MACRA AND MIPS

Chris Dawson
Director of Managed Markets
PTS Diagnostics

The New Market Place

The Perfect Storm!

Unsustainable Healthcare Costs!

Catastrophic Insurance!

Consumer Driven Healthcare!

Aging Population

Shift in HCP Reimbursement!

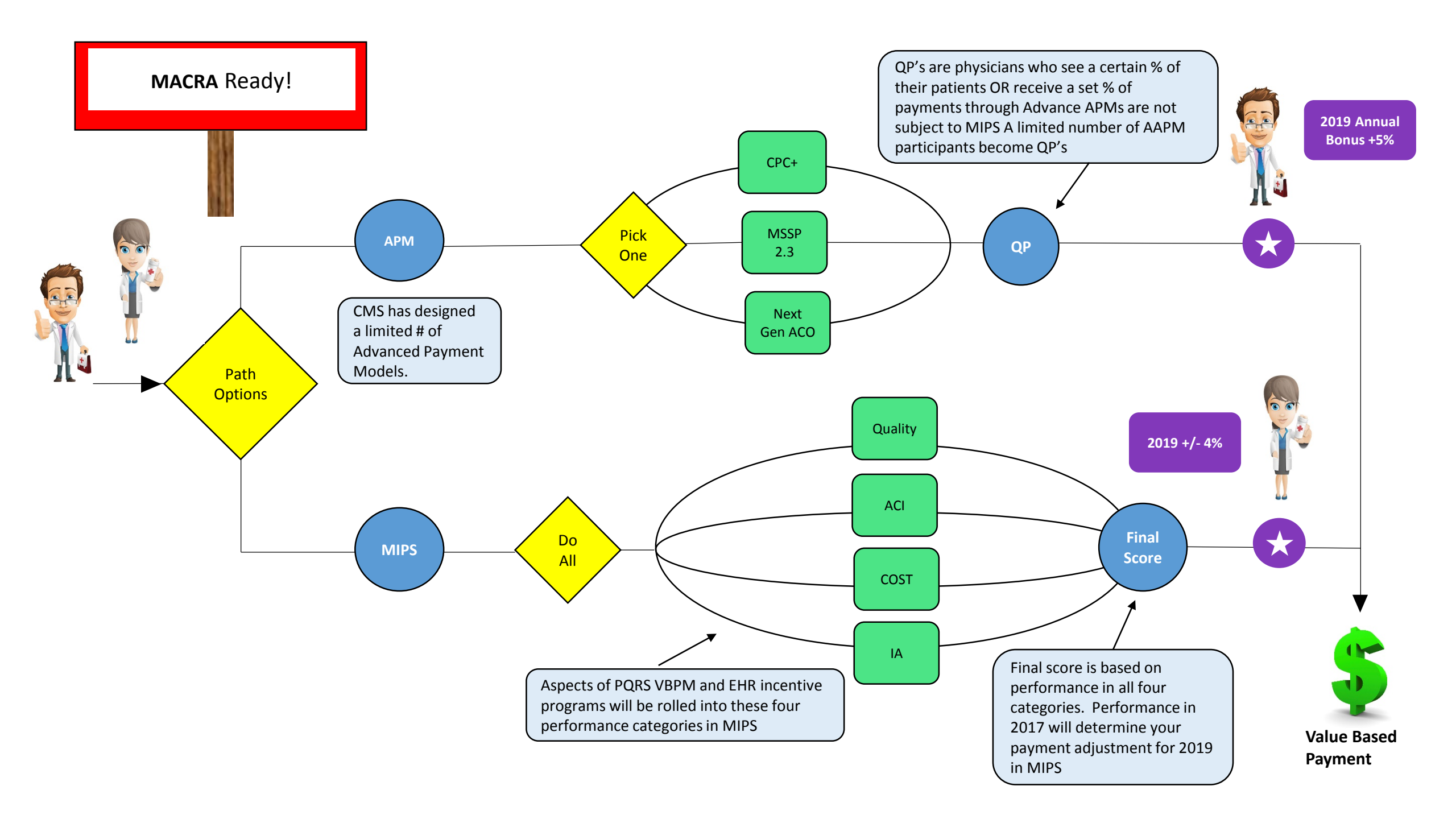
Telemedicine

Patient Non-Compliance!

