The Academy
The Health Management Academy

MACRA Collaborative Strategies for 2017 & Beyond

December 1, 2016

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Overview

Strategic Considerations for 2017 & Beyond

- Strategic Considerations for MIPS Reporting
- Organizational Structure Considerations
- MIPS Scoring Scenarios
- Preparing for the Future of MIPS
- Strategic Considerations for Advanced APMs

MACRA Decision Tree for Clinicians

Advanced Alternative Payment Model ("APM") List:

The following models meet the criteria to be Advanced APMs in the 2017 performance year:

1. Medicare Shared Savings Program Track 2 Accountable Care Organization ("ACO")
2. Medicare Shared Savings Program Track 3 ACO
3. Next Generation ACO
4. Comprehensive End-Stage Renal Disease Care Model
5. Oncology Care Model (two-sided risk agreement)
6. Comprehensive Primary Care Plus

Qualifying Advanced APM Participant ("QP") Steps:

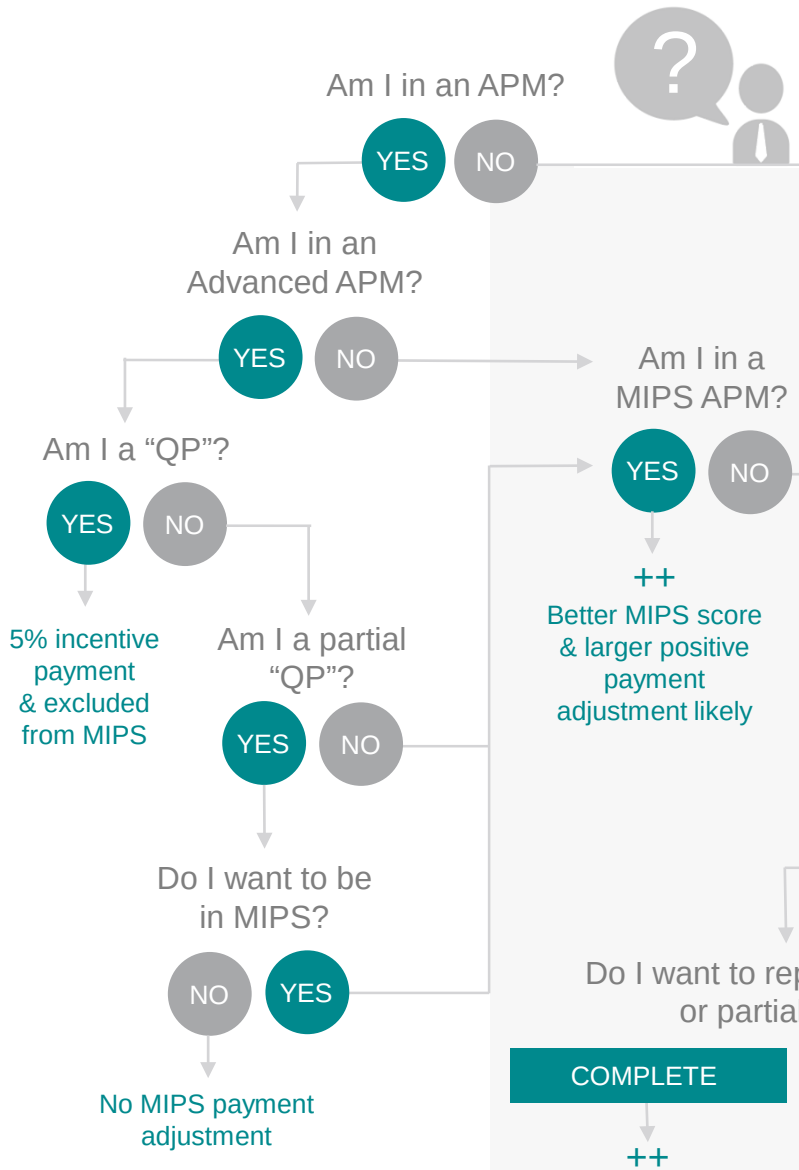
Clinicians must meet the following criteria in order to be deemed a QP:

1. They must practice within an Advanced APM
2. They must be on the Participation List of the Advanced APM Entity by August 31 of the performance year
3. All clinicians, in aggregate, in the Advanced APM Entity must meet certain practice thresholds (in 2017, at least 25% of Medicare payments or 20% of Medicare patients through the Advanced APM)

MIPS APM List:

The following models meet the criteria to be "MIPS APMs" in the 2017 performance year, offering MIPS reporting and scoring benefits to participating clinicians:

1. Medicare Shared Savings Program Track 1 ACO
2. Medicare Shared Savings Program Track 2 ACO
3. Medicare Shared Savings Program Track 3 ACO
4. Next Generation ACO
5. Comprehensive End-Stage Renal Disease Care Model
6. Oncology Care Model (one or two-sided agreements)
7. Comprehensive Primary Care Plus



MIPS Exclusions:

Aside from participating in an Advanced APM, clinicians will only be excluded from MIPS if:

1. They fall below the low-volume threshold of $30,000 in Medicare Part B allowed charges or 100 Medicare Part B beneficiaries
2. They are in their first year of participating in Medicare Part B

Reporting Considerations: Group vs. Individual Reporting?

