Preparing for Regulatory Disruption: Overview and Implications of MACRA

January 2017
Today’s Discussion on the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

1 Post Election Health Care Implications
2 Overview of MACRA
3 Overview of the Quality Payment Program (QPP)
4 MIPS (Merit-based Incentive Payment System)
5 APMs (Alternative Payment Models)
6 Perspectives and Next Steps
Post-election Health Care Implications
Critical health care issues on the horizon

Governing Agenda
How will President-elect Trump and Congress prioritize and approach health care among competing governing interests? Will they pursue programmatic changes to Medicaid? To Medicare? Legislation or regulations aimed at drug prices?

Affordable Care Act (ACA)
How will congressional rules and procedural requirements affect legislative efforts to repeal the ACA? What regulatory changes to the ACA will the new Administration pursue?

Tax reform
Will Congress seek to use tax reform to enact alternative health care policies? Will Congress advance changes to the tax preferences for employer-sponsored coverage?

The role of the states
How will the Trump Administration approach state applications for Medicaid waivers and Innovation Waivers under the ACA? What policies will states pursue as the Trump administration and Congress seek to give them greater authority over health care?

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 Medicare and Medicaid Innovation (CMMI)?

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

<table>
<thead>
<tr>
<th>Employer-Sponsored coverage</th>
<th>Medicare (Part A)</th>
<th>Medicaid and CHIP</th>
<th>Uninsured</th>
<th>Nongroup and other coverage</th>
<th>ACA Exchanges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016</strong> (Change in enrollment from the ACA)</td>
<td>155 (-2)</td>
<td>66 (N/A*)</td>
<td>68 (+13)</td>
<td>27 (-22)</td>
<td>9 (-2)</td>
</tr>
<tr>
<td><strong>2026</strong> (Change in enrollment from the ACA)</td>
<td>152 (-9)</td>
<td>83 (N/A*)</td>
<td>71 (+19)</td>
<td>28 (-24)</td>
<td>7 (-4)</td>
</tr>
</tbody>
</table>

*Changes under the ACA are minimal for individuals under age 65 and numbers are included in “Nongroup and other coverage”


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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.


*Alaska, California and Hawaii have submitted applications for State Innovation Waivers under Section 1332 of the ACA. CMS has approved Hawaii’s waiver.

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## Key dates for Congress and the incoming Administration

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 3</td>
<td>House and Senate scheduled to convene for 115th Congress</td>
</tr>
<tr>
<td>January 20</td>
<td>Presidential inauguration</td>
</tr>
<tr>
<td>January 27</td>
<td>Deadline for certain congressional committees to report ACA repeal legislation</td>
</tr>
<tr>
<td>Week of February 13</td>
<td>Expected release of draft Medicare Advantage call letter for plan year 2018</td>
</tr>
<tr>
<td>March 15</td>
<td>Federal debt ceiling comes back into effect</td>
</tr>
<tr>
<td>First week of April</td>
<td>Expected release of final Medicare Advantage call letter for FY 2018</td>
</tr>
<tr>
<td>April 1</td>
<td>Deadline for Senate Budget Committee to approve a fiscal 2018 budget resolution</td>
</tr>
<tr>
<td>April 15</td>
<td>Deadline for Congress (House and Senate) to adopt a budget resolution; no penalty for missing the deadline</td>
</tr>
<tr>
<td>April 28</td>
<td>Expiration of continuing resolution to fund the federal government</td>
</tr>
</tbody>
</table>

*Source: Deloitte Advisory Regulatory Services for Life Sciences and Health Care*
Timeline of major legislative and regulatory events: 2017–2028

- **2017**
  - **Dec 31**: Statutory deadline for achieving national priority of widespread interoperability of Electronic Health Records (EHRs)

- **2018**
  - **Jan 1**: Start of first performance period for 2019 payment adjustments under MIPS and APMs
  - States may seek Innovation Waivers under the ACA for alternative coverage models
  - Beginning of one-year moratorium for ACA’s health insurer fee

- **2019**
  - **Sep 30**: Funding for Children’s Health Insurance Program (CHIP) expires
  - Expiration of life sciences user fee agreements with FDA
  - **Dec 31**: End of two-year moratorium on medical device excise tax

- **2020**
  - **Jan**: First Medicare payment adjustments under MIPS and APMs
  - **Jan**: Tax on high cost employer-sponsored health coverage (“Cadillac” tax) takes effect
  - Payment rates under the Medicare PFS frozen through 2025
  - Federal contribution for newly eligible Medicaid beneficiaries decreases to 90%
  - **Jan**: Payment adjustments under APM Other Payer Model takes effect