Increasing Diabetes Prevalence!

"Someone has to do something; and it's pathetic it has to be us."
Jerry Garcia

As told by Michael Leavitt; former Gov. of Utah, Secretary U.S. H.H.S.


MACRA Ready!
Path Options
APM
CMS has designed a limited # of Advanced Payment Models.
Pick One
CPC+
MSSP 2.3
Next Gen ACO
QP
QP's are physicians who see a certain % of their patients OR receive a set % of payments through Advance APMs are not subject to MIPS A limited number of AAPM participants become QP's
2019 Annual Bonus +5%
MIPS
Do All
Quality
ACI
COST
IA
Aspects of PQRS VBPM and EHR incentive programs will be rolled into these four performance categories in MIPS
Final Score
2019 +/- 4%
Final score is based on performance in all four categories. Performance in 2017 will determine your payment adjustment for 2019 in MIPS
Value Based Payment

MACRA: Executive Summary
Legislation!

Legislation in Brief

- MACRA (Medicare Access and CHIP Reauthorization Act) passed with *bipartisan* support in April 2015
- Final rule issued October 14, 2016
- 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: 0.0% annual increase
  - 2026 and on: 0.25% annual increase, or 0.75% increase, depending on payment track
- Stipulates development of the Quality Payment Program (QPP)
- Programs to be implemented on:
  January 1, 2019 based on annual performance period starting January 1, 2017

1)Meaningful Use, Physician Quality Reporting System and the Value Based Payment Modifier.
2)Electronic health record.

MACRA: Executive Summary

QPP (Quality Payment Program)!

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, cost, improvement activities, and EHR[2] use—and assigned a positive or negative payment adjustment accordingly

Advanced Alternative Payment Models (APM)

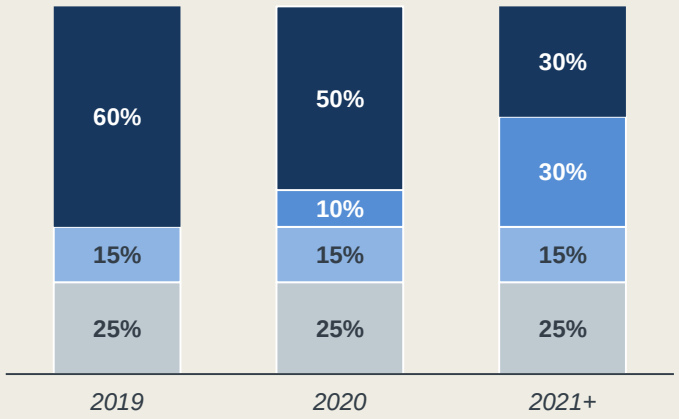
- Requires significant share of patients and/or revenue in payment contracts with downside risk, quality measurement, and EHR requirements
- APM track participants will be exempt from MIPS payment adjustments and qualify for a 5 percent incentive payment in 2019-2024

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," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

MIPS Reporting Requirements At a Glance

MIPS Scoring

Four Categories That Determine MIPS Score *Relative Weight Over Time*



Category	Reporting Requirements
Quality	• Nearly 300 measures to choose from, 80% of which are tailored to specialists • Eligible Clinicians only required to report six measures; in addition, all-cause readmissions will be calculated based on claims • Cross-cutting measure will no longer be required
Cost	• Total per capita costs for all attributed beneficiaries and Medicare spending per beneficiary • Adds 10 episode-based measures, rather than 41 • No longer a component of MIPS performance in program year 2017; weighted at 10% in 2018, 30% in 2019
IA	• Over 90 activities to choose from; some activities weighted higher than others • Full credit requires 40 points, rather than 60 • Preferential scoring for small practices, PCMH[3], and MIPS-APM participants
ACI	• Applies to all clinicians, not just physicians[3] • Clinicians given opportunity to report as group or individual • Reporting minimum: Four Modified Stage 2-equivalent measures or five Stage 3-equivalent measures in 2017, rather than 11 required measures

1) Merit-Based Incentive Payment System.
2) Patient-Centered Medical Home.
3) Eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians.