Group:

- Significantly less reporting burden for clinicians
- Less competition within a group – all receive the same score/payment adjustment

Individual:

- For multispecialty groups, clinicians would be able to choose more tailored measures
- Each clinician possibly more inclined to “perform well”

Reporting Considerations: How/ What to Report to Maximize Score in 2017?

- Only decision that needs to be made before the reporting period: Should I/we “pick 6” or report using the CMS Web Interface?
  - Potentially more flexibility choosing 6 measures – only need 90 day period
- Should I/we submit data for 90 days or the full calendar year?
- Consider QCDRs as a reporting mechanism – emphasis on this in the legislation
  - Can report non-MIPS Quality measures in QCDRs, get easy points in Improvement Activities
- Consider how to maximize Quality score:
  - Different benchmarks for each reporting mechanism – will be published before performance year if possible
  - If a clinician/group reports data via a submission mechanism with only 1 applicable measure, the clinician/group is only responsible for that 1 measure
  - High percentage of topped out Quality measures – can report these with no penalty in transition year
- Ultimately, CMS may move towards requiring one mechanism for reporting everything

Organizational Structure Considerations

- Should you create a low-performer TIN and a high-performer TIN to motivate performance?
- Should you merge small TINs into one “super TIN” to ease burden of MIPS?
- Should you split multi-specialty TINs into smaller TINs to allow certain sub-groups of specialists to choose the measures most relevant to their practice?
  - Separate TIN for low-volume and/or non-patient-facing and/or hospital-based clinicians?
- Should you split TINs into smaller TINs for purposes of MSSP ACO participation?

Scoring in 2017: Consider a Leading Health System in an ACO…

Improvement Activities (20 points):

- Guaranteed **20 points**

Quality (50 points):

- Leading Health System mean Quality score for MSSP in 2015: 95%
- Considering bonus points, should generally score well in Quality: Assume at least 70% category score, estimated **35+ points**

Advancing Care Information (30 points):

- Positioned to score well – even those ACOs with some small practices with limited infrastructure, "core" physician groups that are likely well-prepared pull most of the weight
- Assume at least 70% category score, estimated **21+ points**

Scoring in 2017: Consider a Leading Health System "Core" Physician Group Not in an ACO…

Improvement Activities (15 points):

- Will earn **15 points**

Quality (60 points):

- If picking 6 measures, most Leading Health Systems have technical capabilities to consider benchmarks and determine high-performing measures to report
- Considering bonus points, should generally score well in Quality: Assume at least 70% category score, estimated **42+ points**

Advancing Care Information (25 points):

- Positioned to score well: assume at least 80% category score, estimated **20+ points**

So, to Maximize your MIPS Score in 2017, is it Better to be in a Well-Equipped Large Group or an ACO?

Quality for ACOs: Most ACOs anchored by Leading Health Systems performing very well in Quality; no additional reporting group for groups/clinicians

Quality for non-ACO Groups: May be easier to "control" Quality within Group—can analyze benchmarks and current performance to maximize score

Improvement Activities for ACOs: Guaranteed full credit; no reporting

Improvement Activities for non-ACO Groups: Should be able to easily earn full credit; Groups will have to report, but minimal burden

Advancing Care Information for ACOs: Group likely to score well; scores of other TINs within the ACO may bring down score slightly

Advancing Care Information for non-ACO Groups: May be easier to "control"

Major MIPS advantage to being in an ACO will come when Cost is introduced

MIPS Requirements: What Lies Ahead for the Performance Categories

Quality: Cross-cutting measures will be required within 1-2 years, more outcome measures will be required, current topped out measures will be removed, performance year will increase to full calendar year in 2018