- **2021**
  - **Jan**: Revenue threshold for bonuses and payment updates through eligible APMs increases to 75%
  - **Jan**: Revenue threshold for bonuses and payment updates through eligible APMs increases to 75%

- **2022**
  - **Jan**: MIPS Payment Adjustment Increases to +/-9% for 2022 and subsequent years

- **2023**
  - **Jan**: Revenue threshold for bonuses and payment updates through eligible APMs increases to 75%

- **2024**
  - **Dec 31**: Medicare bonuses under MIPS and APMs expire

- **2025**
  - **Jan**: Permanent payment updates under Medicare Access and CHIP Reauthorization Act (MACRA) take effect: 0.75% for professionals paid through eligible APMs, and 0.25% for MIPS participants

- **2026**
  - **Dec 31**: End of reduction to Medicare payments to health care providers and plans under sequestration

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

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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: 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 SGR formula, MACRA sets updates to the Medicare Physician Fee Schedule (PFS) 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.
What does President-elect Trump mean for MACRA?
At nearly 2,400 pages it contains upcoming deadlines, reporting requirements, and commentary from key stakeholders.

"We are encouraged by CMS's effort to coordinate reporting periods across federal programs and the decision to align with the ONC Interoperability and Certification Programs."  
Heathcare Management and Information Systems Society

"Last month, we applauded CMS for listening to physicians' concerns when writing the regulations, and we look forward to engaging with the new administration and Congress on future implementation work. As MACRA is established law and goes into effect Jan. 1, the American Medical Association will continue to work with the incoming administration to ensure that physicians succeed under its implementation."  
Dr. Andrew Gurman, president of the American Medical Association

"It's disappointing that flexibility provided for quality reporting in 2017 largely disappears in 2018 and beyond. [CMS] missed an opportunity to close the two-year gap between the measurement and payment periods, which would facilitate improved patient care by providing actionable feedback to physicians and more timely incentives."  
MGMA

"We appreciate the need to ease the initial reporting requirements for this historic move to paying clinicians for the value rather than simply the volume of care they deliver. However, this will result in a less robust assessment of quality on which payments are based, and we encourage CMS to revisit and raise standards for MACRA in future rule making."  
NCQA's Paul Cotton

"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."  
Helen Darling, interim president and CEO of the National Quality Forum

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Payment basics under MACRA

MACRA replaces the SGR formula for payments under the Medicare Physician Fee Schedule (PFS) with fixed annual payment updates for all years in the future.

**MACRA creates separate paths for payments under the Medicare Physician Fee Schedule:**

**Advanced Alternative Payment Models (APMs)**

- From 2019-2024, **lump sum payments** equal to 5% of all reimbursement for services rendered under the Medicare PFS.
- Beginning in 2026, annual payment updates of **0.75%** to the Medicare PFS.
- CMS has indicated which Accountable Care Organizations (ACOs) and models under the Center for Medicaid and Medicare Innovation will likely be considered Advanced APMs.

**Merit-based Incentive Payment System (MIPS)**

- For 2019 and subsequent years, **positive or negative** payment adjustments based on clinicians’ performance relative to scores of their peers across four categories: quality, cost, clinical performance improvement activities, advancing care information.
- Beginning in 2026, annual payment updates of **0.25%** to the Medicare PFS.
- Eligible clinicians who do not achieve the APM revenue or patient thresholds will participate in MIPS and be subject to certain reporting requirements.

**Beginning in 2019, clinician Medicare payment adjustments each year will depend on which track the clinician’s medical group falls into.**

Source: Public Law 114-10 (April 16, 2015)
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)
Alternative Payment Models (APMs)
Merit-Based Incentive Payment System (MIPS)

Source: Public Law 114-10 (April 16, 2015)
*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.
Clinicians eligible to participate in Advanced APMs and MIPS

A narrower group of clinicians will initially be eligible for payment adjustments under MIPS than will be eligible to participate in the APM track.

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**Advanced Alternative Payment Models (APMs)**

- 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

**Merit-based Incentive Payment System (MIPS), 2019–2020**

- Physicians*
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

*Participation may be expanded to other professionals paid under the Physician Fee Schedule in subsequent years.*

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*Physician, 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.

