Three-Part MACRA\(^1\) Webconference Series

Open to All Advisory Board Members—Register Today!

MACRA: What You Need to Know Right Now About the Proposed Rule

Available On Demand

- Understand the basics of the MIPS\(^2\) vs. APM\(^3\) track
- Learn the most important (and surprising) things your organization needs to know right away

MACRA: Strategic Implications for Provider Organizations

**Thursday, May 26, 2016**

1-2pm and 3-4pm ET

- Receive key advice on issues such as maximizing pay-for-performance, navigating the transition to risk-based payment, and the future of hospital-physician alignment
- Evaluate the economics of physician payment transition

MACRA: Operational Action Items from the Proposed Rule

**Tuesday, June 7, 2016**

3-4pm ET

- Receive detailed reporting advice, including how to streamline Medicare physician reporting
- Assess key quality program management implications

**Please note:** Each webinar will be archived, with slide deck and recorded audio, within 24 hours of the scheduled presentation at the above hyperlinked landing pages

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2) Merit-Based Incentive Payment System.
3) Advanced Alternative Payment Model.
Today’s Presenters

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Executive Summary

- On April 16, 2015, **The Medicare Access and CHIP Re-Authorization Act (MACRA) of 2015** was signed into law, permanently repealing the Sustainable Growth Rate (SGR) formula and imposing a new payment methodology for Medicare Part B payments starting in 2019.

- The new payment methodology includes two key components:
  1. Locks Medicare part B reimbursement rates at near-zero growth.
  2. Creates two new payment tracks: The Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

- On April 27, 2016, CMS released the proposed rule outlining how it plans to implement the Medicare payment changes stipulated in the law.

- The proposal includes specific reporting requirements under the MIPS track as well as a list of payment models that qualify for the APM track:
  - **Performance period:** 2017 will be the performance period that CMS will use to determine a clinician’s payment track and their payment adjustment under the MIPS in 2019.
  - **MIPS:** MIPS reduces the number of measures clinicians are required to report on in some categories and allows clinicians the flexibility to select from a set of measures to report on based on relevancy to their practice.
  - **APM:** The Medicare Shared Savings Program track one, the Bundled Payment for Care Improvement Program, and the Comprehensive Care for Joint Replacement (CJR) payment models do not count as advanced APMs and thus do not qualify providers for the APM track; CMS only expects 4.5-12% of clinicians to qualify for the APM track in 2019.

- CMS is soliciting public comment on this proposal until June 27th, 2016.

Source: Advisory Board Company interviews and analysis.
Refresher: MACRA in Brief

1. Legislation passed in April 2015 repealing the Sustainable Growth Rate (SGR)
2. Locks provider 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
3. Stipulates development of two new Medicare payment tracks: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
4. Programs to be implemented on Jan 1, 2019
5. On April 27, 2016 CMS released proposed rule outlining plans to implement the two tracks

Two New Payment Tracks Created by MACRA

1. Merit-Based Incentive Payment System (MIPS)
   - Rolls existing quality programs into one budget-neutral pay-for-performance program, in which providers will be scored on quality, resource use, clinical practice improvement, and EHR use, and assigned payment adjustment accordingly

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


1) Medicare Access and CHIP Reauthorization Act.
2) Meaningful Use, Value-Based Payment Modifier, and Physician Quality Reporting System.
3) Electronic Health Record.
Regardless of Track, Baseline Payment Holding Steady

Baseline Medicare Provider Payment Adjustments Under Each Track

- **2015 – 2019:** 0.5% annual update
- **2020 – 2025:** Frozen payment rates
- **Advanced Alternative Payment Models (APM):** 2026 and on 0.75% annual update
- **The Merit-Based Incentive System (MIPS):** 2026 and on 0.25% annual update

**Annual Bonus for APM Participation**

- **5%** Bonus awarded each year from 2019-2024 to providers that qualify for the APM payment track

