MACRA: How the 2018 Quality Payment Program Final Rule Impacts Providers

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Today’s Presenters

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Two-Part 2018 MACRA Webconferences
Providing an Overview and a Detailed Analysis for All Members

MACRA: How the 2018 Quality Payment Program Final Rule Impacts Providers

TODAY

What You'll Learn:

• The most important changes in the 2018 QPP final rule
• Next steps for provider organizations in response to the final rule

2018 MACRA Final Rule Detailed Analysis: Your Guide to New Flexibilities and Challenges in the Quality Payment Program

December 12, 1:00-2:00 PM ET

What You'll Learn:

• The details of 2018 QPP requirements
• Action items on reporting and program management
• How to prepare for success in future years

For More Advisory Board Resources on MACRA
https://www.advisory.com/macra

Source: Advisory Board research and analysis.
1. MACRA Context

2. Reviewing Key Insights from the 2018 Final Rule

3. Charting the Path Forward
Legislation in Brief

- Medicare Access and CHIP Reauthorization Act (MACRA) passed in April 2015
- Repeals the Sustainable Growth Rate (SGR)
- 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
- Stipulates development of the Quality Payment Program, which is two new Medicare Part B payment tracks: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)

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\(^1\) into one budget-neutral pay-for-performance program
   - Clinicians will be scored on quality, advancing care information, improvement activities, and cost—and assigned a positive, neutral, 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\(^2\) requirements
   - APM track participants will be exempt from MIPS payment adjustments and qualify for a 5 percent incentive payment in 2019-2024

Source: The Medicare Access and CHIP Reauthorization Act of 2015; 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, April 25, 2016; Advisory Board interviews and analysis.

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

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Reviewing the Year 2 Timeline

Majority of Providers Still Struggle with Transition to New Model

MACRA Implementation Timeline

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACRA signed into law</td>
<td>April 16, 2015</td>
</tr>
<tr>
<td>First performance year</td>
<td>January 1, 2017</td>
</tr>
<tr>
<td>Final 2018 QPP rule released</td>
<td>November 2, 2017</td>
</tr>
<tr>
<td>CMS releases MIPS cost data to eligible clinicians</td>
<td>July 1, 2018</td>
</tr>
<tr>
<td>Commencement of Medicare payment adjustment</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>Second performance year</td>
<td>January 1, 2018</td>
</tr>
<tr>
<td>Payers submit eligibility information for the all-payer combination model</td>
<td>April – June, 2018</td>
</tr>
</tbody>
</table>

Many Providers Remain Unaware and Unprepared

- **80%** Provider organizations that have not developed their MACRA strategy yet
- **47%** Respondents do not know which payment track they are subject to

Sources:
Strong Bipartisan Support for MACRA Persists

Repeal 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

MACRA Marches Forward; So Must You

Keep Up To Date with the Latest QPP Regulations

Key Takeaways

1. Two trends are clear: **Payment reform continues apace**, and the administration wants to reduce MACRA’s burden

2. Approximately **622,000 eligible clinicians** have to participate in MIPS in 2018

3. CMS is offering “small practice” and “complex patient” bonus points

4. CMS **maintains for another year** several 2017 performance year flexibilities to ease clinicians into MIPS

5. Providers must prioritize their **Quality performance improvement and Cost control efforts** in 2018

6. Rule creates virtual groups for solo practitioners and small practices to participate and succeed under MIPS

7. The final rule **raises the performance bar** to avoid payment penalties in MIPS slightly overall

8. CMS estimates substantially **more providers will qualify for the APM track** in 2018 than 2017

9. CMS will **maintain the Advanced APM qualification criteria**

10. Providers in areas affected by **natural disasters** during 2017 will receive a neutral payment adjustment in 2019
1. MACRA Context

2. Key Insights from the 2018 Final Rule

3. Charting the Path Forward
Release of Final Rule Provides Clarity for 2018

Final Rule in Brief

- Issued November 2, 2017 to implement 2018 program year of Quality Payment Program (QPP), including MIPS and Advanced APM
- 1,653 pages of regulation and rules
- Comment period for final rule lasting till January 1st, 2018
- Final rule applies to 2018, with additional rulemaking to come in future years