Source: Public Law 114-10 (April 16, 2015)
Timeline for MACRA implementation

- **Centers for Medicare & Medicaid Services (CMS) released final rule on MIPS, APM incentives.**
  - Oct 14, 2016
- **Start of first performance period for 2019 payment adjustments under MIPS/APMs.**
  - Nov 9, 2016
  - Jan 1, 2017
- Expected due date for letters of intent for certain AAPMs available in 2018.
  - April 2017
- **Date for HHS to begin providing confidential performance reports to MIPS-eligible clinicians on the individual’s performance on quality and cost.**
  - Apr 10, 2017
  - Jul 1, 2017
- **Cost begins to factor into MIPS performance score.**
  - Dec 14, 2017
  - Jan 1, 2018
- **MIPS adjustment announced for 2019.**
  - Jul 1, 2018
  - Aug 1, 2018
- **Date for HHS to begin providing confidential performance reports to MIPS-eligible clinicians on the individual’s performance on quality and cost.**
  - Jul 1, 2018
  - Aug 1, 2018
- **Start of first performance period for 2021 payment adjustments, including through Other Payer APMs.**
  - Dec 2, 2018
  - Dec 31, 2018
  - Jan 1, 2019

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

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

**Strategic/Competitive**
- Prioritizes strategic physician acquisition/growth decisions related to 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)

**Reputational**
- MIPS Composite Performance Score (CPS) results will be made public and transparency will expose the good and the bad

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

**Patient Engagement**
- Greater coordination of care and two-sided risk for health care providers will raise the stakes for health care providers to foster closer ties with patients and help them actively manage their health

**Clinician Engagement**
- Relationships/Partnerships/Arrangements will need to evolve in order to attract, retain, evaluate and optimize
Strategic activities timeline based on key regulatory dates
The new MACRA law significantly impacts a number of key areas across health care provider organizations

Today

- **Jan. 1, 2017**
  - Beginning of first performance period

- **Jan. 2, 2018**
  - Beginning of first reporting period

- **Jan. 1, 2019**
  - First payment adjustments under MIPS and APMs; Beginning of All-Payer performance period

- **Jan. 1, 2021**
  - All-Payer Model for APM thresholds under MACRA take effect

1. **MIPS Readiness**
2. **Advanced APM Strategy**
3. **Participation in all-Payer Combination Option** (e.g., Medicare Advantage, Medicaid, Commercial)

Source: Public Law 114-10 (April 16, 2015)
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.
- CMS provided greater detail on changes intended to provide greater flexibility for clinicians to participate in MIPS at different levels in 2017.
- 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 Advancing Care Information (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 also was simplified.
- The final rule retains reporting advantages for clinicians who participate in MIPS APMs.
- The final rule weights Cost at 0% for the 2017 performance period. The weight will increase to 10% for 2018, and to 30% in 2019.

### 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 MIPS reporting.

### Advanced APMs

- The final rule retains 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 (Medicare ACO Track 1+) to offer a pathway 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.

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The final rule aims to provide more options for provider organizations to participate in MACRA in 2017.

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

Estimated MIPS Eligibility*

*CMS estimates that nearly 200,000 clinicians (14.4%) will not be considered an eligible type of clinician, 380,000 (32.5%) to be exempted based on the low-volume threshold, and between 70,000 and 120,000 clinicians (approximately 5-8 percent) due to participation in an Advanced APM. For the purposes of the chart above, we averaged 5 and 8 to get our APM exemption percentage.

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
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 Quality Payment Program for the 2017 performance year

Note: CMS counts clinicians as unique combinations of Tax Identification Number (TIN) and National Provider Identifier (NPI).
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 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.

<table>
<thead>
<tr>
<th>Advanced Alternative Payment Models (APMs)</th>
<th>Merit-Based Incentive Payment System (MIPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated 70,000 - 120,000</td>
<td>Estimated 592,000 - 642,000</td>
</tr>
<tr>
<td>Estimated $333 million – $571 million</td>
<td>+/- $199 million</td>
</tr>
</tbody>
</table>

**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
CMS Illustrative example: how the payment adjustment will work

The performance threshold is akin to the "pass/fail" score for MIPS – clinicians with lower scores will get negative adjustments, higher scores get positive adjustments.

The additional performance threshold is the score MIPS eligible clinicians need to achieve to qualify for additional payment adjustment factors for exceptional performance.

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
Overview of MIPS – including changes to the 2017 transition year

The Final Rule weights 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.