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," May 9, 2016, available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf; Advisory Board interviews and analysis.

2017 & 2018 Transitional Years

Flexible Reporting Requirements Ease Providers into MIPS

MACRA Implementation Timeline

Three Options for MIPS Reporting in 2017[1]

1 **Full Measure Set Across All Categories**

Report required MIPS measures for 90 days or more

→ Eligible for moderate positive payment adjustment

2 **More than One Measure**

Report more than one measure for 90 days or more

→ Eligible for small positive payment adjustment

3 **One Measure in Any Category**

Report any measure in any category for any period of time

→ Avoid penalty

Organizations only penalized for non-reporting

Cost category not scored

1) For payment in 2019.

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," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Calculating MIPS Participant Rewards, Penalties

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

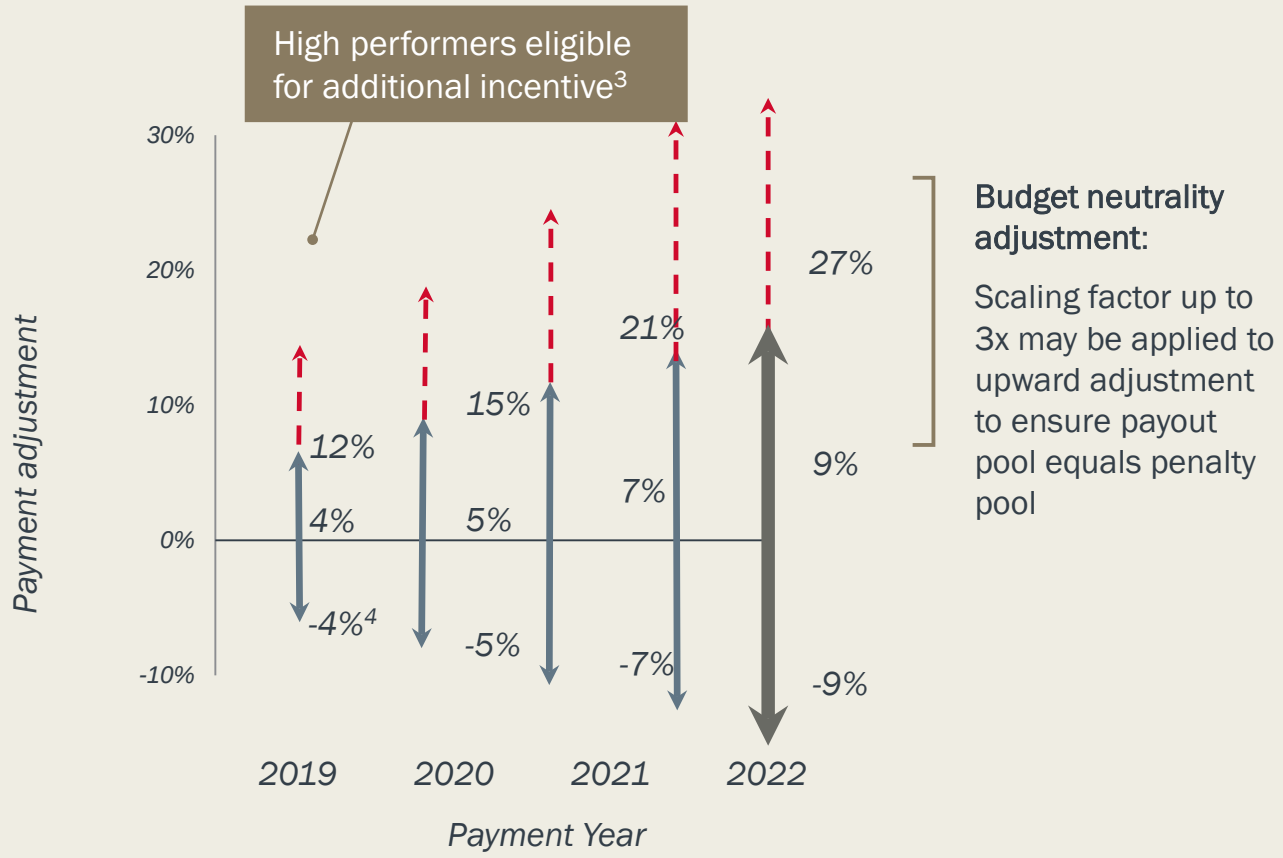
Payment Adjustment Determination

1. Clinicians 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 receives bonus; a score below PT subject to penalty[2]

3

Predetermined Performance Threshold (PT) for 2017 (2019 payment); score below 3 points results in penalty

Maximum Provider Penalties and Bonuses



Budget neutrality adjustment:

