MACRA: What It Means For Your Organization
Context and Tips for Compliance Professionals

Post-election health care implications

Overview of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
Overview of the Quality Payment Program (QPP)
MIPS (Merit-based Incentive Payment System)
APMs (Alternative Payment Models)
Perspectives and next steps
Critical health care issues on the horizon

Governing Agenda

- How will President Trump and Congress prioritize and approach health care among competing governing interests? Will they focus on regulatory changes to the Affordable Care Act (ACA)? Congress may also consider changes to Medicare or Medicaid regulations, or tax policy changes aimed at drug prices.

Affordable Care Act (ACA)

- Will Congress pursue programmatic changes to Medicaid? To Medicare? Legislation or regulations aimed at drug prices?

Tax reform

- Will the Trump Administration adopt the same approach to tax reform as the ACA? What will the rules and procedural requirements for enacting legislation under the ACA be?

The role of the states

- How will the states respond to the new Administration’s announced plan for Medicaid waivers and Innovation Waivers under the ACA? How will states pursue changes to their own health care systems?

Payment Reform

- How will the new Administration and Congress approach payment and delivery reform, including implementation of MACRA and the role of the Center for Medicaid and Medicare Innovation (CMMI)?

Drug Prices

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

The world according to the Congressional Budget Office (CBO):

Will the world actually look like this in 2026?

Projected Sources of Health Coverage Under the ACA, 2016 vs. 2026 (millions of Americans)

To date, 31 states have expanded Medicaid under the ACA.

An additional 11 million people were eligible for Medicaid under the ACA in 2016.
Twelve states and D.C. run Exchanges in 2017
9.6 million people enrolled in coverage in 2016 in the 38 states using the federal Exchange platform, and 3 million enrolled via state-run Exchanges

Post-election and compliance

- Government compliance scrutiny and initiatives not likely diminishing
- Expect bipartisan support for efforts to control costs and government spending
- Data will be more available, more complex and more powerful
- Staying current and monitoring timeframes will be essential

Overview of MACRA
MACRA: Political context
MACRA is a bipartisan law that is poised to transform the future direction of health care

"We’re pleased to see the administration responded to many of our concerns and followed our recommendation to provide clinicians and practitioners more flexibility in the issuance of the final rule for MACRA ... This historic law has been a collaborative effort from the start. We are encouraged by this final rule and CMS’s commitment to ongoing collaboration with Congress and the health care community."

Energy and Commerce Committee Chairman Fred Upton (R-MI), Ranking Member Frank Pallone, Jr. (D-NJ), House Ways and Means Committee Chairman Kevin Brady (R-TX), and Ranking Member Sander Levin (D-MI)

MACRA in the post-election environment


"MACRA was passed on a very strong bipartisan basis to move us towards value-based reimbursement and care delivery, so I fully anticipate that the foundational needs of healthcare with respect to the needs of health IT… those are still going to be priorities in any changes to overall healthcare policy."

5 — Tom Leary, vice president of government relations at the Healthcare Information and Management Systems Society (HIMSS)

"The reality is, Medicare needs to be reformed," Childs said. "So you need some mechanism to test and scale new models in fee-for-service Medicare. And so I think CMMI will in the end survive."

2 — Helen Darling, interim president and CEO of the National Quality Forum

"We don’t see that that (MACRA) is going to be repealed. It was bipartisan, nearly a unanimous vote."

3 — Anders Gilberg, senior vice president of government affairs for the Medical Group Management Association

"I want to make sure people take the opportunity to plow ahead and not use anything that happened in the election as a distraction."

1 — Andrew Slavitt, CMS Acting Administrator

"Last month, we applauded CMS for moving in the right direction when altering the regulations, and we look forward to engaging with the new administration and Congress on future implementation work. As MACRA is implemented, the American Medical Association will continue to work with the incoming administration to ensure that no unnecessary compliance burdens are added to physicians and their staff, so that patients receive the care they need."

