Advisory Board | Medical Group Strategy Council

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

Rob Lazerow
Managing Director

Hamza Hasan
Practice Manager

Tony Panjamapirom
Senior Consultant

Julie Riley
Practice Manager

November 20, 2017

Today's Presenters

Rob Lazerow

Managing Director,

Health Care Advisory Board

Hamza Hasan

Practice Manager,

Medical Group Strategy Council

Tony Panjamapirom

Senior Consultant,

Health IT Advisor and Quality Reporting Roundtable

Julie Riley

Practice Manager,

Physician Practice Roundtable

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

MACRA: The Executive Summary

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

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

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.

Reviewing the Year 2 Timeline

Majority of Providers Still Struggle with Transition to New Model

MACRA Implementation Timeline

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: CMS; Black Book Research, "Black Book Research, "Black Book Identifies 10 Top MACRA Trends Challenging Providers with Value-Based Care and Quality Metrics" available at https://www.newswire.com/news/black-book-identifies-10-top-macra-trends-challenging-providers-with-19404157 PR Newswire,, "Survey: Physician Groups Accelerate Adoption of Medicare's Chronic Care Management Program, While MACRA Awareness Remains Relatively Low" available at http://www.prnewswire.com/news-releases/survey-physician-groups-accelerate-adoption-of-medicares-chronic-care-management-program-while-macra-awareness-remains-relatively-low-300470008.html; Advisory Board research and analysis.

Strong Bipartisan Support for MACRA Persists

Repeal Unlikely—Safest Bet on Implementation

Legislation Enjoyed Bipartisan Support

92-8 Senate vote in favor of MACRA

392-37 House vote in favor of MACRA

> 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*

!

The 2018 final rule was released without any mention of GOP congressional or administrative action to delay QPP implementation, or to repeal or amend the law itself.

Source: Price T, "Obamacare Agency Escapes Congressional Oversight", available at: www.budget.house.gov; https://energycommerce.house.gov/news-center/press-releases/bipartisan-energy-and-commerce-ways-and-means-leaders-comment-final-macra; "H.R.2- Medicare Access an CHIP Reauthorization Act of 2015", Congress.gov; Advisory Board analysis.

MACRA Marches Forward; So Must You

Keep Up To Date with the Latest QPP Regulations

At the Helm

10 takeaways on the 2018 MACRA final rule

12:41 PM on November 3, 2017 by Tony Panjamapirom, PhD and Rob Lazerow

CMS on Nov. 2 released the 2018 final rule with comment period to implement the second year of MACRA's Quality Payment Program (QPP). Public can submit comment through January 1, 2018.

We're thoroughly analyzing the 1,653-page rule and will have comprehensive insights and action items to share in our upcoming webconferences. Make sure to mark your calendars for:

- November 20 at 3 p.m. ET, for an expert panel discussion on the strategic implications.
- December 12 at 1 p.m. ET for a detailed analysis and operational action items

In the meantime, here are 10 initial takeaways from our experts:

1. **Two overall trends are clear: Payment reform continues apace, and the administration wants to reduce the regulatory burden of MACRA on providers**. The 2018 rule was the Trump administration's first opportunity to put their stamp on MACRA's QPP, and they largely left the structure the same. The final rule gives clinicians more ways to succeed in the program, while also offering flexibility to providers, especially solo practitioners and small practices.

2. **The final rule reduces the number of clinicians subject to the Merit-Based Incentive Payment System (MIPS) track in 2018 to approximately 622,000**. In 2017, CMS exempted providers that had less than $30,000 in Medicare Part B revenue or saw fewer than 100 Medicare Part B patients per year. For 2018, the agency will exempt providers and groups with less than $90,000 in Medicare Part B allowed charges or that care for less than 200 Medicare Part B patients, excluding about 123,000 more clinicians from MIPS. These clinicians—mostly those who work in small practices and those that practice in rural regions and Health Professional Shortage Areas—would be exempt from participating in the QPP altogether.

5 things everyone should know about MACRA

3. **CMS is also easing MIPS burdens by offering bonus points to small practices and groups that treat a large share of complex patients**. Small practices (those with 15 or fewer clinicians) can earn five additional points to their MIPS final score if they submit data on at least one performance category. Additionally, CMS will award providers up to five bonus points if their patient population is deemed particularly complex, as measured by a combination of Hierarchical Conditions Category (HCC) risk scores and the number of dually eligible patients treated.