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

1) The mean or median of the composite performance scores for all MIPS eligible professionals with respect to a prior period.
2) Bonus, penalty size correspond with how far providers deviate from the PT.
3) High performers eligible for additional incentive of up to 10% for MIPS eligible providers that exceed the 25th percentile.
4) In payment year 2019 clinicians only penalized for not reporting.

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," May 9, 2016, available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf; Advisory Board interviews and analysis.

The New Market Place

What does this look like for HCP's who choose MIPS?

CMS MIPS (Merit-based Incentive Program)

Dr. Smith

Good MIPS score!
HCP gains an *additional 4.0% in reimbursement in year 1*!
If he/she continues delivering quality, cost effective care;
Reimbursement *escalates to +9.0% in year 4*!

Dr. Jones

Poor MIPS score.
HCP *loses 4.0%* in reimbursement in year 1!
Loss *escalates to -9.0% in year 4!*
PR Problem!

Advancing Risk Through Physician Reimbursement

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

1. MIPS Bonuses/Penalties

+/-4% Maximum annual adjustment, 2019

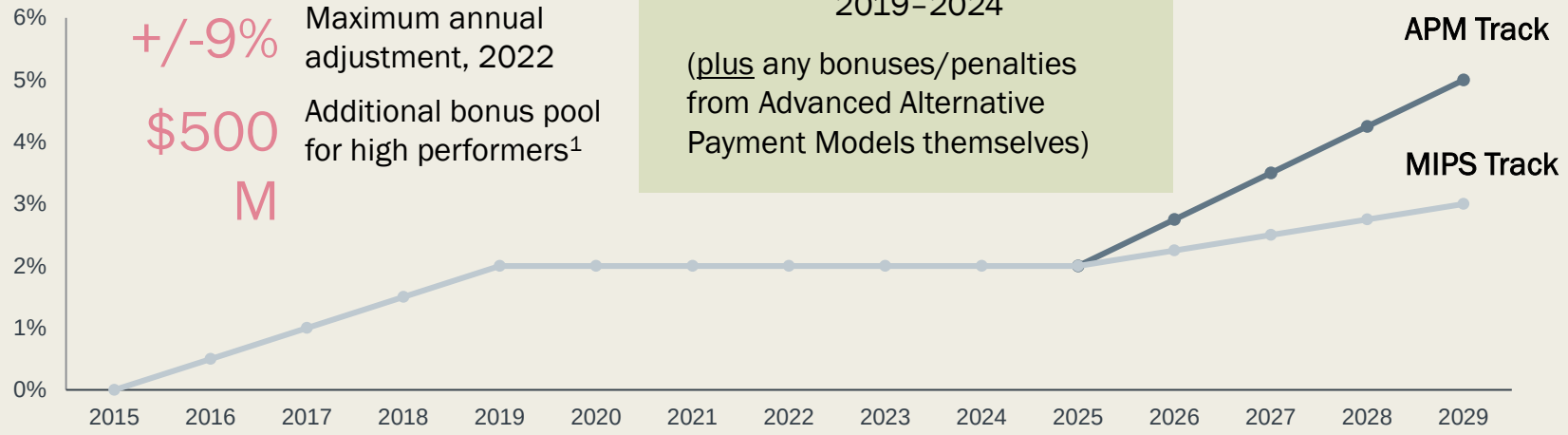
+/-9% Maximum annual adjustment, 2022

$500 M 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 Alternative Payment Models themselves)