APMs That Do, Don’t Qualify Providers for APM Track

Advanced APM-Ineligible Payment Models

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

But participation in these models may positively affect MIPS payments¹

Advanced APM-Eligible Payment Models

- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO Model
- The Oncology Care Model Two-Sided Risk Arrangement²
- Comprehensive ESRD³ Care Model (Large Dialysis Organization Arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Certain commercial contracts with sufficient risk, including Medicare Advantage (starting in 2021)


¹) Under Clinical Practice Improvement Activities category.
²) Available in 2018.
³) End stage renal disease.
Key Implications for Provider Organizations

Eight Strategic Implications for Provider Organizations from the MACRA Proposed Rule

1. Nearly all providers are affected and thus should take notice
2. There is no time to waste with decision making (and we don’t even have the final word)
3. Provider groups should assume they are in the MIPS track for the first year
4. Under the MIPS, providers have a lot of flexibility in selecting performance measures that align with their practice
5. APM Scoring in MIPS has a significant upside
6. While it may speed up pace of adoption, MACRA alone is not a sufficient impetus to assume payment risk
7. MACRA may accelerate physician consolidation
8. Moving forward, MACRA likely to have other significant downstream effects on medical group operations and how physicians practice
#1: Nearly all providers are affected and thus should take notice

**A Sweeping Impact Across Providers**

Who’s Included and Who is Exempt

### Included

- Medicare Part B payments (i.e. clinician professional payments)
- Physicians, PAs\(^1\), NPs\(^2\), Clinical Nurse Specialists, Certified Registered Nurse, Anesthetists
- Groups that include any of the above clinicians

### Excluded

- Medicare Part A (i.e. inpatient, outpatient technical hospital payments)
- Clinicians, groups that fall under low volume threshold:
  - $10,000 or less in Medicare charges AND
  - 100 or fewer Medicare patients
- Providers in their first year billing Medicare

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**836,000**

Estimated number of clinicians affected by MACRA changes in first performance year

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"MACRA is to care delivery reform what the ACA\(^3\) was to coverage reform."

*Andy Slavitt, CMS Acting Administrator*

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1) Physician Assistant.
2) Nurse Practitioner.
3) Affordable Care Act.
#2: There is no time to waste with decision making (and we don’t even have the final word)

Not Much Time to Prepare

Narrow Window for Providers to Ensure APM Eligibility in 2019

MACRA Implementation Timeline

- Providers may not be certain which track they will fall into when reporting in 2017
- Performance period
- Providers notified of track assignment
- Payment adjustment

Merit Based Incentive Payment System (MIPS)

Advanced Alternative Payment Models (APM)

Application Deadlines for Common Advanced APMs

- **MSSP Track 2 and Track 3:** Notice of intent to apply due May 31, 2016; apply by July 29, 2016

- **Next Generation ACO:** Letter of intent was due May 20, 2016; complete application by June 3, 2016

Details Still Subject to Change

But General Framework of MIPS and APM Established in Law

Early Industry Reactions to Proposed Rule

- Proposal too complex
- Timeline too rapid
- Particularly challenging for small practices
- Limited risk adjustment, doesn’t account for SES
- EHR use requirements still difficult
- Disappointment MSSP Track 1 not eligible for APM Track

(Limited) Flexibility to Address Concerns

CMS Could Change
- Timing of performance period
- MIPS scoring methodology
- Flexibility for certain clinicians
- Criteria for “more than nominal” risk
- Entity level for scoring and determinations

Only Congress Can Change
- Timing of payment adjustments
- MIPS category weights broadly
- Types of clinicians subject to MACRA
- Requirement of “more than nominal” risk
- Range of penalties and bonuses


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1) Socioeconomic status.
2) Electronic Health Record.
Where Does My Group Fall?