4. **CMS maintains for another year several 2017 performance year flexibilities intended to ease clinicians into MIPS requirements**. Most notably, clinicians are allowed to continue using 2014 Edition Certified Electronic Health Record Technology (CEHRT), rather than upgrading to 2015 Edition technology, to report the Advancing Care Information (ACI) transition measures (i.e., Modified-Stage 2 equivalent measure set). Clinicians that exclusively use CEHRT to report the ACI objectives and measures (i... measure set... for 109... score.

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

Sources: CMS; Advisory Board research and analysis.

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

Sources: CMS, "Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year," November 16, 2017, available at: https://federalregister.gov/d/2017-24067; Advisory Board research and analysis.

Competition to Intensify with Smaller MIPS Track

Expanded Exemptions and APM Growth Reduce MIPS Participants

Distribution of Clinicians Billing Medicare in 2018

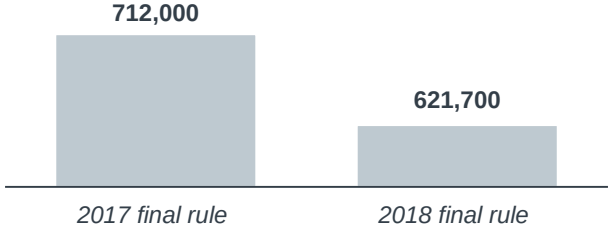
		Estimated Number
Exempt Clinicians	Ineligible clinician type	~315,243 (20%)
	Below volume threshold	~540,347 (35%)
Eligible Clinicians	MIPS Track	~621,700; (40%)
	APM Track	~70,732; (5%)[1]

! 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 Declining[2]



MIPS Expected to Shrink Further as APM Track Grows

185K-250K

Total ECs estimated to qualify for Advanced APM incentives in 2018

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.

Sources: CMS; Advisory Board research and analysis.

In the Meantime, Some Automatic Exemptions in 2017

Providers Affected by Natural Disasters Avoid 2017 Reporting, 2019 Penalty

Hardship Issues	Participation Option	Financial Implications
Extreme and Uncontrollable Circumstances in 2017  e.g. Hurricanes Harvey, Irma, and Maria	**Option1: Take an Automatic Hardship**  • No need to submit a hardship application • No MIPS data submission, and receive 3 points	 **Only Penalty Avoidance**
	Option2: Participate in MIPS  • Submit data for at least two MIPS performance categories • All MIPS scoring and payment adjustment policies apply	 **Penalty Avoidance and Potential Incentive Payments**

Identifying MIPS ECs in Affected Areas

- Based on the practice location address listed in PECOS[1]
- 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[1]
- 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

19%

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

Offering virtual group reporting option

- TINs[2] 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

1%

Percent ECs CMS estimates will participate in virtual groups in 2018

1) Eligible clinicians.
2) Tax identification numbers..

Sources: CMS; Advisory Board research and analysis.

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

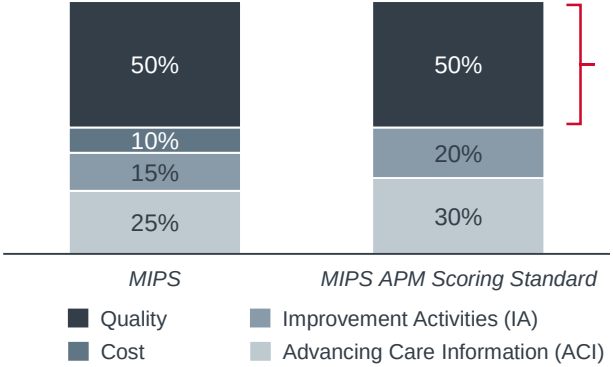
1) MSPB = Medicare Spending per Beneficiary.
2) CEHRT = certified EHR technology.

Sources: CMS; Advisory Board research and analysis.