Baseline payment updates[2]:

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 (APM track)

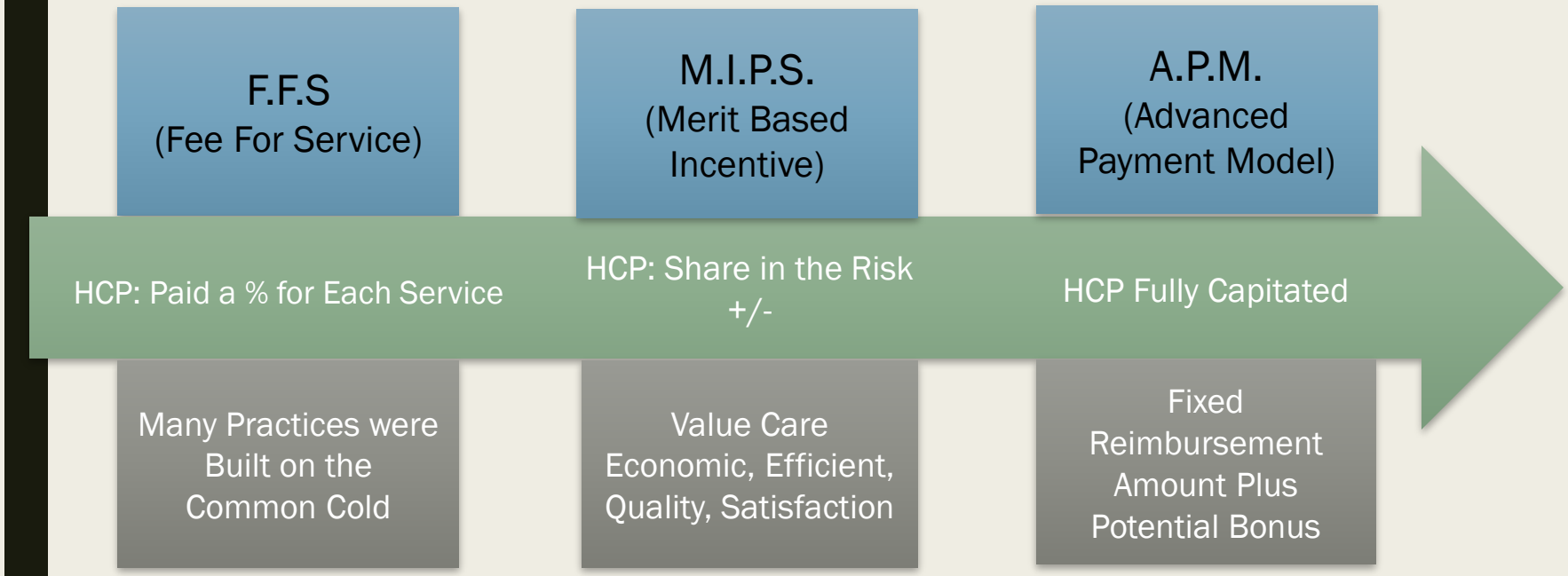
1) Clinicians with a threshold final score of 70 or higher eligible for additional bonus.

2) Relative to 2015 payment.

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," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

The New Market Place

CMS is Moving to a *Risk Based* Payment Model!