1. Participate in an Advanced APM?
   - Yes: Meet QP\(^1\) Threshold?
     - Yes: APM
     - No: Participate in a MIPS APM?
       - Yes: Meet Partial QP Threshold?
         - Yes: Optionally Choose MIPS?
           - Yes: MIPS APM Scoring Standard
           - No: MIPS
         - No: NO
       - No: NO
   - No: NO

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1) Qualifying Participant

Source: Advisory Board research and analysis.
#3: Provider groups should assume they are in MIPS track for the first year

## Strict Advanced APM Eligibility Requirements

### Few Near-Term Opportunities to Join Advanced APM

#### Advanced APM Criteria

- **Threshold to trigger losses no greater than 4%**
- **Loss sharing at least 30%**
- **Maximum possible loss at least 4% of spending target**
- **Certified EHR use**
- **Quality requirements comparable to MIPS**

#### Proposed Medicare Advanced APMs

<table>
<thead>
<tr>
<th>Proposed Medicare Advanced APMs</th>
<th>Enrollment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive ESRD(^1) Care LDO(^2) Arrangement</td>
<td>CLOSED</td>
</tr>
<tr>
<td>MSSP Track 2 and Track 3</td>
<td>NOIA(^4) due May 31, 2016; apply by July 29, 2016</td>
</tr>
<tr>
<td>Next Generation ACO</td>
<td>LOI(^5) was due May 20, 2016; complete application(^6) by June 3, 2016</td>
</tr>
<tr>
<td>Oncology Care Model Two-Sided Risk</td>
<td>CLOSED</td>
</tr>
</tbody>
</table>

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1) End-stage renal disease.
2) Large dialysis organization.
3) Comprehensive Primary Care Plus.
4) Notice of intent to apply.
5) Letter of intent.

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Qualifying Participant Status the Next Requirement

How to Determine If APM Entity Meets QP Status

APM Entities Must Meet Percent of Payments or Patient Counts

Example of Payment Qualification

APM Entity 1
Payments = 15%

TIN 1 = 26%
TIN 2 = 9%
TIN 3 = 11%

APM Entity 2
Payments = 33%

TIN 1 = 48%
TIN 2 = 18%
TIN 3 = 33%

Clinicians currently projected to qualify for APM track in 2019

4.5% - 12%

CPC+ Qualifies Slightly Differently Than Other APMs

Medical Home Models Must Meet One of Following Criteria to Qualify as Advanced APMs:

- Withhold payment for services to the APM entity and/or ECs
- Reduce payment rates to the APM entity and/or ECs
- Require the APM entity to owe payments to CMS
- Lose the right to all or part of otherwise guaranteed payments

CPC+ Participants Must Meet Two Conditions to Qualify for APM track:

1. Be part of a group that has fewer than 50 clinicians

2. Meet specific revenue at-risk thresholds under the Medical Home Model

Revenue at risk thresholds under CPC+ to qualify for APM track:

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

CPC+ is the only Medical Home Model CMS has approved as an Advanced APM

1) Eligible Clinicians.
2) Comprehensive Primary Care Plus
3) Starting in performance year 2018.
4) Percentage of APM Entity’s total Medicare Parts A and B revenue.

Source: CMS, Advisory Board Company interviews and analysis.
The Math Behind QP Thresholds

25% Payment threshold for QPs in 2019

Numerator: All payments for services furnished by ECs in the APM Entity to attributed beneficiaries

Denominator: All payments for services furnished by the ECs in the APM Entity to attribution-eligible beneficiaries

20% Patient count threshold for QPs in 2019

Numerator: Unique number of attributed beneficiaries to whom ECs in the APM Entity furnish services

Denominator: Number of attribution-eligible beneficiaries to whom ECs in the APM Entity furnish services

Attribution-Eligible Beneficiary Criteria

1. Not enrolled in Medicare Advantage nor Medicare Cost Plan
2. Medicare not a second payer
3. Medicare Parts A and B enrollment
4. At least 18 years old
5. US Resident
6. At least 1 E&M claim within the APM entity

Sources: CMS Quality Payment Program, Source: Advisory Board research and analysis.