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\[\text{Broad themes of MACRA} \]

**Providers now have dollars at stake**
For the first time, providers may see a reduction in their reimbursement and ultimately their pay due to performance on quality and cost metrics

**Focus on Cost and Efficiency**
Patients and payers have increased sensitivity to cost, especially avoidable cost.
Providers that can be more efficient, while still maintaining high quality, will differentiate themselves

**Data Transparency**
Quality and cost data will become increasingly available to the public

**New Drivers of Patient Access**
Availability of high quality care delivered in a cost efficient manner will become a greater factor in referral patterns and access to patients overall

**Payment reform is not going away**
The current system is unsustainable

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MACRA: Disruptive by design

MACRA is a game changer...the law will drive the future of health care payment and delivery system reform for clinicians, providers, and plans across their payer mix.

With the repeal of the Sustainable Growth Rate (SGR) formula, MACRA sets updates to the Medicare Physician Fee Schedule (IPS) for all years in the future.

MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to move away from the traditional fee for service system.

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

Introduction to MIPS and APMs

MACRA establishes two paths for receiving payment adjustments in the future.

**Merit-Based Incentive Payment System (MIPS)**
- MIPS payment adjustments are percentage increases or decreases to the physician fee schedule.
- Each clinician will receive an individual MIPS score, but may report as an individual or a group.
- The MIPS score is compared to national averages to determine a payment adjustment.
- MIPS scores will be shared publicly via Physician Compare.

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

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

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

Payment updates, bonuses and adjustments under MACRA

MACRA creates two separate paths for payments in addition to the Physician Fee Schedule (PFS):

**Physician Fee Schedule (PFS)**
- Non-QP: 0% in 2021, 2022, 2023, 2024, 2025, 2026+.
- QP: 0.75% in 2026+.

**Alternative Payment Models (APMs)**
- Updates: 2019: +/-4%, 2020: +/-5%, 2021: +/-7%, 2022 and subsequent years: +/-9%.
- MIPS Performance Range: 5% for 2019 through 2024.
- OR
- MIPS Performance Range: +/-4% for 2022 and subsequent years.

*For 2019 through 2024, the highest performing MIPS eligible clinicians who receive a positive payment adjustment will be eligible to share up to $500 million each year for "exceptional performance" payments. This upside is limited by the statute to +10% of Medicare charges.*

Source: Public Law 114-10 (April 16, 2015).
A narrower group of clinicians will initially be eligible for payment adjustments under MIPS than will be eligible to participate in the APM track.

Clinical groups eligible to participate in Advanced APMs and MIPS:
- Physicians
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional
- Physical or occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist

Clinicians eligible to participate in Advanced APMs and MIPS, as defined under current law, includes: a doctor of medicine or osteopathy; a doctor of dental surgery or of dental medicine; a doctor of podiatric medicine; a doctor of optometry; and a chiropractor.

Timeline for MACRA implementation:
- Jan. 1, 2019: First payment adjustments under MIPS and APMs; Beginning of all-payer performance period.
- Jan. 1, 2021: Beginning of first performance period for 2021 payment adjustments, including through Other Payer APMs.

Strategic activities timeline based on key regulatory dates:
- Dec. 2, 2018: Statutory deadline for achieving national priority of widespread interoperability of EHRs.

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

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

Source: Public Law 114-10 (April 16, 2015).
Implications of MACRA across health care organizations

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

- **Financial**
  - Affects future Medicare payments to health care providers.
  - Shapes care delivery models and revenue streams.

- **Clinical**
  - Requires system-level interventions to add on or modify workflows.
  - Enhances the evaluation of clinical quality variations.

- **Strategic/Competitive**
  - Prioritizes strategic physician acquisition/growth decisions.
  - Guides who (Primary Care Physicians (PCPs)/Specialties, etc.), where, when, how (types of arrangements).

- **Technological**
  - Requires robust clinical data capabilities (data governance, capture, collection, validation, and reporting).