### Components of MIPS Composite Performance Score (CPS)

<table>
<thead>
<tr>
<th>Performance Periods</th>
<th>Quality</th>
<th>Cost</th>
<th>Advancing Care Information</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>60%</td>
<td>0%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>30%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>2019</td>
<td>30%</td>
<td>30%</td>
<td>25%</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Overview of General MIPS Reporting Requirements for 2017 Performance Year

**Quality**
- Replaces the Physician Quality Reporting System (**PQRS**)
- Report up to **six measures** – including an outcome measure – for a minimum of 90 days

**Cost**
- Replaces **Value-based Modifier**
- **Calculated from claims**; no data submission required
- Counted in score beginning in 2018

**Advancing Care Information**
- Replaces Medicare Electronic Health Records (**HER Incentive Program for Providers** (**Meaningful Use**)
- Report **five required measures** for a minimum of 90 days
- Submit up to nine measures for a minimum of 90 days for **additional credit**

**Improvement Activities**
- Attest to completion of up to **four activities** for a minimum of 90 days
- Special consideration for smaller practices, patient-centered medical homes and certain APMs

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

**QUALITY**

- **Outcome:** *Diabetes: HbA1c Poor Control (> 9%):* % of pts 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
- **Cross-cutting:** *Controlling: High Blood Pressure:* % of pts 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period
- **Process:** *Preoperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:* % of surgical patients aged 18 years & older undergoing procedures with the indications for a 1st OR 2nd generation cephalosporin prophylactic antibiotic, who had an order for a 1st OR 2nd generation cephalosporin for antimicrobial prophylaxis

**COST**

- **Breast:** *Mastectomy for Breast Cancer:* episode is triggered by a patient’s claim with any of the interventions assigned as Mastectomy trigger codes
- **Cardiovascular:** *Acute Myocardial Infarction (AMI) without PCI/CABG:* episode is triggered by an inpatient hospital claim with a principal diagnosis of any AMI trigger code
- **Cerebrovascular:** *Ischemic Stroke:* episode is triggered by an inpatient hospital claim with a principal diagnosis of any StrokIsc trigger codes
- **Neurology:** *Parkinson Disease:* episode is triggered by two (2) Evaluation & Management codes (E&Ms) with a principal or secondary diagnosis of any Parkinsons trigger code occurring within 30 calendar days

**ADVANCING CARE INFORMATION**

- **Protect Patient Health Information:** Attest yes that a security risk analysis has been conducted during the performance period
- **Electronic Prescribing:** % of prescribed medications that queried a drug formulary and were electronically transmitted during the performance period
- **Provide Patient Access:** % of patients provided access to view, download or transmit their health information online

**IMPROVEMENT ACTIVITIES**

- **Expanded Practice Access:** Provide 24/7 access to MIPS Eligible Clinicians (ECs), groups, or care teams for advice about urgent & emergent care
- **Population Management:** Use of a qualified clinical data registry (QCDR) to generate regular feedback reports that summarize local practice patterns & treatment outcomes
- **Care Coordination:** Participation in the CMS Transforming Clinical Practice Initiative

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

Any clinician who is not eligible for MIPS has the option to volunteer to report on applicable measures and activities under MIPS; however, these clinicians will not receive a MIPS payment adjustment.
Who is eligible to participate in MIPS?

Unless they meet one of the following criteria:

1. **New Medicare-enrolled eligible clinicians**
   - Newly enrolled in Medicare during the performance period
   - Did not previously submit Medicare claims as an individual, an entity, part of a physician group or under a different TIN

2. **Qualifying (QP) & Partial Qualifying (Partial QP) APM Participants**
   - Partial QPs 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

3. **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 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>
<tr>
<td>100 Medicare Patients</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 threshold

**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**

**OR**

**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).
Group Reporting / Scoring Under MIPS

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

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. C  65
Dr. B  65  Dr. D  65

Group reporting requires data to be aggregated (i.e. TIN numerator and TIN denominator) for all performance categories

Quality Measure 1: 400/550
Quality Measure 2: 332/480
Quality Measure 3: 120/130
Quality Measure 4: 535/600
Quality Measure 5: 225/300
Quality Measure 6: 100/110

Data is converted to a group composite score

65
## MIPS Performance Category Measures and Activities

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

### Individual Reporting Mechanisms

<table>
<thead>
<tr>
<th>Quality</th>
<th>Clinical Practice Improvement Activity (CPIA)</th>
<th>Advancing Care Information</th>
<th>Resource Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>* ✓</td>
<td>* ✓</td>
<td>✓</td>
<td>X</td>
</tr>
</tbody>
</table>