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



Number of MIPS APM Quality Measures

15	21	16	13
ACO[2]	CPC+	Comprehensive ESRD[3] Care	Oncology Care Model

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

Comprehensive List of APMs
Reference MIPS APMs at **qpp.cms.gov**

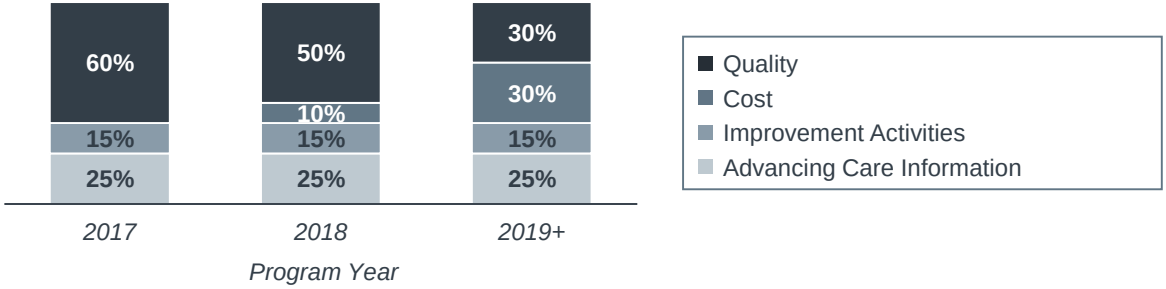
1) Cost category will increase to 30% in future years in MIPS and Quality decrease to 30%. However, Cost performance is not included under the MIPS APM scoring standard.
2) Next Generation ACOs and MSSP ACOs report 14 CMS Web Interface Quality measures; final rule adds CAHPS for MIPS Survey to Quality 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



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…

CMS

Sources: CMS; Advisory Board research and analysis.

MIPS: A Zero-Sum Game for Clinicians

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

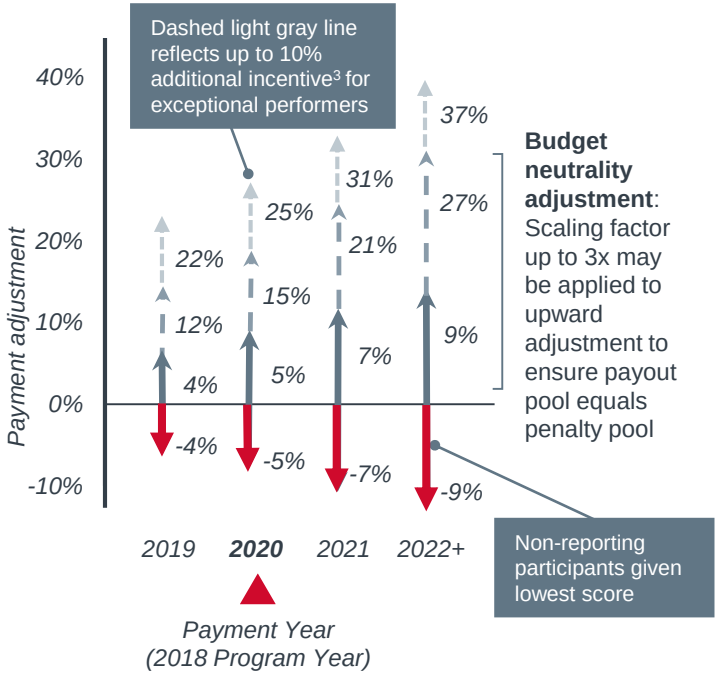
Payment Adjustment Determination

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[1]

! 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

Maximum EC Penalties and Bonuses



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.

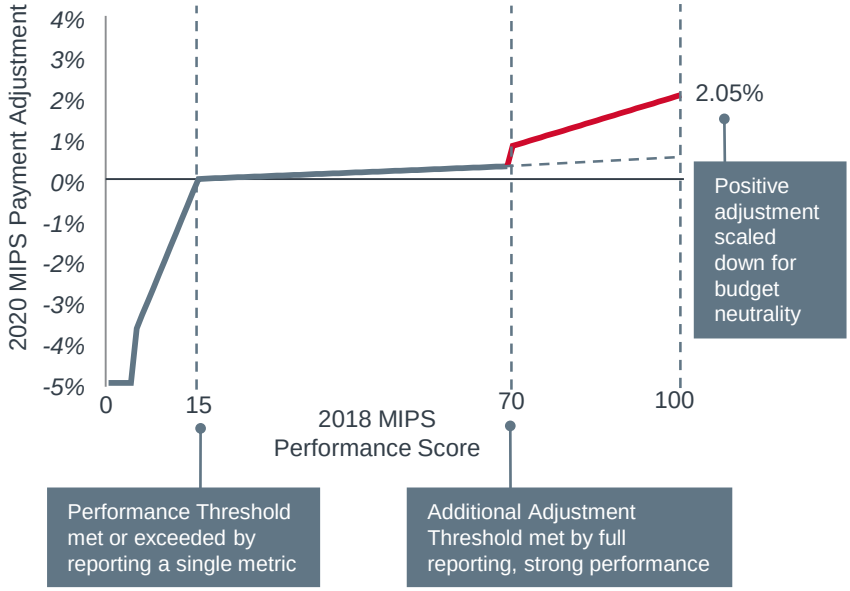
Sources: CMS; Advisory Board research and analysis.