Proposed Rule Highlights

1. Fewer Providers in MIPS
2. Added Flexibility for Smaller Groups
3. Requires a Renewed Focus on Quality Improvement
4. Inclusion of Cost Performance Adds to 2018 MIPS Difficulty
5. New Program Options Significantly Increasing APM Participation

Resource in Brief: The MACRA Resource Page

- Resource page with curated MACRA educational and strategy guides
- Visit: https://www.advisory.com/macra

Competition to Intensify with Smaller MIPS Track

Expanded Exemptions and APM Growth Reduce MIPS Participants

Distribution of Clinicians Billing Medicare in 2018

<table>
<thead>
<tr>
<th>Exempt Clinicians</th>
<th>Eligible Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineligible clinician type</td>
<td>Below volume threshold</td>
</tr>
<tr>
<td>~315,243 (20%)</td>
<td>~540,347 (35%)</td>
</tr>
<tr>
<td>MIPS Track</td>
<td>APM Track</td>
</tr>
<tr>
<td>~621,700; (40%)</td>
<td>~70,732; (5%)¹</td>
</tr>
</tbody>
</table>

¹ Estimated Number

Finalized Low-Volume Threshold
Clinicians, groups with:
- ≤$90,000 in Part B Medicare charges
  OR
- 200 or fewer Medicare patients

Number of MIPS Eligible Clinicians Gradually Declining²

- 2017 final rule: 712,000
- 2018 final rule: 621,700

MIPS Expected to Shrink Further as APM Track Grows

185K-250K Total ECs estimated to qualify for Advanced APM incentives in 2018

Sources: CMS; Advisory Board research and analysis.

1) Projection based on PY 2017 data and thus is lower than CMS final rule summary projection of APM participation which is 185,000-250,000
2) All numbers rounded to nearest thousand.
3) Eligible Clinicians.

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In the Meantime, Some Automatic Exemptions in 2017

Providers Affected by Natural Disasters Avoid 2017 Reporting, 2019 Penalty

Hardship Issues

Extreme and Uncontrollable Circumstances in 2017

- e.g. Hurricanes Harvey, Irma, and Maria

Participation Option

Option 1: Take an Automatic Hardship

- No need to submit a hardship application
- No MIPS data submission, and receive 3 points

Option 2: Participate in MIPS

- Submit data for at least two MIPS performance categories
- All MIPS scoring and payment adjustment policies apply

Financial Implications

- Only Penalty Avoidance
- Penalty Avoidance and Potential Incentive Payments

Identifying MIPS ECs in Affected Areas

- Based on the practice location address listed in PECOS¹
- Affected areas designated on the Federal Emergency Management Agency FEMA's website

¹ PECOS = The Provider Enrollment, Chain and Ownership System

Sources: CMS; Advisory Board research and analysis.
Final Rule Aims to Ease Burden for Small Groups

CMS Highlighting Flexibility, Ease of Reporting as Key Goals

Augmenting MIPS scoring for small practices

- Small practices defined as those with 15 or fewer ECs
- Five-point bonus to MIPS score, awarded to small groups that report at least one category in 2018
- Easing requirements for specific MIPS categories in 2018

Offering virtual group reporting option

- TINs with 10 or fewer ECs can join together to report as virtual group in 2018; assessed, scored collectively as group under MIPS
- No limit on number of TINs in group, no restrictions on geography, specialty
- Virtual groups must be declared by December 31, 2017

19% Percent ECs CMS estimates will be part of small groups in 2018

1% Percent ECs CMS estimates will participate in virtual groups in 2018

Sources: CMS; Advisory Board research and analysis
3. Requires a renewed focus on quality improvement

Renewed Focus on Quality and Cost in 2018

Critical to Sustain High Quality and Low Cost for the Entire Year

Quality

- Increase to full-year reporting period requirement for all submission methods
- Data completeness requirement rises to 60% for many submission methods
- Reward year-over-year performance improvement
- Cap maximum points available for highly topped-out measures

Cost

- Included as 10% of MIPS final score
- Steep ramp-up to legally-mandated 30% weight in 2019
- Performance based on full-year claims data; no additional reporting required
- Assessed on Total Per Capita Cost and MSPB\(^1\) measures
- May propose new episode-based measures in future rulemaking

Improvement Activities

- No change to 90-day reporting period or scoring policies
- Additional activities to choose from
- Majority of ECs must participate in a Patient-Centered Medical Home (PCMH) to receive full group credit

Advancing Care Information

- No change to 90-day reporting period
- 2014 Edition CEHRT\(^2\) permitted; bonus available for exclusive use of 2015 Edition CEHRT to report ACI measures
- More providers may qualify for ACI reweighting or hardship exceptions
- Effective 2017, prior Meaningful Use (MU) exclusions available for certain Base score measures

Sources: CMS; Advisory Board research and analysis.