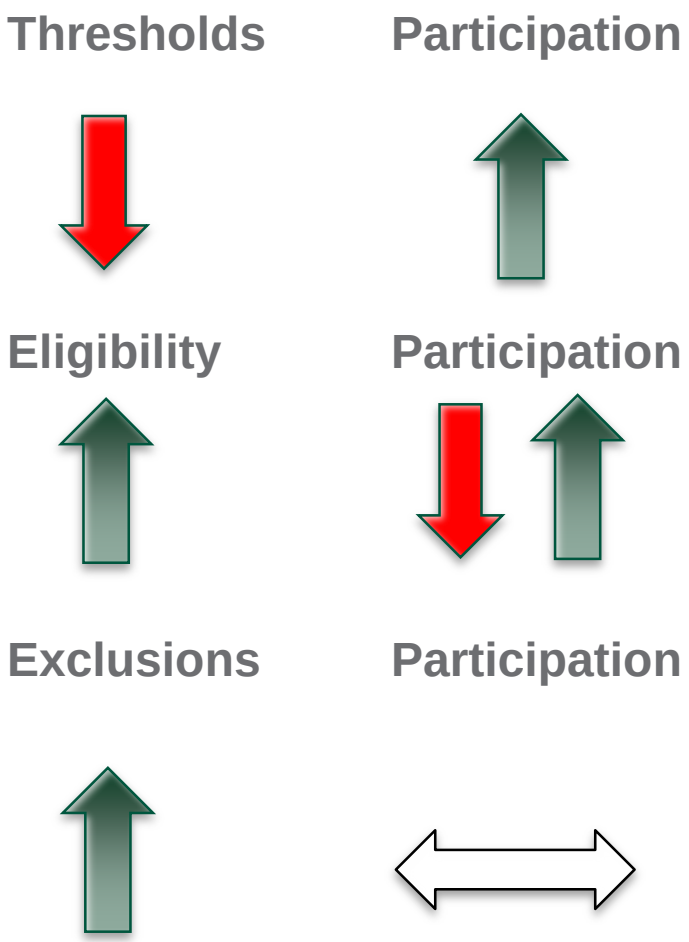
Improvement Activities: Denominator may increase, performance in activities may be measured

Advancing Care Information: Benchmarks may be established; improvement may be measured; may introduce peer group comparison; greater focus on tying patient health outcomes with the use of health IT; thresholds for group reporting whereby groups can only report as groups if ≥ 50% of eligible patient encounters are captured in CEHRT

Cost: New categories/codes, new episode-based measures

MIPS Exclusions: What Lies Ahead

- Low-volume thresholds?
  - Will be reduced over time, increasing MIPS eligible clinicians
- MIPS Participation?
  - Downward pressure over time as eligible clinicians become QPs through Advanced APM participation, but upward pressure as well, as more clinicians become MIPS-eligible beginning in 2021
- Legislative/regulatory niche exclusions?
  - Likely that additional carve-outs and re-weighting will occur for certain specialty, sub-specialty, and uniquely positioned eligible clinicians (e.g. exclusion from Advancing Care Information for eligible clinicians who practice primarily in Ambulatory Surgical Centers)