1) Medicare Part B covered professional services.
2) During the performance period.
3) Evaluation and management.
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MIPS Requirements Coming Into Focus

### Four Categories That Determine MIPS Score

<table>
<thead>
<tr>
<th>Category</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System (PQRS)</td>
</tr>
<tr>
<td></td>
<td>• Over 200 measures to choose from, 80% tailored to specialists</td>
</tr>
<tr>
<td>Cost/Resource Use</td>
<td>• Score based on Medicare claims; no reporting requirement for clinicians</td>
</tr>
<tr>
<td></td>
<td>• Total per capita costs for all attributed beneficiaries and Medicare spending per beneficiary</td>
</tr>
<tr>
<td></td>
<td>• New episode-based cost measures for specialists</td>
</tr>
<tr>
<td></td>
<td>• Part D costs</td>
</tr>
<tr>
<td>Clinical Practice Improvement</td>
<td>• Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety</td>
</tr>
<tr>
<td></td>
<td>• Over 90 activities to choose from; some weighted higher than others</td>
</tr>
<tr>
<td></td>
<td>• Clinicians in certain APMs and qualified Patient-Centered Medical Homes⁄ receive favorable scoring</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>• Replaces the Medicare EHR Incentive Program for eligible professionals (EPs) (also known as “Meaningful Use”)</td>
</tr>
<tr>
<td></td>
<td>• Applies to all clinicians, unlike previous Medicare EP Meaningful Use requirements (which only applied only to Medicare physicians)</td>
</tr>
<tr>
<td></td>
<td>• No longer requires all-or-nothing measure reporting</td>
</tr>
<tr>
<td></td>
<td>• Requires fewer measures, providers scored on participation and performance</td>
</tr>
<tr>
<td></td>
<td>• Opportunity to report as group or individual</td>
</tr>
</tbody>
</table>

1) Medical homes are recognized if they are accredited by: the Accreditation Association for Ambulatory Health Care; the National Committee for Quality Assurance (NCQA) PCMH recognition; The Joint Commission Designation, or the Utilization Review Accreditation Commission (URAC).

2) Eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians.

Significant Flexibility in MIPS Quality Category

MIPS requires providers to report on at least 6 **quality metrics** selected from over 200 options. Selections must include at least 1 **outcome metric** and 1 **“cross-cutting” metric**.

CMS will use claims data to calculate 3 **population-based measures**:
- All-cause hospital readmission measure
- Acute conditions composite measure
- Chronic conditions composite measure

**Bonus points** are awarded for:
- Reporting extra outcome metrics
- Reporting metrics in high-priority domains
- Reporting via certified EHR technology

**Sample Outcomes Measures**
- Hemoglobin A1C control
- Depression remission at six months
- ED visits in last 30 days of life
- Functional status change for orthopedic patients
- Surgical site infections

**Sample Cross-cutting Measures**
- Documentation of advanced care plan
- Tobacco use screening and intervention
- Control of high-blood pressure

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1) CMS specifies exceptions for certain specialties and clinicians without six applicable metrics and/or without applicable outcome metrics.

2) “Cross-cutting” metrics are metrics broadly available to all clinicians with patient-facing encounters regardless of specialty.

3) High-priority domains are appropriate use, patient safety, efficiency, patient experience, and care coordination.

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 four categories

2. Score compared to CMS-set performance threshold\(^1\) (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\(^2\)

Maximum EC Penalties and Bonuses

- Highest performers eligible for up to 10% additional incentive\(^3\)

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

- Non-reporting participants given lowest score


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1) The mean or median (as selected by CMS) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary.
2) Payment adjustment size correspond with how far the score deviates from the PT.
3) High performers eligible for additional incentive of up to 10% for MIPS eligible providers that exceed the 25th percentile.

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Your P4P\textsuperscript{1} to Do List

Aim For Highest Possible Performance in Existing CMS Programs

1. **Quality**
   - Gauge performance on PQRS measures, and consider proposed new MIPS measures

2. **Resource Use**
   - Evaluate cost measures on VBPM Quality and Resource Use Reports (QRUR)

3. **CPIA**
   - Assess CMS inventory of proposed CPIA activities

4. **ACI**
   - Review MU dashboards and analyze performance under new scoring methodology

**Additional Resources**
- Webconference: [MACRA: Operational Action Items from the Proposed Rule](#) (June 7\textsuperscript{th} 3-4PM ET)
- Detailed list of Proposed MIPS Measures *Coming Soon*

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\textsuperscript{1} Pay for performance

Source: Advisory Board research and analysis.
In an APM, But Not Qualifying for the APM Track