Key Points:

1. FFS "0" Risk!
2. MIPS Share in the risk!
3. APMs Greatest risk!
4. APMs are the ultimate goal for CMS!

The New Market Place

ACO & MIPS Value Based Healthcare

More than ever, HCP's have financial incentive to:

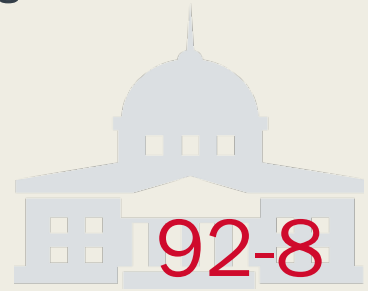
1. *Control cost!*
2. *Keep patients out of the hospital!*
3. *Improve Patient Satisfaction!*
4. *Improve Care Effectiveness!*

What Happens if ACA (Obamacare) is Repealed?

Strong Bipartisan Support for MACRA Persists

Repeal or Perpetual Delays Unlikely

Legislation Continues to Enjoy Bipartisan Support



Senate vote in favor of MACRA

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

"This historic law has been a **collaborative effort from the start.** We are encouraged by this final rule and CMS's commitment to ongoing collaboration with Congress and the health care community."

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

Source: House Energy and Commerce Committee, "Bipartisan Energy and Commerce, Ways and Means Leaders Comment on Final MACRA Rule," available at: energycommerce.house.gov; "H.R.2- Medicare Access and CHIP Reauthorization Act of 2015", Congress.gov; CMS, "Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," October 14, 2016; Advisory Board interviews and analysis.

AMA Update

- **CMS proposes more flexibility, transition time for QPP's 2nd year**The Centers for Medicare and Medicaid Services (CMS) has released a proposal that could affect how doctors practice next year and how they will be paid in 2020. Year two of the Medicare Quality Payment Program (QPP) could serve as another transition year for physicians adjusting to value-based payment if a proposed rule, released June 20 by CMS, is implemented.

  The QPP, created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was rolled out this year. Physicians were given four options for their level of implementation under a "pick your pace" approach. These include participating in an Advanced Alternative Payment Model (APM) and three different levels of participation in the QPP's Merit-based Incentive Payment System (MIPS). How physicians perform this year will affect payments in 2019.

  The new proposal includes more accommodations for small practices and, if it's implemented as written, CMS estimates 94 percent of eligible clinicians will receive either a positive or neutral adjustment to their Medicare payments in 2020, based on the success of their MIPS participation next year.

  The AMA commended CMS for its approach to the second year of the program.

  "CMS is proposing a number of policies to help physicians avoid penalties under the Quality Payment Program," said AMA President David O. Barbe, MD. "The Administration showed it heard the concerns raised by the AMA on behalf of practicing physicians. In proposing these rules, the administration has taken another step to make sure the promise of MACRA—where physicians are rewarded for improvement and for delivering high-quality, high-value—will be fulfilled."

  A major accommodation to small practices was expanding the low-volume threshold for exemption from MIPS. For 2017, physicians who made $30,000 or less on Medicare Part B charges or saw 100 or fewer Medicare patients are exempt from MIPS quality-reporting requirements. For 2018, CMS proposes tripling the financial threshold, increasing it to $90,000, while doubling the patient threshold to 200.

Possible Impact

- Safeguards rural practices from taking a significant negative financial hit
- Slows the pace of total reform by giving practices increased time for transformation
- AMA and CMS are showing continued transparency and cooperation which increases the chances of success long term
- Smaller physician practices may not feel the urgency to consolidate due to the improved exclusion criteria