- **Claims**
- **QCDR**
- **Qualified registry**
- **EHR**
- **Administrative Claims***

- **Attestation**
- **QCDR**
- **Qualified registry**
- **EHR**
- **Administrative Claims***

- **Attestation**
- **QCDR**
- **Qualified registry**
- **EHR**

- **Calculated using administrative claims data**
- **No submission required**

### Group Reporting Mechanisms

- **QCDR**
- **Qualified registry**
- **EHR**
- **CMS Web Interface (groups of 25 or more)**
- **CMS approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism)**
- **Administrative Claims***

- **Attestation**
- **QCDR**
- **Qualified registry**
- **EHR**
- **CMS Web Interface (groups of 25 or more)**
- **Administrative Claims***

- **Attestation**
- **QCDR**
- **Qualified registry**
- **EHR**
- **CMS Web Interface (groups of 25 or more)**

- **Calculated using administrative claims data**
- **No submission required**

*No data submission requirements for certain measures performance on the quality performance category and for certain activities in the CPIA performance category, CMS will use administrative claims data to calculate performance on this subset of the MIPS quality and CPIA performance categories.*
Pick your pace for Performance Year 1

CMS 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

<table>
<thead>
<tr>
<th>Negative 4% payment adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>No MIPS performance data submitted to MIPS</td>
</tr>
</tbody>
</table>

**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**

Average to high overall performance across the three categories for at least a 90-day period; MIPS eligible clinicians who receive a final score at or above the additional performance threshold will receive an additional adjustment.

### MIPS Adjustment Factors Based on Final Scores

- **Performance Threshold = 3**
- **Threshold for Additional Adjustment Factor = 70**

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

### Anticipated Available for 2017

1. MSSP Track 2
2. MSSP Track 3
3. Next Generation Accountable Care Organization (ACO) Model
4. Comprehensive Primary Care Plus (CPC+)
5. Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model - Large Dialysis Organization (LDO) arrangement
6. Comprehensive ESRD Care Model - non-LDO arrangement
7. Oncology Care Model (OCM) two-sided risk arrangement

### Anticipated Available Beginning 2018

1. Medicare ACO Track 1+
2. Acute Myocardial Infarction (AMI)* Bundle
3. Coronary Artery Bypass Graft (CABG)* Bundle
4. Surgical Hip/Femur Fracture Treatment (SHFFT)* Bundle
5. New Future Episode Payment Model based on Bundled Payment for Care Improvement (BPCI)*
6. Comprehensive Care for Joint Replacement (CJR)* Bundle

### 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 reopen in 2017 for 2018.
- **Additional Options:** The Physician-Focused Payment Technical Advisory Committee (PTAC) plans to open the proposal process December 1, 2016.

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*To qualify as an Advanced APM, participants must opt into Track 1 of each bundled payment model, requiring the use of Certified Electronic Health Record Technology.

**Source:** CMS, Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) (July 2016), CMS, 2016 Fact Sheet: The Quality Payment Program (October 25, 2016)
APM incentive payments
Organizations will need to have increasing percentages of physician portfolios in Advanced APMs over time

**QP Payment Amount Thresholds**

- **Qualifying Participant**
- **Partial Qualifying Participant**

**QP Patient Count Thresholds**

- **Qualifying Participant**
- **Partial Qualifying Participant**

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

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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 Qualifying Participant (QP) in an APM Entity Group.

2017 QP Performance Period

- **Snapshot #1**: March 31, 2017
- **Snapshot #2**: June 30, 2017
- **Snapshot #3**: 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.

Source: Final Rule with Comment Period on Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive (November 4, 2016)
## 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>• 8% of average estimated total Part A and B revenue of participating APM entities</td>
<td>• 3% of all expenditures for which an APM entity is responsible</td>
</tr>
<tr>
<td>• No marginal risk or minimum loss ratio</td>
<td>• Available for all performance years</td>
</tr>
<tr>
<td>• Available for performance years 2017 and 2018; will increase for the third and subsequent performance years</td>
<td></td>
</tr>
</tbody>
</table>

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)

**Source:** CMS, Proposed Rule: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)
In order to achieve Qualifying Participant (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.

Fee For Service (FFS)
* CMS also allows for APM Entities to achieve QP Status through an Advanced APM using the patient count method.