Groups in Non-Advanced APM or Below QP Threshold Get MIPS Boost

1. APM (Meet QP Threshold?)
   - YES
   - NO

2. Exempt from MIPS (Meet Partial QP Threshold?)
   - YES
   - NO

3. MIPS APM Scoring Standard (Optionally Choose MIPS?)
   - YES
   - NO

4. MIPS (Participate in a MIPS APM?)
   - YES
   - NO

#5: APM scoring in MIPS has significant upside

Source: Advisory Board research and analysis.
**“Special” MIPS APM Eligibility Requirements**

**Preferential Scoring for ECs Without QP Status or in MIPS APMs**

<table>
<thead>
<tr>
<th><strong>MIPS APM Criteria</strong></th>
<th><strong>Applies to Two MIPS EC Scenarios</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Entities participate in the APM under agreement with CMS</td>
<td>✔ Below QP Volume Threshold in Advanced APM</td>
</tr>
<tr>
<td>✔ Entities include ≥1 MIPS EC on participation list</td>
<td></td>
</tr>
<tr>
<td>✔ Bases payment incentives on performance on cost/utilization and quality measures</td>
<td>✔ Any Volume in MIPS APM</td>
</tr>
</tbody>
</table>

**“Big Fish, Little Pond” Under MIPS APM Scoring Standard?**

MIPS APM scoring will be applied to all others in MIPS. Will that preferential scoring create the top-performer tier in MIPS?

**Proposed Medicare Advanced APMs**
- Comprehensive ESRD Care LDO Arrangement
- CPC+
- MSSP Track 2 and Track 3
- Next Generation ACO
- Oncology Care Model Two-Sided Risk

**Proposed MIPS APMs**
- Comprehensive ESRD Care non-LDO Arrangements
- MSSP Track 1
- Oncology Care Model One-Sided Risk

Preferential Scoring for MIPS APMs

Advantage to Achieve “Exceptional Performance” Incentives

Comparison between MIPS CPS Weighting and Scoring Standard for MIPS APMs

<table>
<thead>
<tr>
<th>MIPS</th>
<th>MSSP</th>
<th>NextGen</th>
<th>Other APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>10%</td>
<td>20%</td>
<td>20%</td>
<td>75%</td>
</tr>
<tr>
<td>15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25%</td>
<td>30%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

**MIPS APM Scoring Standard**

- Quality
- Resource Use
- Clinical Practice Improvement Activities (CPIA)
- Advancing Care Information (ACI)

$500M

Extra pool of incentives for MIPS ECs whose performance exceptionally exceeds a specified threshold

**Reporting**
- Quality measures submitted through CMS Web Interface by MSSP/Next Gen ACO on behalf of MIPS participants; Quality category is not reported for other MIPS APMs
  - ACI/CPIA – submit data per MIPS requirements

**Scoring**
- Performance evaluated collectively at the APM Entity level
- Scoring Standard CPS stays at 100% with readjusted weights for the remaining performance categories
- Automatic 30 points for CPIA; Resource Use is not scored

Source: CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 FR 28161, [https://federalregister.gov/a/2016-10032](https://federalregister.gov/a/2016-10032); Health Care IT Advisor research and analysis.
#6: While it may speed up pace of adoption, MACRA alone not a sufficient impetus to assume payment risk

**Don’t Be Blinded by the 5%**

Critical to Decide Based on Full Financial Picture

### Best Case in 2019

<table>
<thead>
<tr>
<th>APM Track</th>
<th>FFS Medicare Revenue</th>
<th>APM-Specific Revenue</th>
<th>APM Track Bonus (^2)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS APM</td>
<td>FFS Medicare Revenue</td>
<td>Shared Savings Earnings from APM</td>
<td>MIPS Positive Payment Adjustment (^3)</td>
<td>Total</td>
</tr>
</tbody>
</table>

### Worst Case in 2019

<table>
<thead>
<tr>
<th>APM-specific loss may not be offset by 5% bonus</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>APM Track</th>
<th>FFS Medicare Revenue</th>
<th>APM-Specific Revenue</th>
<th>APM Track Bonus (^2)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS APM</td>
<td>FFS Medicare Revenue</td>
<td>Shared Savings Earnings from APM</td>
<td>MIPS Negative Payment Adjustment</td>
<td>Total</td>
</tr>
</tbody>
</table>

1) Fee for service.
2) 5% bonus based on fee-for-service revenue in 2018.
3) MIPS=APM favorable scoring helps drive MIPS positive adjustment.