Two Criteria to Qualify for APM Track

Clinicians Assessed Within Entity to Determine Advanced APM Eligibility

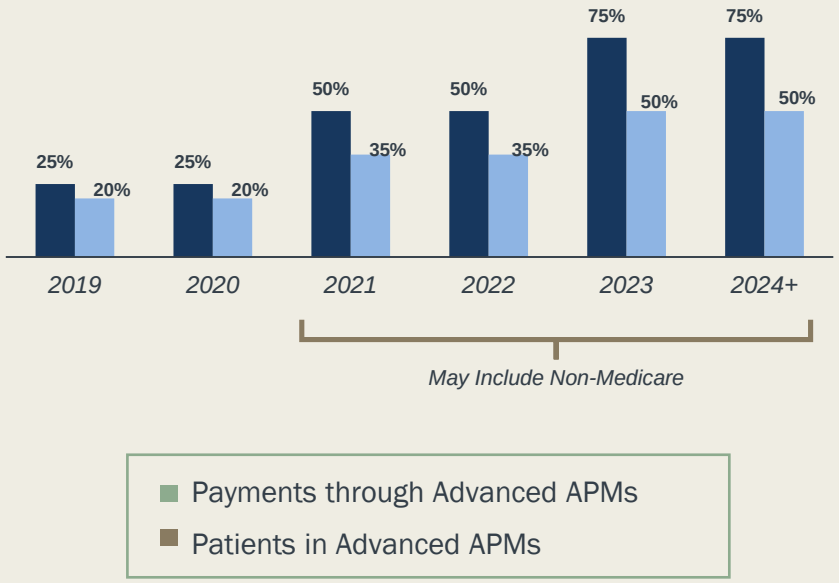
1 Final Advanced APM Criteria

Financial Risk Criteria

- Meet revenue-based standard (average of at least 8% of revenues at-risk for participating APMs) or
- Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)

- Certified EHR use
- Quality requirements comparable to MIPS

2 APM Entities Must Meet Percent of Payments or Patient Counts



1) End-stage renal disease.
2) Large dialysis organization.

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," May 9, 2016, available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf; Advisory Board interviews and analysis.

Two Categories of CMS Payment Models

More Models Expected to Qualify as Advanced APMs in 2018 and Beyond

Advanced APM-Ineligible Payment Models

- Medicare Shared Savings Program (MSSP) Track 1
- Bundled Payments for Care Improvement Initiative (BPCI)

CMS has indicated it plans to modify BPCI models to be eligible in the future

Advanced APM-Eligible Payment Models

- Medicare Shared Savings Program (MSSP) Tracks 2 and 3
- Next Generation ACO Model
- The Oncology Care Model Two-Sided Risk Arrangement[2]
- Comprehensive ESRD[3] Care Model (Large Dialysis Organization Arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Comprehensive Care for Joint Replacement (CJR)
- MSSP Track 1+ *(to come)*
- Medicare Episode-Based Payment Model
- Certain commercial contracts with sufficient risk, including Medicare Advantage