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.

Flat Trajectory for Baseline Physician Payments

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 performers[1]

2. APM Bonuses/Penalties

5% Annual lump-sum bonus from 2019-2024

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

Baseline payment updates[1]:

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

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.

Advanced APM Track Criteria Unchanged for 2018

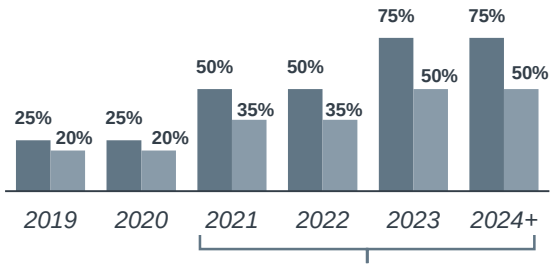
New Policies for Forthcoming All-Payer Combination APM Track

Final Medicare Advanced APM Criteria

Financial Risk Criterion

- ☑ 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



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

CMS aligned[2] 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.

More Opportunities to Participate in Advanced APMs

CMS to Expand List of Qualifying Programs in 2018 and Beyond

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

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

1) Center for Medicare and Medicaid Innovation.
2) Medicare Shared Savings Program.
3) Bundled Payments for Care Improvement.
4) Comprehensive Care for Joint Replacement; Other cardiac and orthopedic episode payment models are proposed for cancellation.
5) Certified electronic health record technology.

Sources: CMS; NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; CMS, "Next Generation Accountable Care Organization Model (NGACO Model)," January 11, 2016, available at: www.cms.gov; CMS, "2016 Medicare Shared Savings Program Organizations," October 2016, available at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt; Advisory Board interviews and analysis.

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

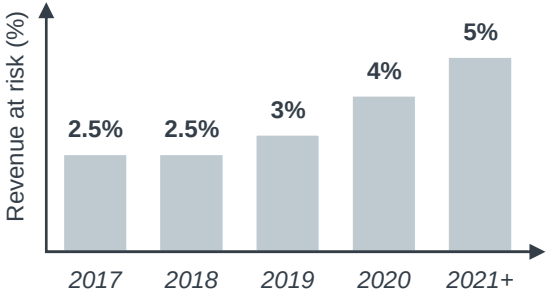
Dual Participation in CPC+ and MSSP

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

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[1] under CPC+ to qualify for APM track



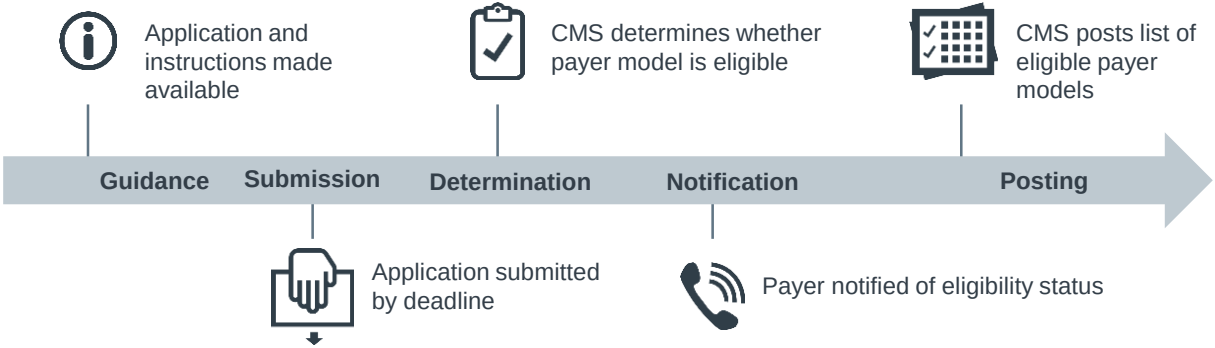
1) Defined as the average estimated total Medicare Parts A and B revenue of providers and suppliers at risk.