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

## Provider Organizations
- Independent groups
- Small practices
- Health Systems
- Independent SNFs
- Hospitals
- Employed groups

## Alignment, Partnership Vehicles
- ACO Involvement
- Practice acquisition
- Independent Practice Association
- Hospital employment
- Group mergers
- Clinically Integrated Networks
- Formally contracted hospital-physician alignment

### Why would MACRA drive alignment?
- Share risk, enter into Advanced APM
- Gain access to EHR, reporting infrastructure without sole up-front investment
- Achieve greater market presence, economies of scale
- Improve negotiating position with vendors, payers

Source: Advisory Board research and analysis.
Disputing That It’s the End of Small Practices

CMS Pushes Back On Surprising Data From Proposed Rule

**Smaller Practices to Bear the Brunt?**

*CMS Estimated Penalties and Bonuses in 2017, By Practice Size*

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Percent Likely to Be Penalized</th>
<th>Percent Likely to Receive Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>12.9%</td>
<td>87.0%</td>
</tr>
<tr>
<td>2-9</td>
<td>29.8%</td>
<td>70.2%</td>
</tr>
<tr>
<td>10-24</td>
<td>40.3%</td>
<td>59.7%</td>
</tr>
<tr>
<td>25-99</td>
<td>54.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td>100 or more</td>
<td>81.3%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Overall</td>
<td>54.1%</td>
<td>45.9%</td>
</tr>
</tbody>
</table>

**Components of MACRA That Support Small Practices**

- $100M revenue over 5 years allocated to support small practices

**Under MIPS:**

- Exclusion if <$10K in Medicare charges
- Ability to report as “virtual” groups
- Flexibility in scoring based on applicable measures
- Fewer required measures in Quality and Advanced Care Information Categories

**Under APM:**

- CPC+ eligible APM for <50 clinician practices

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**CMS Qualifies Data Amid Concerns**

“CMS expects small practices and solo physicians to do just as well under MIPS as large physician groups so long as the small groups report quality measures.”

*Andy Slavitt, CMS Administrator*

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1) 2017 performance estimates using 2014 data.

“Virtual” Groups Can Mitigate Risk for Small Groups

Virtual Groups in Brief

- Groups of MIPS-eligible clinicians (ECs) who collectively report metrics without a shared TIN\(^1\) for the period of one performance year
- Intended to reduce reporting and technology burden on smaller practices, those in rural areas
- CMS requesting public comment on fundamental operational details

More Questions Than Answers

- How will small groups be advised to choose their virtual partners? Will they receive performance data on those partners prior to developing a virtual group?
- Will CMS cap be placed on the number of virtual groups that will be formed in the first performance year?
- Will CMS set a maximum cap on the number of ECs in a single virtual group?
- Will CMS set restrictions on the specialty make up, location characteristics of virtual groups?


1) Tax Identification Number

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Future Implications of MACRA

Addressing Important Questions On MACRA’s Impact

Will some providers stop taking Medicare?
- Hospitals and health systems: *Highly unlikely*
- Large independent multispecialty groups: *Probably not*
- Small, single specialty independent practices: *Possibly, depends on market, specialty*

Will physician referral patterns change?
- Probably, but not dramatically in near term
- MIPS Resource Use Category promotes cost of care reduction across providers
- Increased ACO adoption will also bolster change

Will MIPS scores factor into consumer, private payer evaluation of providers?
- Possibly in long term, but not immediately
- Many private payers may remain in “wait and see” mode
- Physician Compare site, where MIPS scores will be incorporated, not widely used by consumers

Source: Advisory Board Company interviews and analysis.