1) MSPB = Medicare Spending per Beneficiary.
2) CEHRT = certified EHR technology.

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All MIPS APMs Now Measured on Quality in 2018

Different Category Weights Apply to ECs in MIPS APMs

Comparison Between Default MIPS Category Weights\(^1\) and Scoring Standard for MIPS APMs in 2018

<table>
<thead>
<tr>
<th>MIPS</th>
<th>MIPS APM Scoring Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Improvement Activities (IA)</td>
</tr>
<tr>
<td>Cost</td>
<td>Advancing Care Information (ACI)</td>
</tr>
</tbody>
</table>

Comparison of MIPS and MIPS APM Scoring Standards:

- MIPS: 50% Quality, 30% Improvement Activities (IA), 20% Advancing Care Information (ACI)
- MIPS APM Scoring Standard: 50% Quality, 20% Improvement Activities (IA), 30% Advancing Care Information (ACI)

Number of MIPS APM Quality Measures:

- ACO\(^2\): 15
- CPC+: 21
- Comprehensive ESRD\(^3\) Care: 16
- Oncology Care Model: 13

MIPS APM Scoring Standard Applies to Two MIPS EC Scenarios:

1. Below QP\(^4\) Volume Threshold in Certain Advanced APMs\(^5\)
2. Any Volume in MIPS APMs

MIPS APMs at [qpp.cms.gov](http://qpp.cms.gov)

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1. Cost category will increase to 30% in future years in MIPS and Quality decrease to 30%. However, Cost performance is not included under the MIPS APM scoring standard.
2. Next Generation ACOs and MSSP ACOs report 14 CMS Web Interface Quality measures; final rule adds CAHPS for MIPS Survey to Quality scoring starting 2018.
3. ESRD = End-Stage Renal Disease.
4. Includes Partial QPs that elect to participate in MIPS, and all ECs that fall below the Partial QP volume thresholds.
5. Not all Advanced APMs meet the definition of a MIPS APM, e.g., episode payment models are Advanced APMs, but not MIPS APMs.

Sources: CMS; Advisory Board research and analysis.
2018 QPP Final Rule Brings Back Cost at 10%

Full-Year Reporting, Cost Category, Topped-out Measure Phase-out Arrive

2018 MIPS Category Weights Finalized

<table>
<thead>
<tr>
<th></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>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Key Trends Looking Forward

Cost Measurement to Begin in 2018, Increase Significantly in 2019
Cost category to account for only 10% of performance for 2018 program year, but increases to 30% in 2019, as required by MACRA; CMS plans to propose new episode-based measures in future years

Quality Scoring to Phase-out “Topped-out” Measures
Although we proposed a 3-year timeline to identify and propose to remove (through future rulemaking) topped out measures, we would like to clarify the proposed time-line is more accurately described as a 4-year timeline. After a measure has been identified as topped out for 3 consecutive years, we may propose to remove the measure through notice-and-comment rulemaking for 4th year…
MIPS: A Zero-Sum Game for Clinicians

Stronger Performers Benefit at Expense of Those with Low Scores/No Data

Payment Adjustment Determination

1. ECs assigned score of 0–100 based on performance across three categories

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

3. A score above PT results in upward payment adjustment; a score below PT results in a downward adjustment

Maximum EC Penalties and Bonuses

- Dashed light gray line reflects up to 10% additional incentive for exceptional performers

- Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool

QPP Year 2 PT Increases; New Bonuses Points Available

- MIPS final score of 15 avoids a negative payment adjustment, and 70 earns the exceptional performance bonus

- New 2018 MIPS bonus points: small group and complex patient

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) Additional pool of $500M available for exceptional performers to receive additional incentive of up to 10% for MIPS-eligible providers that exceed the 25th percentile above the PT.