- **Operational**
  - Requires organization-wide collaboration and coordination of eligibility, multiple moving parts and regulatory requirements.

- **Clinical**
  - Requires clinicians to change/add incremental workflow and assess and improve clinical quality outcomes.

- **Financial**
  - Affects future Medicare reimbursement for all clinicians paid under the Medicare PFS.

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

- **Compliance**
  - **Devil in the Details**
    - Stay current on whether your EHR technology remains certified.
    - Be wary of promoting market accessibility with publicly reported data.
    - Ensure data integrity and accuracy.
    - Prepare PHI for reporting.
    - Collaborate with stakeholders.
    - Audit to be sure data fields populate correctly.
    - Establish internal experts on each model.
    - Establish edits to catch disqualified claims for incarcerated, deceased or not lawfully present in US individuals that CMS will recoup.
    - Stay current on whether your EHR technology remains certified.

- **Compliance: Danger in incentives**
  - What gets measured, gets reported.
  - Watch for sudden changes in practice patterns.
  - Audit original records to assure proper reporting.
  - PHI now a revenue source.
  - Help physician behavior adjust for the right reasons for all patients.
Overview of the Quality Payment Program (QPP)

Key takeaways from the Final Rule

2017 as a Transition Year

- The Final Rule locks in January 1, 2017 as the beginning of the first performance period.
- The Final Rule allows any amount of funds to be accumulated for Quality, Improvement Activities, or Advancing Care Information (ACI) for the first year.
- CMS provided greater detail on changes intended to provide greater flexibility for clinicians to participate in MIPS at different levels.
- Clinicians who do not report any MIPS measures or activities will receive the full negative 4% payment adjustment.

Updates to MIPS

- The Final Rule sets the MIPS performance threshold at three points for 2017. Clinicians who report at least one measure for Quality, Improvement Activities, or ACI will not get a negative payment adjustment.
- CMS reduced the number of required measures for ACI and Improvement Activities to be submitted in order to be eligible for maximum positive adjustments.
- Quality reporting was also simplified.
- CMS retained reporting advantages for clinicians who participate in MIPS.
- The Final Rule set a minimum of 90% for the 2017 reporting period. The weight will increase to 100% for 2018, and to 30% in 2019.
- CMS retained definitions from the proposed rule for AAPM criteria related to financial risk.
- The list of anticipated Advanced APMs for 2017 remains the same as originally proposed.
- CMS declared its interest in creating a new Advanced APM for existing MSSP Track 1 ACOs to achieve AAPM status beginning in 2018.
- The Physician Focused Payment Technical Advisory Committee (PTAC) is reviewing submissions from health care stakeholders for future AAPMs. PTAC will make recommendations to CMS as to whether proposed models should be tested.

Organization of Clinical Networks

- Individual or Group reporting options remain unchanged from the proposed rule, reinforcing the emphasis on the organization of Tax Identification Numbers (TINs) for group performance.

Estimated MIPS exclusions for CY 2017 transition year

In the MACRA Final Rule, CMS increased the low-volume threshold for the first performance year to $30,000 in Part B allowed charges or 100 Medicare patients. Eligible clinicians who do not exceed the low volume threshold have the option to participate voluntarily in MIPS, but would not be subject to payment adjustments.
The QPP by the numbers
CMS estimates that MIPS payment adjustments for 2019 will be +/- $199 million, while APM incentives will be between $333 million and $571 million.