Sources: CMS; Advisory Board research and analysis.

Decoding the Other-Payer AAPM[1] Eligibility Process

Most Commercial Payers Not Included in First Phase Determinations

General Process for Payers[1] to Request Other Payer AAPM Determination



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.

Sources: CMS; Advisory Board research and analysis.

What's In, What's Out: 2018 QPP Final Rule

Advanced Alternative Payment Models (Advanced APM)

Merit-Based Incentive Payment System (MIPS)

Finalized Policies

- **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

- **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

Not Finalized For 2018

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

- **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

1) CPC+ = Comprehensive Primary Care Plus.

Sources: CMS; Advisory Board research and analysis.

1 MACRA Context

2 Key Insights from the 2018 Final Rule

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

Imperative #1: Focus on boosting 2018 MIPS performance

2 Introduces significant **Incentives to Take on Risk**

Incentives reduce physician reporting burden and increase payment opportunities

Imperative #2: Refine your Medicare risk strategy

3 May significantly transform **Provider Partnership**

Increased collaboration across provider landscape presents new opportunities to formalize partnerships

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%

2017
QPP Year 1

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

2018
QPP Year 2

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

2019
QPP Year 3

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,[1] and claims submission[2]

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

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

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.

!

Episode-based Measures Gone, But Not Forgotten

CMS in process of field-testing eight episode-based measures for future program years

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]

See our Playbook for Maximizing Your Performance in MACRA for more detail: advisory.com/MACRA

1) Outpatient..
2) Inpatient.

Sources: CMS; Advisory Board research and analysis.

Migration to Downside Already Underway

An Increasingly Popular Strategy

Changing the Calculus Around ACO Participation

40 Participants in downside ACO models, 2016 → **87** Participants in downside ACO models, 2017

117%
Percent increase in downside ACO model participation, 2016-2017

CMS Projects Continued APM Participation Growth in 2018 Program Year

120,000
Maximum clinicians CMS estimated would qualify for the APM track, 2017

→

245,000
Maximum clinicians CMS projects will qualify for the APM track, 2018

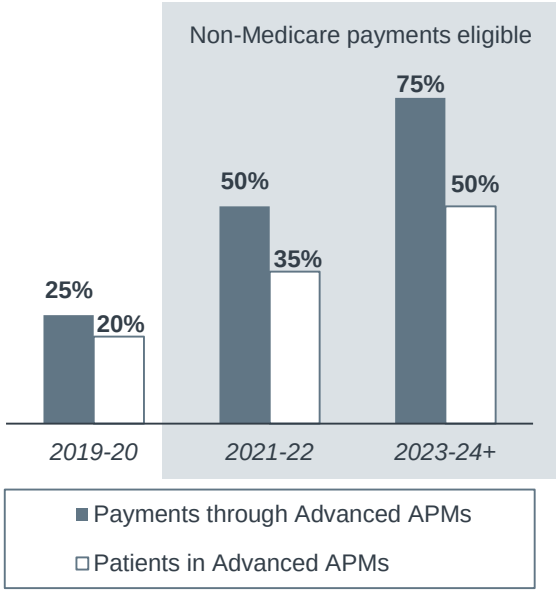
104%
Potential percent increase in clinicians qualifying for APM track, 2017-2018

Source: CMS, "Medicare Program; CY 2018 Updates to the Quality Payment Program," June 30, 2017; NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; CMS, "Next Generation Accountable Care Organization Model (NGACO Model)," January 11, 2016, available at: www.cms.gov; CMS, "2016 Medicare Shared Savings Program Organizations," October 2016, available at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt; Advisory Board interviews and analysis.