Sources: CMS; Advisory Board research and analysis.
Ease of Avoiding Penalties May Mean Light Bonuses

But Low Bar Rises Quickly After 2018

Hypothetical 2020 MIPS Payment Adjustments
*Based on CMS Example of 2018 Provider Score Distribution*

- 604K Estimated number of MIPS eligible clinicians
- 2.9% Estimated\(^1\) percentage of MIPS ECs with penalties
- 74.4% Estimated\(^1\) percentage of ECs with exceptional performance
- $500M Additional funds to be distributed to ECs above Additional Adjustment Threshold

1) CMS estimate assumes at least 90% of ECs within each practice size category would participate in quality data submission.

Sources: CMS; Advisory Board research and analysis.

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Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

1. MIPS Bonuses/Penalties
   
   +/−5%
   Maximum annual adjustment, 2020

   +/-9%
   Maximum annual adjustment, 2022

   $500M
   Additional bonus pool for high performers¹

2. APM Bonuses/Penalties

   5%
   Annual lump-sum bonus from 2019-2024
   (plus any bonuses/penalties from Advanced Payment Models themselves)

Source: The Medicare Access and CHIP Reauthorization Act of 2015; 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, April 25, 2016; Advisory Board interviews and analysis.

Baseline payment updates¹:

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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Advanced APM Track Criteria Unchanged for 2018

New Policies for Forthcoming All-Payer Combination APM Track

Final Medicare Advanced APM Criteria

☑ Meet revenue-based standard (average of at least 8% of revenues at-risk for participating APMs) or

☑ Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)

☑ Certified EHR use

☑ Quality requirements comparable to MIPS

Required Payments or Patients Thresholds Per Payment Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments through Advanced APMs</th>
<th>Patients in Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>25%</td>
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</tr>
<tr>
<td>2021</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2022</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2023</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>2024+</td>
<td>75%</td>
<td>50%</td>
</tr>
</tbody>
</table>

May Include Non-Medicare¹

Engage Payers to Determine Future All-Payer Combination APM Track Eligibility

CMS aligned² the Advanced APM criteria under the Medicare option with the forthcoming All-Payer Combination option. Organizations should reach out to their payers in 2018 to assess the payment models that may qualify for this option in QPP Year 3.

¹ In all-payer combination option, Medicare Advanced APM volume threshold (i.e., 25% payments, 20% patients) must also be met, in combination with other-payer Advanced APM volumes.
² Add 8% revenue-based nominal amount standard for 2021 and 2022 payment years in addition to previously established 3% expenditures-based standard.

Sources: CMS; Advisory Board research and analysis.
### Expanded Medicare Options (2018+)

**Accountable Care Organizations**
- CMMI\(^1\) introducing MSSP\(^2\) Track 1+ in 2018; reopening applications for Next Generation ACOs; anticipating Vermont Medicare ACO initiative to qualify

**Medicare Advantage**
- CMS considering developing model for MA to qualify for the APM track in 2018

**Medical Home Models**
- CMMI reopening CPC+ applications; exempting round 1 participants from fewer than 50 clinicians requirement

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### Anticipated All-Payer Models (2019+)

**Medicaid APM or Medical Home**
- Submissions for states and eligible clinicians open and close in 2018

**CMS Multi-Payer Models**
- Submissions for payers open and close in 2018

**Medicare Advantage**
- Submissions for payers open and close in 2018

**Remaining Other Payer Arrangements**
- No submissions open in 2018

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CMS Makes it Easier for CPC+ to Qualify for APM Track

Two Key Changes to Qualification Requirements

1. Enables existing CPC+ practices to qualify as APMs in 2018, despite size

   **2017 Final Rule:** Beginning in 2018, CPC+ participants must have fewer than 50 clinicians to be eligible for the APM track

   **2018 Final:** Round 1 CPC+ participants with greater than 50 clinicians can qualify as APMs in 2018; all others must have fewer than 50 clinicians to qualify

2. Reduces risk thresholds in 2018, and beyond

   **2017 Final Rule:** Must have 3% of revenue at risk in 2018, 4% in 2019, 5% in 2020+ to meet QP thresholds

   **2018 Final Rule Revenue at risk thresholds** under CPC+ to qualify for APM track

   - 2017: 2.5%
   - 2018: 2.5%
   - 2019: 3%
   - 2020: 4%
   - 2021+: 5%

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**Dual Participation in CPC+ and MSSP**

- Overrides CPC+ as a qualifying APM model; participation in MSSP Track 1 prevents receipt of 5% APM bonus

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1) Defined as the average estimated total Medicare Parts A and B revenue of providers and suppliers at risk.