Projected participation in the QPP for the 2017 performance year

MIPS and Advanced APMs: by the numbers
The Final Rule outlines the estimated impact of the Quality Payment Program for 2019: Both in the number of clinicians that fall under MIPS and APMs and the dollar amounts under each model.
Overview of MIPS – including changes to the 2017 transition year

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

Component of MIPS Composite Performance Score (OPDs) & Performance Periods 2017-2019

<table>
<thead>
<tr>
<th>Year</th>
<th>60%</th>
<th>50%</th>
<th>40%</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>15%</td>
<td>15%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2018</td>
<td>15%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2019</td>
<td>15%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
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</table>

Adjustment Factors Based on Final Scores

<table>
<thead>
<tr>
<th>MIPS Adjustment Factor</th>
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</thead>
<tbody>
<tr>
<td>Final Score</td>
</tr>
<tr>
<td>Performance Threshold ≥ 2</td>
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</tbody>
</table>

Sample MIPS measures

<table>
<thead>
<tr>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes:</td>
</tr>
<tr>
<td>Park (1)-Cerebrovascular: % of all patients age 65 years and older with a discharge diagnosis of Cerebrovascular disease who underwent a procedure within 30 calendar days of initial assessment.</td>
</tr>
<tr>
<td>Process (1): Prophylactic Cephalosporin, First Line for Prevention of Postoperative Infection: % of patients who underwent a surgical procedure of any type who were discharged with a cephalosporin around the time of surgery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread: Medicare for Home Transfers: episode is triggered by an inpatient claim with any of the following interventions assigned on the discharge claim:</td>
</tr>
<tr>
<td>Advanced Care Information: Preventing Care Gaps in Adult/Adolescent HIV Care: episode is triggered by an inpatient hospital claim with a principal diagnosis of any HIV trigger code occurring within 30 calendar days.</td>
</tr>
<tr>
<td>Improvement Activities: Participation in the CMS Transforming Clinical Practice Initiative: episode is triggered by an individual trigger code occurring within 30 calendar days.</td>
</tr>
</tbody>
</table>

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (December 6, 2016)
Cost – the components of the performance score

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

Value modifier cost measures

Total Costs per Capita
- Includes payments under both Part A and Part B, but not Part D
- Attributed at the physician group and solo practicing level using the Medicare-enrolled Physician Identification Number (TIN) and a two-step attribution methodology
- Risk-adjusted and payment-standardized
- Focuses on delivery of primary care services

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

Episodes of care
- Breast
  - Mastectomy
- Cardiovascular
  - Aortic/Mitral Valve Surgery
  - Coronary Artery Bypass Graft (CABG)
- Gastrointestinal
  - Colonoscopy and biopsy
  - Transurethral resection of the prostate (TURP) for benign prostatic hyperplasia
  - Hip/Femur Fracture or Dislocation Treatment, Explant (F2-SMS)
  - Hip Replacement or Repair
  - Knee Arthroplasty (Replacement)
- Ophthalmologic
  - Cataract and lens procedures
  - Vitreoretinal
- Musculoskeletal
  - Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based
  - Hip Replacement or Repair
  - Knee Arthroplasty (Replacement)

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

Clinicians eligible to participate in MIPS

Any affected clinicians are termed as "MIPS eligible clinicians" and will participate in MIPS.

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

2019–2020
- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

2021 and Beyond
- Physician or occupational therapists
- Clinical social workers
- Speech-language pathologists
- Audiologists
- Clinical psychologists
- Dietitians/Nutritional professionals
- Physical or occupational therapists
- Clinical social workers
- Speech-language pathologists
- Audiologists
- Clinical psychologists
- Dietitians/Nutritional professionals
- Nurse midwives
- Clinical psychologists
- Dietitians/Nutritional professionals

Who is eligible to participate in MIPS?

Unless they meet one of the following criteria:

- New Medicare-enrolled clinicians
  - New clinicians enrolled in Medicare during the performance period
  - Did not previously submit Medicare claims or an application for participation in an Advanced Alternative Payment Model (APM) or promoting the participation of a physician group or under a different Taxpayer Identification Number (TIN)

- Qualifying (Q) & Partial Qualifying (Partial-Q) APM Participants
  - Partial-Qs can elect to report under MIPS or not, which determines whether or not they will be subject to MIPS adjustments
  - These participants are in advanced APMs

- Low-volume threshold
  - Individual MIPS eligible clinicians or groups who:
    a. Have Medicare billing charges less than or equal to $30,000; or
    b. Provide care for 100 or fewer Part B-enrolled Medicare beneficiaries

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

The MIPS low volume threshold exclusion is applied the same regardless of whether an Eligible Clinician (EC) reports as a group or an individual.