In 2017

In 2018

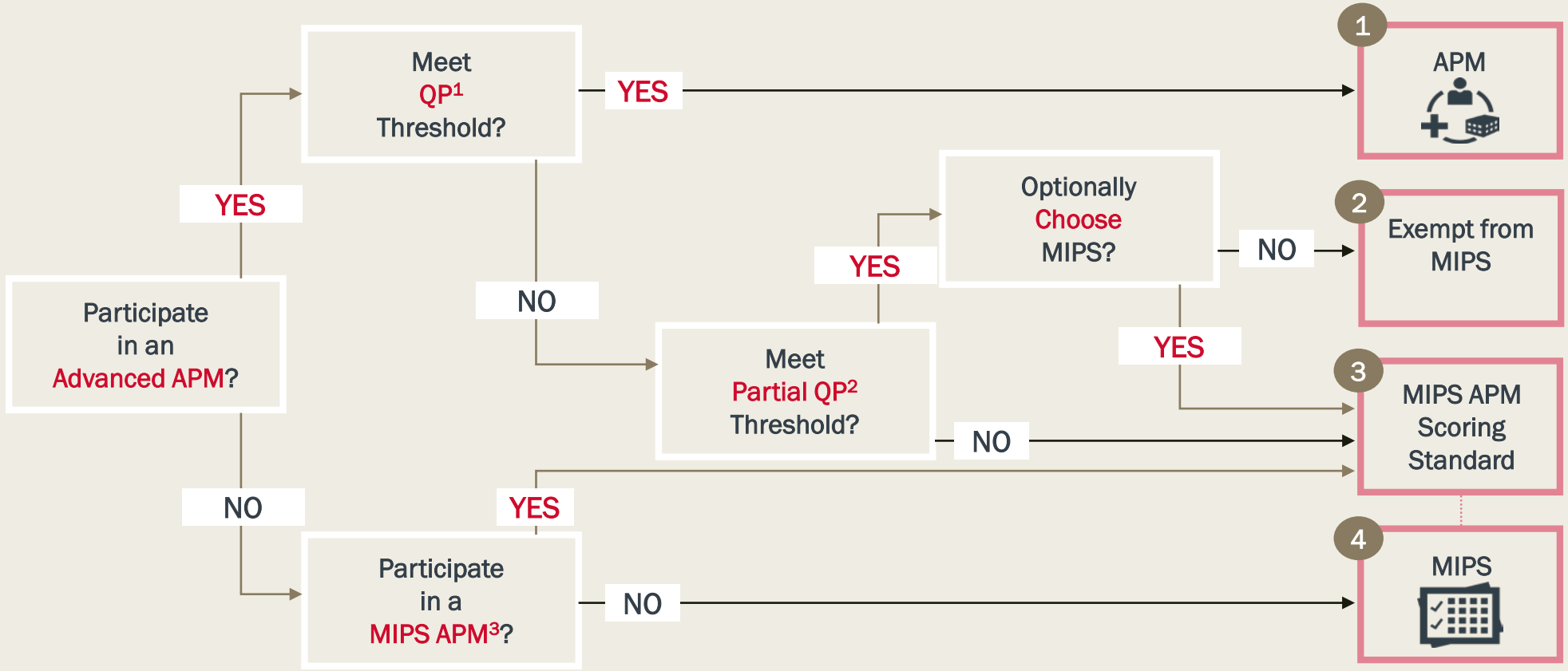
In 2019

1) .
2) Available in 2018.
3) End stage renal disease.

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," May 9, 2016, available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf; Advisory Board interviews and analysis.

Which Track Do I Qualify?

Four Provider Categories Emerging



! Circumstances That May Exclude Providers in a Given Year

- Low total patient volume
- New Medicare provider

1) Qualifying Participant; 25% of payments or 20% of patients tied to Advanced Alternative Payment Model in 2017.
2) Partial Qualifying Participant; 20% of payments or 10% of patients tied to Advanced Alternative Payment Model in 2017.
3) Alternative Payment Model that does not qualify as Advanced, but does qualify clinician for favorable scoring under MIPS categories.

Source: Advisory Board interviews and analysis.

Requiring a Dual Focus

Two Considerations for Independent Medical Groups

Rethink

Risk Model Strategy

- Evaluate current participation in alternative payment models
- Compare new and existing models to understand costs and benefits to the group
- Determine if participation in new models in the coming years will be beneficial
- Assess performance of other providers in APMs and your network more broadly

Maximize

Performance in MIPS

- Establish a clear strategy for reporting success
- Use 2017 to work out operational kinks in preparation for 2018
- Understand which reporting mechanism offers the most benefits to your group
- Use prior performance to better predict and understand performance under MIPS

Additional Resources


MACRA: How the Final Rule Impacts Providers


Medical Group Success Under MACRA


2017 MIPS Measures Tool

Source: Advisory Board interviews and analysis.

Eighth National Accountable Care Organization Summit

- HIE (Health Information Exchange), community based EMR that can be shared through out traditional and non traditional settings.
- CMS taking comment on allowing all risk patients a physician treats to be counted towards the threshold that allows them to be under the APM program.
- States such as New Jersey are currently running pilots to consider specific ACO development for Medicaid patients.
- Bundle Busters / Super Users ; usually patients who have chronic conditions and utilize out of network or higher cost providers. Earlier engagement with these patients and creating tools that track these patients in real time when services are executed such as Home Health.
- 75% of physicians are not prepared or knowledgeable in regards to the MACRA and MIPS rollout and implementation.