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Sources: CMS; Advisory Board research and analysis.
Decoding the Other-Payer AAPM¹ Eligibility Process

Most Commercial Payers Not Included in First Phase Determinations

General Process for Payers¹ to Request Other Payer AAPM Determination

1. Application and instructions made available
2. CMS determines whether payer model is eligible
3. CMS posts list of eligible payer models
4. Application submitted by deadline
5. Payer notified of eligibility status

QPP Year 3 Payers Eligible for First Phase Determination
- Title XIX (i.e., Medicaid)
- CMS Multi-Payer Models (e.g., CPC+)
- Medicare Health Plans (e.g., Medicare Advantage)

Information Requested in 2018 by CMS for Year 3 Other AAPM Determination
1. Model name
2. Model description
3. Term of the model
4. Locations where model operates
5. Participant eligibility
6. Evidence to support how the APM criteria are met

¹ AAPM = Advanced Alternative Payment Model.
² The deadlines are different between payer types. CMS also allows an EC-initiated process (that includes requests from APM entities), and submission periods occur later than the payer-initiated process.
## What’s In, What’s Out: 2018 QPP Final Rule

### Advanced Alternative Payment Models (Advanced APM)
- **More participants**, more Advanced APMs qualify in 2018
- **No maximum provider limit** for Round 1 CPC+\(^1\) participants
- **All-Payer Combination** APM option details, applications open in 2018, program starts in 2019

### Merit-Based Incentive Payment System (MIPS)
- **Exclusions expanded**, results in more providers excluded from MIPS
- **Framework maintained**, many category requirements remain as-is
- **Quality and Cost category changes**, key determinant of highest performing ECs

### Finalized Policies
- **Different performance periods** for Medicare and All-Payer APMs
- **Limitation that all-payer eligibility** can only be determined at the individual level

### Not Finalized For 2018
- **Facility-based scoring option** not finalized for 2018
- **“Mix-and-match” reporting** within a single category not finalized for 2018

### Potential Future New Policies
- **Medicare Advantage** may help providers qualify for the APM track before 2019
- **New physician focused payment models** may be proposed in the future
- **Part D drug costs** may be included in Cost category
- **Episode-based cost measures** may be introduced

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1) CPC+ = Comprehensive Primary Care Plus.

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Sources: CMS; Advisory Board research and analysis.
1. MACRA Context

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3. Charting the Path Forward
MACRA Accelerates Three Key Trends

2018 an Opportunity to Position Organization for Long-Term QPP Success

1. Ups the ante on physician Pay-for-Performance
   - Physician performance now more competitive; average performance will no longer be sufficient

2. Introduces significant Incentives to Take on Risk
   - Incentives reduce physician reporting burden and increase payment opportunities

3. May significantly transform Provider Partnership
   - Increased collaboration across provider landscape presents new opportunities to formalize partnerships

Imperative #1:
Focus on boosting 2018 MIPS performance

Imperative #2:
Refine your Medicare risk strategy

Imperative #3:
Leverage MACRA as vehicle for partnership

Source: Advisory Board research and analysis,
Stakes Legally Mandated to Increase in 2019

QPP Set to Get Tougher By Law, By Design

4% at risk
Low performance bar, multiple reporting period options, Cost category weight at 0%

5% at risk
Few changes, with most Year 1 flexibilities retained:
- Year-long reporting period for Quality
- Cost category increases to 10%
- Retain Year 1 ACI measure and CEHRT requirements

7% at risk
MACRA-mandated changes take place, expect fewer flexible options, with more challenging requirements:

- **Quality**
  Full year reporting period, and potentially higher data completeness thresholds

- **Cost**
  Weight required to increase to 30%, often difficult to inflect improvement

- **ACI**
  2015 Edition CEHRT upgrade required to report Stage 3-equivalent, more difficult measures

Sources: CMS; Advisory Board research and analysis
Reassess Quality Strategy Against 2018 Changes

Stay the Course with ACI and IA Reporting Approach

1. **Report Full Year Quality Data**
   - Assess whether to report full-year data in 2017 to prepare for 2018 requirement
   - Maximize your potential positive payment adjustment by improving performance
   - Satisfy data completeness requirement; threshold increases to 60% for EHR, Qualified Registry, QCDR, and claims submission