Source: Public Law 114-10 (April 16, 2015)
Arrangement of Clinicians in Advanced APMs

CMS determines which APMs qualify as Advanced APMs and which Advanced APM Entities meet thresholds to qualify for Advanced APM Incentive Payments.

Advanced APMs meet the three requirements: 1) require use of a certified EHR; 2) tie payment for covered services to quality measures similar to those under MIPS; 3) be a Medical Home or bear more than nominal risk for monetary losses. Clinicians who meet thresholds for revenue or patients through an Advanced APM qualify for APM Incentive Payments.

Advanced APM Entities are groups of clinicians that meet the required Advanced APM thresholds. One health system may have multiple Advanced APM Entities depending on the arrangements in which their clinicians participate. One Advanced APM entity may include physicians that participate in multiple Advanced APMs.

Clinicians who meet revenue or patient attribution thresholds through one or more Advanced APMs are excluded from MIPS and qualify for Advanced APM Incentive Payments. Qualifying participants can participate in one or more Advanced APMs through one or more Advanced APM entities.
APM participation is not an all or nothing proposition. Eligible Clinicians who do not meet QP thresholds may still be excluded from MIPS or receive bonus points or additional benefits within MIPS.

*MIPS Eligible Clinicians who participate in APMs may not be subject to quality and resource use scoring categories, resulting in an adjustment of their CPS weighting.
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)
Advanced APMs
The Final Rule reiterates 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 groups 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 MAO 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. "In essence, the "All-Payers Combination Option” creates a new incentive for providers 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. Greater adoption of APMs outside of Medicare FFS is a priority.

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.

What does this mean for our Medicare Advantage business?

Which physicians are likely to perform well under risk-based contracts and MIPS?

What does the future provider-plan relationship look like?

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?

Into which Advanced APM’s should we move and in which performance year?

Do we need to re-examine all of our joint ventures?

What does this mean for our Medicare Advantage business?
MACRA - Five Key Considerations

**Complexity - Comprehensive Proposed Rule**
On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released a comprehensive proposed rule on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the law. The proposed rule details the complex interactions of existing programs, as well as new focus on cost and quality under new payment tracks.

**Urgency - Performance Period Starts January 1, 2017**
The Administration proposes using January 1, 2017 as the beginning of the performance period for clinicians for payment adjustments occurring in 2019, leaving less than six months to prepare. All clinicians will report through MIPS during the first reporting year.

**Financial Impact - Need to think beyond Medicare**
MACRA is poised to accelerate the move toward risk-bearing, coordinated care models in Medicare, Medicaid and the commercial markets. Health systems and providers will need to evaluate how the shift of patients and revenue to risk-based contracts will change their financial projections.

**Strategic and Tactical Decision Making (short, medium and long term)**
Health systems will face a long list of strategic and tactical decisions in the face of the new requirements of MACRA and the ensuing changes in local health care markets. To maximize prospects of performing well under the new payment tracks, health systems will need to evaluate key functions of their organization, ranging from tax structure of employed clinician groups to clinical IT infrastructure, to changes to care delivery and coordination.

**Heavy Lifting Needed - Implementation of Change at System, Regional and Local level**
Leaders of geographically diverse health systems will face unique challenges as they execute their MACRA strategies over time. Recognizing the unique dynamics and stakeholders of regional and local health care markets, health system leaders will need to provide for varied approaches to implementing changes and operationalizing the system’s MACRA strategy.
Journey for Health Systems: Devising a “No Regrets” Strategy

MACRA accelerates the directional journey we are on from volume to value

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.
Smart next steps

1. **Begin internal discussions** with key enterprise stakeholders (including potentially the board of directors) on forthcoming MACRA impacts.

2. **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.

3. **Plan and prepare for tactical changes and/or enhancements** associated with **MIPS readiness** particularly given the Performance Range began January 1, 2017.

4. **Make informed, strategic choices** around moving in a swift and responsible manner towards **Advanced APMs** and Other Payer Advanced APMs.
Claudia Douglass
Managing Director | Deloitte 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 in both consulting 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 leadership at professional conferences. Claudia is a Fellow in the American College of Healthcare Executives and certified in project management as a Project Management Professional. She holds a B.B.A. in Finance and Marketing from the University of Miami and a Master of Health Services Administration degree from the University of Michigan.

Education

- B.B.A., Finance and Marketing - University of Miami
- Master of Health Services Administration - University of Michigan