<table>
<thead>
<tr>
<th>MIPS Low Volume Thresholds (Must Meet One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30,000 Medicare Charges</td>
</tr>
</tbody>
</table>

**Illustrative Example**

TIN 12345 includes 100 clinicians who had $500,000 in aggregate Medicare charges and saw 6,000 patients during the measurement period.*

- 40 ECs meet one of the low volume thresholds
- 60 ECs do not meet either low volume thresholds

**Reporting Options:**

- **Group Reporting:**
  - Aggregate data is submitted for all 100 ECs in the TIN, including those who individually meet the exclusion.
  - All ECs receive the same MIPS score and payment adjustment.

- **Individual Reporting:**
  - Submit 60 individual sets of data for the ECs who are not excluded from MIPS.
  - The 60 ECs will receive a unique MIPS score and payment adjustment.
  - The 40 excluded ECs do not receive a MIPS score or payment adjustment.

*2017 low volume thresholds are calculated from September 1, 2015 to August 31, 2016 and from September 1, 2016 to August 31, 2017. ECs/Groups who are below the threshold in either time period are excluded.

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

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**Group Reporting / Scoring Under MIPS**

Providers who report as a group will have an "individual" score on Physician Compare, but that score will be the group score based on aggregate reporting.

**Illustrative Example**

TIN 12345 includes 4 clinicians:

- Dr. A
- Dr. B
- Dr. C
- Dr. D

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

- Dr. A: 65
- Dr. B: 65
- Dr. C: 65
- Dr. D: 65

**Data is converted to a group composite score**

**65**

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

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**MIPS Performance Category Measures and Activities**

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

- **Quality**
  - Clinical Practice Improvement Activity (CPIA)
  - Advancing Care Information

- **Measurement**
  - 2016
  - 2017

- **Submit**
  - Submitted using administrative claims
  - No submission required

**Clinical Practice Improvement Activity (CPIA)**

- **Measures**
  - Qualified registry
  - EHR
  - CMMS
  - Administrative Claims

**Advancing Care Information**

- **Measures**
  - Qualified registry
  - EHR
  - CMMS
  - Administrative Claims

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

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Pick your pace for Performance Year 1

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

**MIPS Adjustment**

**Negative 4% payment adjustment**

No MIPS performance data submitted to MIPS.

**Neutral to small positive adjustment**

Low overall performance in the categories on which they choose to report for at least a 90 day period may receive a final score at or slightly above the performance threshold.

**Higher positive adjustment**

Averaging high overall performance across the three categories and at least one of the categories on which they choose to report for at least a 90 day period may receive a final score at or above the additional performance threshold will receive an additional adjustment.

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**Compliance: Devil in the Details**

1. **Participate in design of score calculation formulas**
2. **Designate on-site compliance leaders**
3. **Structure system to track by TIN**
4. **Track reporting requirements**
5. **Give input on physician and AP compensation models**
6. **Develop system to track: Clinician eligibility and exemptions**
7. **Calculate low volume threshold calculation synchronizes with individual or group reporting**
8. **Verify data before reporting**

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**IMPROVEMENT ACTIVITIES**

- **Healthcare: Models and existing shared service Program Track 1: Participants automation improvements**
- **MIPS 2 initiative**
- **Partner with quality assurance professionals**
- **Accomplish all for minimum of 90 days**

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**ADVANCING CARE INFORMATION**

- **Be sure EHR is properly certified and face compliance with clinical data on its or not**
- **Track reporting categories with values of certified EHR technology**
- **Cited reasons for additional measures for extra credit**
- **Identify potential areas for improvement: Health and technology**
- **Provide an additional measure that supports attestations**
- **Maintain ongoing education that supports attestations**
- **Maintain system for recording activities and change TIN**