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Key Considerations for MIPS Related Policies

Payment Adjustment Two Year Look-Back Policy

Performance period  | Payment adjustment year
---                   | ---
2017                 | 2018 | 2019

Key Considerations for Public Comment

- **Clinician onboarding.** EC affiliation changes pose challenges, for example:
  - **Payment adjustment** – practices may “inherit” an EC’s past MIPS performance score and related payment adjustment
  - **Performance reporting** – practices must onboard ECs quickly, and incoming ECs may require separate, individual reporting

- **Group reporting.** How will CMS account for a variety of ECs within the group? Do all ECs report the same measures, and report every category even those that qualify for special considerations?

- **Performance feedback.** Will clinicians have enough information in order to benchmark, predict performance, and make course corrections for a given performance year?

- **Public reporting data.** Which measures should or should not be made available on the Physician Compare?

1) Tax ID Number
2) National Provider Identifier
Key Considerations for APM Related Policies

APM Incentive Payment Timeline

- **Performance period**
- **APM incentive base period**
- **APM incentive payment**

2017  2018  2019

Key Considerations for Public Comment

- **APM incentive timing.** How will CMS calculate the incentive if the APM contract ends during the base period?
- **PQP MIPS decision.** Will ECs have enough information to determine whether or not to participate in MIPS if later deemed PQPs?
- **APM participant list.** CMS seeks public comment on how to define the clinicians that are part of the APM Entity. Should this include those on the participation list or also affiliates?
- **Advanced APM CEHRT use.** The APM track require CEHRT use among the Advanced APM’s participant entities. Should the requirement be set to 50% use CEHRT in the first year, and 75% in future years?
- **MSSP MU requirements.** Currently, MSSP measures MU participation. How will the previously defined MU definition harmonize with the new definition in MACRA?

Track Assignment Notification Occurs After Performance Period

Participants notified 6 months after the performance period concludes, at the earliest. APM Entities that are not QPs or PQPs are subject to MIPS payment adjustments.
Three-Part MACRA Webconference Series

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MACRA: What You Need to Know Right Now About the Proposed Rule

Available On Demand
• Understand the basics of the MIPS vs. APM track
• Learn the most important (and surprising) things your organization needs to know right away

MACRA: Strategic Implications for Provider Organizations

Thursday, May 26, 2016
1-2pm and 3-4pm ET
• Receive key advice on issues such as maximizing pay-for-performance, navigating the transition to risk-based payment, and the future of hospital-physician alignment
• Evaluate the economics of physician payment transition

MACRA: Operational Action Items from the Proposed Rule

Tuesday, June 7, 2016
3-4pm ET
• Receive detailed reporting advice, including how to streamline Medicare physician reporting
• Assess key quality program management implications

Please note: Each webinar will be archived, with slide deck and recorded audio, within 24 hours of the scheduled presentation at the above hyperlinked landing pages
One-Day Intensive to Prepare Your Practice for the Coming Transition

New Provider Imperatives Under MACRA

**Understand Policy**
- What are the emerging Medicare policies and protocols under MACRA?
- How do I educate executives and physicians on how these changes will impact their practice?

**Assess Eligibility, Readiness**
- Which track (MIPS or APM) does my organization qualify for? Is it feasible for us to pursue the APM track?
- How prepared is my organization to participate in the relevant track?

**Craft Strategic Plan**
- What organizational changes do we need to implement to effectively make this transition?
- How can I position my organization for continued success?

The Information & Guidance You Need to Inform Your Strategic Plan

**Policy Update**
Analysis of program requirements and updates released by CMS to get you up to speed on the details of MACRA

**Organizational Briefing**
Discussion examining how MACRA will impact your organization and the major strategic questions to consider

**Eligibility Determination**
Evaluation of organization’s participation in existing quality reporting programs, ability to qualify for APM track

**Readiness Assessment**
Diagnostic designed to identify performance improvement opportunities and direct organizations toward a viable transition strategy

**Strategic Options Discussion**
Best practices for building the infrastructure required to transition; guidance on metric selection and/or strategy for pursuing APMs

**Action Plan Recommendation**
Suggested areas of focus and next steps to implement structural and operational changes required for successful performance

For more information, please contact Anna Hatter at HatterA@advisory.com
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