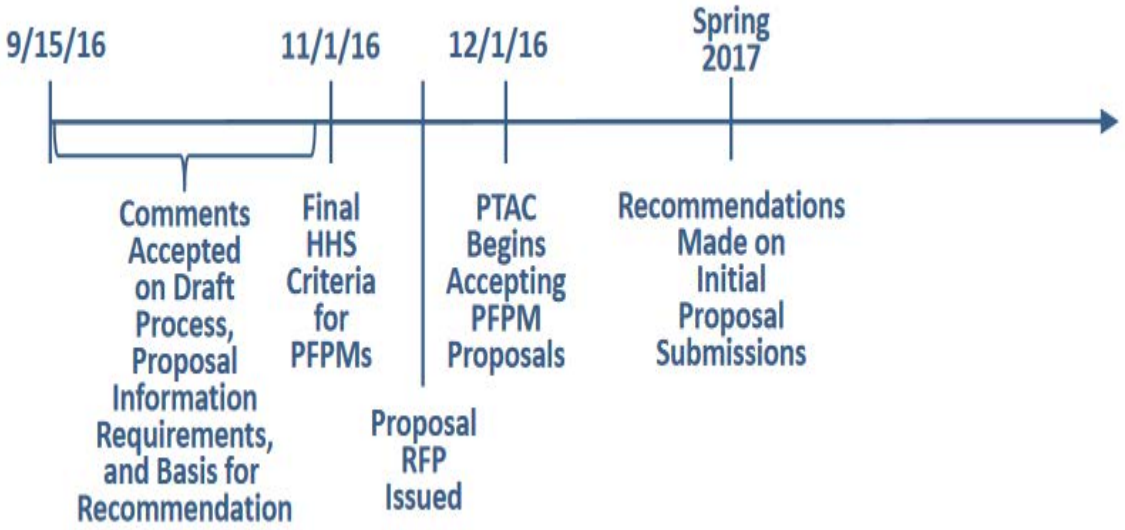
Questions For Specialists

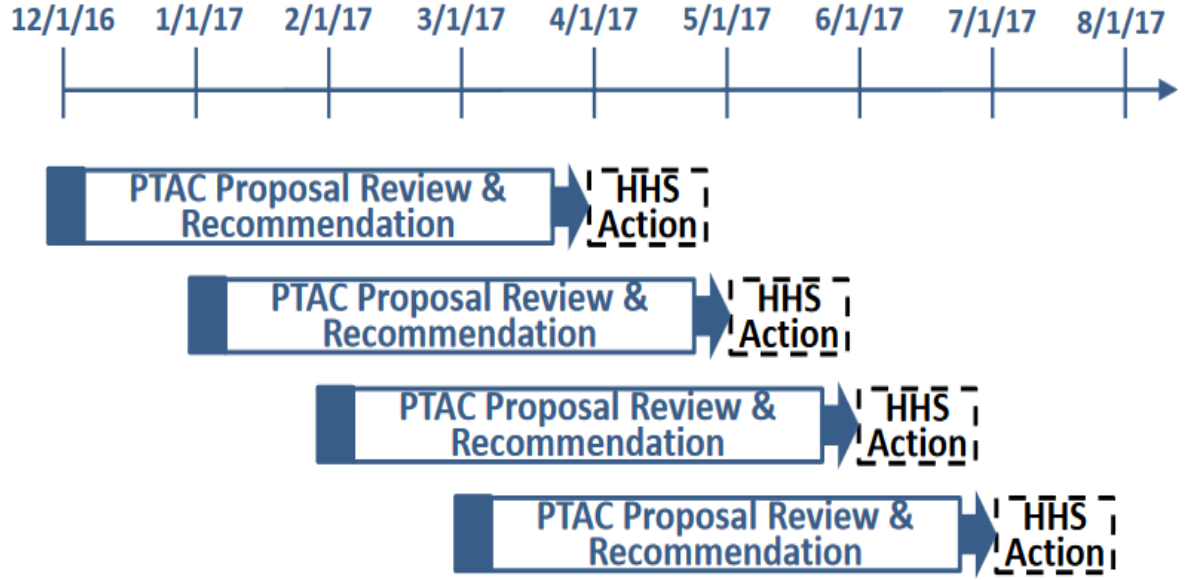
- How difficult will it be for a specialist to perform well in MIPS?
  - Ability to report is important
  - EHR use will play a critical part in maximizing performance
- How well do specialists fit in existing Advanced APM models?
  - Episode-based models/bundles more favorable, although future of these models is uncertain
- Should specialists consider developing their own specialty or episode-specific Advanced APM?
  - Yes, if possible
  - PTAC
  - Revenue-standard provides enhanced flexibility

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

- Federal advisory committee comprised of 11 members that provides independent advice to the Secretary
- PTAC will solicit input from providers and others for new payment models that can be either Advanced APMs or APMs
- Upon review, PTAC will recommend proposals to CMS for implementation testing
  - CMS is not required to accept PTAC's recommendation
  - CMS can work directly with individual stakeholders who submitted their proposals to PTAC
  - No timeline for review of PTAC recommendations

Creating An Advanced APM: PTAC Process





Source: Centers or Medicare and Medicaid Services

Creating An Advanced APM: Other Pathways

- CMMI: 19 model design factors
  - CMMI is a creation of the Affordable Care Act, its future is uncertain
- Arrangements with commercial payers and state Medicaid agencies
  - Must meet the Advanced APM criterion from the MACRA QPP final rule
- Legislation
  - Congress has shown some receptivity to considering legislative changes that would result in the creation of new payment models

Advanced APM Checklist

- ✓ Composition
  - Determination of which eligible clinicians should participate in an Advanced APM to maximize performance under both the Advanced APM model and MACRA
- ✓ Partial Qualifying Participant election
  - Tracking MIPS performance and focusing on specific measures throughout the year if it is likely that a MIPS election will be made
- ✓ APM Incentive Distribution
  - With APM incentive payments made to TINs, an allocation structure must be determined in advance
- ✓ 2019—Other-Payer APM Strategy
  - A strategy should be developed in 2017 to be prepared for 2019 deployment
- ✓ Overlapping model interplay
  - Specifically, the interplay between ACOs and all other APMs

Disclosure

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December 2016