2. **Reassess Topped-out Measures**
   - Review topped-out measures annually
   - Replace measures subject to capped score in 2018 immediately (best long-term approach)
   - Consider alternative reporting mechanism if measure is designated as topped-out with existing mechanism (potential short-term approach)

3. **Earn Year-Over-Year Improvement Score**
   - Meet minimum reporting requirements in 2018 to earn improvement score
   - Boost performance to increase measure achievement score and receive improvement score
   - Build clinician performance improvement incentives into MIPS strategy

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1) QCDR = Qualified Clinical Data Registry.
2) All payer data required for EHR, Qualified Registry, and QCDR.

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Source: Advisory Board research and analysis.
Use 2018 to Practice Cost Performance

Cost a Significant Performance Differentiator in 2019

Two Measures Contribute to Score in 2018

1. **Total Cost per Capita:**
   Specialty-adjusted measure; Includes all payments under Medicare Parts A and B.

2. **Medicare Spending per Beneficiary:**
   Cost of Medicare Part A and B services 3 days before and 30 days after inpatient admission.

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Our Best Tips for Managing Total Cost

- **Prioritize risk adjustment**
  Improve HCC capture to reduce impact of complex patients on score

- **Develop a short-list of top cost-savings opportunities**
  Evaluate cost performance in post-acute, drug spend, OP\(^1\), IP\(^2\)

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Sources: CMS; Advisory Board research and analysis.
Migration to Downside Already Underway

An Increasingly Popular Strategy

Changing the Calculus Around ACO Participation

<table>
<thead>
<tr>
<th>Participants in downside ACO models, 2016</th>
<th>Participants in downside ACO models, 2017</th>
<th>Percent increase in downside ACO model participation, 2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>87</td>
<td>117%</td>
</tr>
</tbody>
</table>

CMS Projects Continued APM Participation Growth in 2018 Program Year

<table>
<thead>
<tr>
<th>Maximum clinicians CMS estimated would qualify for the APM track, 2017</th>
<th>Maximum clinicians CMS projects will qualify for the APM track, 2018</th>
<th>Potential percent increase in clinicians qualifying for APM track, 2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>120,000</td>
<td>245,000</td>
<td>104%</td>
</tr>
</tbody>
</table>
MACRA Solidifies Role of Medicare ACOs

Medicare ACOs Not Just a Stepping Stone to MA Risk

MA Contributes to APM Thresholds Beginning in 2021…

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments through Advanced APMs</th>
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<tbody>
<tr>
<td>2019-20</td>
<td>20%</td>
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</tr>
<tr>
<td>2021-22</td>
<td>35%</td>
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<tr>
<td>2023-24+</td>
<td>75%</td>
<td></td>
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…But Providers Must Still Meet Traditional Medicare Threshold

Two Ways to Qualify for APM Track in 2021

- Is Medicare Threshold Score >50%?
- NO
  - Is Medicare Threshold Score >25%?
    - NO
      - Is All-Payer Threshold Score >50%?
        - NO
          - APM
        - YES
          - APM
        - YES
          - APM
  - YES
    - APM

Defining an Intentional Approach to Medicare Risk

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.

**Study in Brief: Medicare Risk Strategy**
Research study reviewing menu of options for taking on Medicare risk; available at [advisory.com/hcab](advisory.com/hcab)

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

An Array of Partnership Options

- Clinically integrated network.
- Independent practice association.
- Skilled nursing facility.
- Pseudonym.

"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.
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

**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
MACRA Resources to Support You

Webconferences
- 2018 MACRA Final Rule Detailed Analysis
- MACRA: How the 2018 QPP Final Rule Impacts Providers
- 2017 MACRA Final Rule Detailed Analysis
- MACRA: How the Final Rule Impacts Providers
- The No-Regrets Approach to MACRA
- Rethinking Your Medicare Risk Strategy Under MACRA

Tools
- Guide to MIPS Participation and Special Statuses
- 2017 MIPS Final Score Estimator
- 2017 MIPS Audit Checklist
- 2017 MIPS Measures List

Research
- 6 experts on what the 2018 MACRA final rule means for you
- 10 takeaways on the 2018 MACRA Final Rule
- Playbook for Maximizing Performance in MACRA

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

Source: Advisory Board research and analysis.