MACRA Solidifies Role of Medicare ACOs

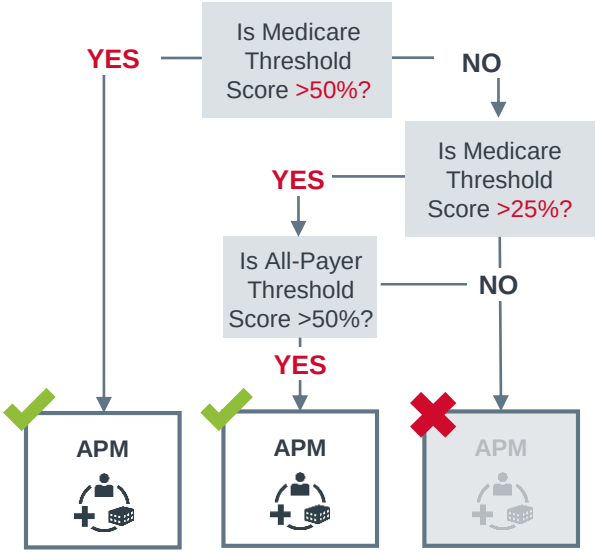
Medicare ACOs Not Just a Stepping Stone to MA Risk

MA Contributes to APM Thresholds Beginning in 2021…



…But Providers Must Still Meet Traditional Medicare Threshold

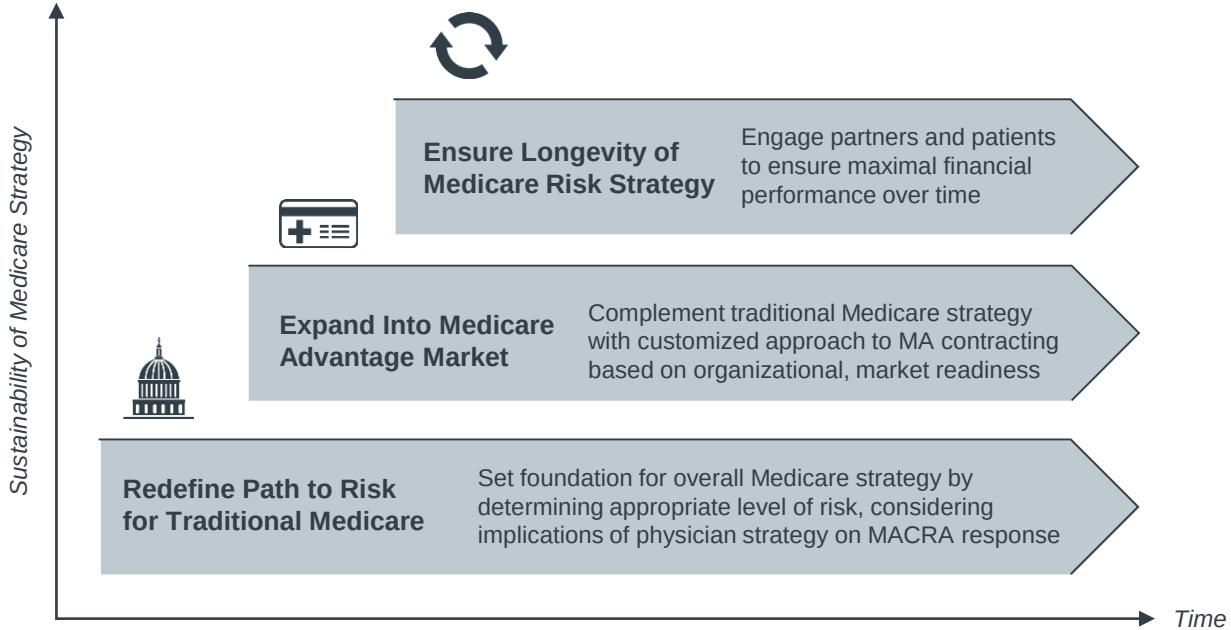
Two Ways to Qualify for APM Track in 2021



Source: CMS, "All-Payer Combination Option," available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-All-Payer-Overview.pdf, accessed October 3, 2016; Health Care Advisory Board interviews and analysis.

Defining an Intentional Approach to Medicare Risk

Three Steps to Establishing a Sustainable Medicare Risk Strategy



Study in Brief: Medicare Risk Strategy

Research study reviewing menu of options for taking on Medicare risk; available at advisory.com/hcab

Source: Health Care Advisory Board interviews and analysis.

Seeking Company to Weather Together?

An Array of Partnership Options

1) Clinically integrated network.
2) Independent practice association.
3) Skilled nursing facility.
4) 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[4] CI Network*

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.