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**PHI Access and Security now Revenue Source**

- **Secure PHI access**
- **B-Prescribing**
- **Patient Access to her EHR**
- **PHI Access and Security now Revenue Source**
- **Maintain access to PHI and security now Revenue Source**
- **Maintain ongoing education that supports attestations**
- **Maintain data security during and after PHI access**
APMs

Key highlights: Advanced APMs

Requirements for Advanced APMs

<table>
<thead>
<tr>
<th>Available for 2017</th>
<th>Anticipated Available Beginning 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MSSP Track 2</td>
<td>1. Medicare ACO Track 1+</td>
</tr>
<tr>
<td>2. MSSP Track 3</td>
<td>2. Acute Myocardial Infarction (AMI)*</td>
</tr>
<tr>
<td>3. Next Generation Accountable Care Organization (ACO) Model</td>
<td>3. Coronary Artery Bypass Graft (CABG)*</td>
</tr>
<tr>
<td>4. Comprehensive Primary Care Plus (PCP+)</td>
<td>4. Surgical Hip/Femur Fracture Treatment (SHFFT)*</td>
</tr>
<tr>
<td>5. Comprehensive Acute Kidney Disease (AKD) Care Model – two-sided risk arrangement</td>
<td>5. New Future Payment Model based on Bundled Payment for Care Improvement (BPCI)*</td>
</tr>
<tr>
<td>6. Oncology Care Model (OCM) two-sided risk arrangement</td>
<td>6. Comprehensive Care for Joint Replacement (CJR)*</td>
</tr>
<tr>
<td>7. Comprehensive Care for Joint Replacement (CJR)*</td>
<td>7. New Future Payment Model based on Bundled Payment for Care Improvement (BPCI)*</td>
</tr>
<tr>
<td>8. Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)</td>
<td>8. Comprehensive Care for Joint Replacement (CJR)*</td>
</tr>
</tbody>
</table>

Key Considerations

- Enrollment: Application cycle for 2017 is closed
- Timing: Next application cycle for MSSP will begin in April 2017 for 2018. Next Generation ACO and CPC+ applications to re-open in 2017 for 2018

Additional Options: The Physician-Focused Payment Technical Advisory Committee (PTAC) opened the proposal process December 1, 2016

The Other Payer Option: Under Other Payer Advanced APMs, at least 25% of Medicare payments for covered professional services must be through CMS approved Advanced APMs. Overall, the sum of all Medicare payments to an APM must meet the specified threshold.

QP Payment Amount Thresholds

- The threshold for QP status in advanced APMs increases dramatically in just five years. Many organizations are looking to the Other Payer Advanced APM option beginning in the 2019 performance year.

QP Patient Count Thresholds

- The threshold for QP status in advanced APMs increases dramatically in just five years. Many organizations are looking to the Other Payer Advanced APM option beginning in the 2019 performance year.
Advanced APM QP Determination Snapshots

Eligible clinicians on the participant list at one of three determination points throughout a performance period will be considered a QP in an APM Entity Group.

2017 QP Performance Period

- SNAPSHOTS: March 31, 2017
- June 30, 2017
- August 31, 2017

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

Impact of APM participation thresholds in 2019 and 2020

APM participation is not an all or nothing proposition. ECs who do not meet QP thresholds may still be excluded from MIPS or receive bonus points or additional benefits within MIPS.

Advanced APM nominal risk standard

The final rule generally reduced the level of overall risk required to be considered an Advanced APM and outlined two distinct approaches to determining whether payment arrangements satisfy the nominal risk standard.

