board interviews and analysis.
1. MACRA Context

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MACRA Accelerates Three Key Trends

2017 an Opportunity to Position Organization for Long-Term QPP Success

Ups the ante on provider Pay-for-Performance

Provider performance now more competitive. Average performance will no longer be enough.

Introduces significant Incentives to Take on Risk

Incentives reduce physician reporting burden and increase payment opportunities. New on-ramp to risk

May significantly transform Provider Alignment

Increased alignment across provider landscape presents new opportunities for partnerships.

Quality reporting optimization

Overall strategy design

Source: Advisory Board research and analysis,
Though Requirements Lax, Transition Year Critical

Imperative #1: Use the transition year to your advantage

Stakes Get Dramatically Higher in 2018 and Beyond

Progression of Reporting Requirements, Payment at Risk by Performance Year

- 2017
  - Non-reporting only way to incur payment penalty—maximum penalty is 4%
  - Three flexible reporting period options
  - Cost weighted at 0%
  - Two options for reporting in ACI

- 2018
  - Poor performance can incur payment penalty—maximum penalty is 5%
  - Must report full year
  - Cost weighted at 10%
  - Must report Stage 3 measures in ACI

- 2019
  - Poor performance can incur payment penalty—maximum penalty is 7%
  - Must report full year
  - Cost weighted at 30%
  - Must report Stage 3 measures in ACI

Source: CMS, “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; Advisory Board interviews and analysis.
Three Steps to Take Advantage of Reporting Flexibility

1. Report Full Year
   - In 2018 full year reporting is required, get into the practice immediately
   - Maximize your return on reporting by qualifying for modest positive payment adjustment

2. Report 2018 Requirements
   - Use 2017 as practice for 2018
   - Try out new reporting requirements to work out kinks
   - Enhance performance for 2018 when payment is on the line

3. Use Data to Inform Performance
   - CMS will provide a wealth of feedback in 2017
   - Performance will be calculated for measures that aren’t scored in 2017 performance period
   - Feedback valuable for maximizing score long-term

CMS, “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; Advisory Board interviews and analysis.
MACRA Just One Piece of a Much Bigger Picture

Critical Reasons to (Re-)Discuss Payment Reform Now

Medicare Risk A Complicated Landscape

1. Diminishing FFS Payments
   - ACA Productivity Adjustments
   - Process-focused Pay-for-Performance

2. Evolution of Alternative Payment Model Options
   - Physician Group Practice (PGP) Transition Demonstration
   - Acute Care Episode (ACE) Demonstration
   - Pioneer ACO Model

3. Increased Pressure on Physicians to Take Risk
   - Physician Quality Reporting System (PQRS)
   - Meaningful Use
   - Value-Based Payment Modifier

Past
- Outcomes-focused Pay-for-Performance
- 2017 OPPS Proposed Rule Site-Neutral Payments Provision

Present
- Medicare Shared Savings Program (MSSP)
- Next Generation ACO (NGACO) Model
- Comprehensive Primary Care Plus (CPC+)
- Bundled Payments for Care Improvement (BPCI) Initiative
- Comprehensive Care for Joint Replacement (CJR) Model
- Episode Payment Models (EPM)

Source: Advisory Board interviews and analysis.
We have already defined our strategy. Now the need is to navigate MACRA within the context of that strategy that we’ve been laying out for the past 4 years.”

Joe Mott, VP Population Health and Healthcare Transformation
Intermountain Healthcare
Three Steps to Establishing a Sustainable Medicare Risk Strategy

1. **Redefine Path to Risk for Traditional Medicare**
   - Set foundation for overall Medicare strategy by determining appropriate level of risk, considering implications of physician strategy on MACRA response.

2. **Expand Into Medicare Advantage Market**
   - Complement traditional Medicare strategy with customized approach to MA contracting based on organizational, market readiness.

3. **Ensure Longevity of Medicare Risk Strategy**
   - Engage partners and patients to ensure maximal financial performance over time.

**Source:** Advisory Board interviews and analysis.
Seeking Company to Weather Together?

An Array of Partners and Alignment Options

"If we’re going to take risk with you, no more of this discussion of whether you are willing to do patient satisfaction surveys or get your medical home application into NCQA. You have to do it now, or you’re not in. That’s been our intent all along, but MACRA is allowing us to speed it up.”

President, Jacobs Health Care

Your To Do Steps for Alignment

- Engage provider partners to determine requirements for entry into alignment model
- Consider referral relationship and value of more formal partnership
- Evaluate how alignment affects reporting strategy

Source: Physician Practice Roundtable 2016 MACRA Pulse Check Survey; Advisory Board interviews and analysis.
More Layers to Alignment Decisions than Before

Critical to Understand Impact of Potential Partners on MACRA Performance

Alignment Efforts May Have Inadvertent Outcome

Partnering to Form ACO
- Expand options for beneficiaries
- Fulfill service line deficits

Alignment Efforts Improve Network Scale
- Growth in physician network increases number of attributed beneficiaries, ability to manage risk
- Improves transparency into physician performance, ability to shift practice patterns

Possibility MIPS Score Diluted by Adding ACO Partners
- All ACO participants receive same aggregate score
- New additions to ACO might have lower quality performance
- Takes time to align goals of participants

Source: Advisory Board interviews and analysis.
MACRA: Your New Tool for Growth

Creating New Urgency for Larger Group Employment

Alignment Requests Likely Coming from Smaller, Medicare-Heavy Practices

- Often lack EMR
- No history of group affiliation
- Minimal insight into performance
- Likely not taking risk

61%
Percent of physicians in practices of 10 physicians or less

Your To Do Steps for Growth

- Carefully evaluate physicians that approach you
- Consider re-approaching those you’ve been casually courting
- Crystallize your value proposition

The Advisory Board’s Suite of MACRA Solutions

Targeted Offerings to Meet Your Organization’s Needs

Research Memberships

- Publications, web conferences, and blog posts that cover the key requirements of MACRA and implications for providers
- On-site policy briefing available for key stakeholders

MACRA Intensive

- On-site session designed to identify readiness gaps and develop implementation strategy
- Three parts: policy education; performance assessment; and strategic discussion with leadership

Quality Reporting Roundtable

- Service to help providers navigate quality reporting programs requirements, including MACRA and Meaningful Use
- On-call experts, policy monitoring, audit support, best practices, and networking opportunities

Recommended For:

- Organizations that need foundational understanding of MACRA across key stakeholder groups
- Organizations that need to assess readiness and confirm strategic planning approach
- Organizations that need ongoing strategic guidance and long-term program management support

Additional Custom Strategic Support Available

- Hands-on support to help organizations design and implement large-scale business transformation needed for health care reform
- Areas of expertise include value-based payment models, physician alignment, and EHR optimization
Questions about the QPP Final Rule?

Remember to Register for our Webconference on the Details

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