<table>
<thead>
<tr>
<th>Revenue-based standard</th>
<th>Benchmark-based standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 5% of average estimated total Part A and B revenue of participating APM entities</td>
<td></td>
</tr>
<tr>
<td>- No marginal risk or minimum loss ratio</td>
<td></td>
</tr>
<tr>
<td>- Available for performance years 2017 and 2018; will increase for the third and subsequent performance years</td>
<td></td>
</tr>
<tr>
<td>- 7% of all expenditures for which an APM entity is responsible</td>
<td></td>
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<tr>
<td>- Available for all performance years</td>
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</tbody>
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NOTE:
- MIPS Eligible Clinicians who participate in MIPS or APMs may not be subject to quality and resource use scoring categories, resulting in an adjustment of their CPS weighting.

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

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

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Bundled Payment Models to qualify as Advanced APMs in 2018

CMS’s Proposed Rule on Bundled Payment Models for High-Quality, Coordinated Cardiac and Hip Fracture Care would create a track for each of the five proposed models with the potential to qualify as Advanced APMs.

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

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

APM

MIPS

Arrangement of Clinicians in Advanced APMs

Advanced APM thresholds

In order to achieve QP status through an Advanced APM, the APM entity must meet the specified payment amount thresholds for Medicare Part B claims through an Advanced APM.

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

CMS also allows for APM Entities to achieve QP Status through an Advanced APM using the patient count method.
Potential of the Other Payer Combination Option

The Other Payer Combination Option is poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare.

**2021**
Beginning in 2021, health care professionals can also qualify for APM Incentive Payments through Other Payer Advanced APM thresholds.

**2022**
In order to qualify in 2021 and 2022, Qualifying APM Participants (QPs) must receive at least 50% of the sum of payments by Medicare and other payers through Advanced APMs and Other Payer Advanced APMs.

**2023**
For 2023 and subsequent years, QPs must receive at least 75% of payments through Advanced APMs and Other Payer Advanced APMs.

Under Other Payer Advanced APMs, at least 25% of Medicare payments for covered professional services must be through Advanced APMs.

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

Implications of the Final Rule on MIPS and APM Incentives for MA

**The QPP and Medicare Advantage (MA)**

**Implications of the Final Rule on MIPS and APM Incentives for MA**

**Advanced APMs**
The Final Rule stipulates that MA and other private plans paid to act as insurers on Medicare’s behalf are not Medicare Advanced APMs in their current form.

**Quality Rating Systems**
CMS relies on the Five Star Quality Rating System to hold Medicare Advantage Organization (MAOs), accountable for health care outcomes. MIPS measures, on the other hand, are tied directly to individual and group of providers. Both measurement systems need to be examined for future alignment.

**MA “Capitation” as Financial Risk**
Where we currently stand (i.e., the Medicare-only option), MA capitation does not count as an advanced APM in part because CMS is not directly paying providers — the MA is.

**All-Payer Combination Options**
A provider can qualify for the APM incentive payment established by MACRA through, in part, participation in an Advanced APM with MAOs. To examine an All-Payer Combination, CMS provides an example of how to engage with MAOs in establishing certain types of value-based arrangements.

Legislative changes would be needed for CMS to require MAOs to adopt the use of APMs in payment arrangements.


Compliance: Devil in the Details

1. Track CMS reports on improper payments identified by RAC in your region.
2. Develop multi-year compliance plan to account for new APMs.
3. Establish system to review quarterly MAC reports on most frequent and expensive payment errors and address them.
4. Check eligibility of clinicians prior to implementation snapshot (first is 3/31/17).
5. Ensure compliance responsibility for each entity and model is clear.
6. Develop knowledge on your compliance staff of the new APMs.
7. Follow topics approved by CMS for RAC audits.
Compliance: Danger in incentives

- **What gets measured, gets reported**
- Partner with Revenue Cycle to track and audit satisfaction of payment thresholds
- Develop clinician matrices by APMs
- Start small pilot test subsets of clinician groups to assess your systems and approach
- Verify certified EHR requirements are met
- Be sure the model fits
- Congress has required CMS to develop incentives to reward individuals for reporting any errors that lead to recoupment
- Establish system that fosters internal reporting
- Address any reported errors from staff or patients and document results
- Be sure the model fits
- Congress has required CMS to develop incentives to reward individuals for reporting any errors that lead to recoupment
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Perspectives and next steps

What we are hearing from health systems and health plans

- In order to be successful, we'll need access to real-time claims data.
- Which physicians are likely to perform well under risk-based contracts and MIPS?
- What does the future provider-plan relationship look like?
- Do we need to re-examine all of our joint ventures?
- Into which Advanced APMs should we move and in which performance year?
- How do we change our care delivery model to better deliver better outcomes more efficiently?
- How should our physician compensation and incentives change, if at all?
- What does this mean for our MA business?
Challenges exist in developing and maturing MACRA capabilities

MACRA accelerates the directional journey from volume to value

Journey for Health Systems

Assisting clinicians to manage reimbursement and reputation risk is critical to future success, and ultimately, is the link to brand enhancement and patient engagement

Moving from volume driven reimbursement to risk-based payment models requires clinical and financial integration across the entire health system enterprise, within your delivery models, and across your local payer mix

Aligning provider networks (both employed and non-employed clinicians) with new payment models is imperative to your growth strategy and risk management

Access to real time and accurate data to improve performance, reduce utilization, and manage financial risk is one of the highest operational priorities

Next steps to consider

- Begin internal discussions with key enterprise stakeholders (including potentially your board of directors) on forthcoming MACRA impacts
- Perform a thorough impact assessment to understand how MACRA will impact Strategic, Financial, Clinical, Technological, Operational, and Organizational priorities as well as exploration of strategies to gain access to higher percentage of the premium dollar
- Plan and prepare for tactical changes and/or enhancements associated with MIPS readiness particularly given the Performance Range began January 1, 2017
- Make informed, strategic choices around moving in a swift and responsible manner towards Advanced APMs and Other Payer Advanced APMs
Next steps to consider on compliance

- Develop a compliance education plan on MACRA requirements and practical functioning of each payment model
- Design a system to verify the key representations associated with the types of claims under each model such as clinician and practice eligibility and elections, quality measures, improvement activities and advancing care information
- Collaborate to designate responsibility for attestation to satisfaction of the payment model requirements and who will monitor and maintain documentation to demonstrate compliance
- Establish a system of appropriate claim edits and an audit plan to catch mistakes, respond to any notices of deficiencies from payers and re-educate clinicians and billing staff as needed

Claudia Douglass
Managing Director | Deloitte Risk and Financial Advisory

Profile
Claudia Douglass is a Managing Director in the Advisory Life Sciences and Health Care Practice of Deloitte & Touche LLP, and has over 20 years of experience in the healthcare industry as both a consultant and with large health systems in senior leadership roles in the areas of strategic planning, operations and financial management. Claudia's experiences include a focus on developing and leading complex strategic initiatives across multiple business units, primarily in the areas of quality and patient experience, population health and cost management. She has presented on the topics of customer relationship management and supply chain strategy at professional conferences. Claudia is a Fellow in the American College of Healthcare Executives and Project Management Professional. She holds a B.A. in Finance and Marketing from the University of Miami and a Master of Health Services Administration degree from the University of Michigan.

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Maureen is the health care practice leader at Smith Moore Leatherwood LLP, which has offices located throughout the Southeast. With over 30 years of experience, Maureen has defended providers in fraud and abuse investigations, OCR and OIG investigations, billing and regulatory compliance, patient liability claims, managed care and risk management, professional liability, privacy, medical records, and contracts. Maureen has also handled varied health care business transactions and agreements. Mahureen was recognized in the 2016 Benchmark Litigation, a Top 50 Women in Health Law in America, and in The Best Lawyers in America for Health Care Law. She is a member of the American Health Lawyers Association and the North Carolina Association of Health Care Attorneys. Maureen's experience includes handling all aspects of health care transactions and regulatory compliance, and she has been involved in health care law for more than 25 years in the North Carolina area and in benchmark litigation. She is a Fellow in the American College of Trial Lawyers.

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QUESTIONS?