MACRA and the Future of Physician Payment
What Medical Group and System Executives Need to Know

MACRA and the Future of Physician Payment
What Health System and Medical Group Executives Need to Know
Election 2016 and the Emergence of TrumpCare

MACRA: The End of Fee for Service?

New Pathways to Risk in Specialty and Primary Care

Congratulations, Mr. President

Trump Wins in Stunning Upset

Congress and Executive Branch Now in Republican Control

51-52/100
Senate Republicans

236/435
House Republicans

Source: Health Care Advisory Board interviews and analysis.
Health Care Back at the Top of the Agenda

Health Care Industry Unexpectedly Facing Newfound Uncertainty

Seeking Immediate Change

“We’re not going to have a two-year period where there’s nothing. It will be repealed and replaced…And it’ll be great health care for much less money.”

President-Elect Donald Trump

GOP Victory Sparks Investor Concerns with Health Plans, Providers

Change in Stock Price, Nov 9th, 2016

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Change in Stock Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centene Corp.</td>
<td>(19%)</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>(16%)</td>
</tr>
<tr>
<td>Tenet Healthcare</td>
<td>(23%)</td>
</tr>
<tr>
<td>CHS</td>
<td>(21%)</td>
</tr>
<tr>
<td>HCA</td>
<td>(11%)</td>
</tr>
</tbody>
</table>

Meet the Nominees

President-Elect Trump Selects Health Policy Team

**HHS Secretary:** Rep. Tom Price

- Six-term Representative from Georgia and current chairman of House Budget Committee; retired orthopedic surgeon
- Sponsor of the Empowering Patients First Act, a proposed GOP alternative to the ACA

**CMS Administrator:** Seema Verma

- National health policy consultant from Indiana
- Helped shape Medicaid expansion in IN, OH, KY, TN including implementation support through federal waivers

Together, Chairman Price and Seema Verma are the dream team that will transform our healthcare system.”

President-Elect Donald Trump
### Ryan’s Plan Adheres to Traditional Conservative Aims

**“A Better Way” Plan Likely to Form Basis of Republican Policies**

#### Comparison of Ryan Plan to ACA Provisions

<table>
<thead>
<tr>
<th>Insurance Market Regulation</th>
<th>Ryan Proposals</th>
<th>Change from ACA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Preserve pre-existing coverage protections <em>if</em> individual maintains continuous coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preserve ability for children to remain on parents’ plans through age 26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fund state-run high risk pools</td>
<td>Largely maintains ACA-based reforms</td>
</tr>
<tr>
<td>Medicaid Reform</td>
<td>• Allow states to choose between two funding options:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Per capita allotment of funds similar to managed care plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Block grant so state can implement customized program</td>
<td>Significant shift from status quo with states granted flexibility to change benefit design, reduce coverage</td>
</tr>
<tr>
<td>Medicare Reform</td>
<td>• Combine Medicare Parts A and B</td>
<td>Shift from delivery system reform focus to consumer purchasing in Medicare population</td>
</tr>
<tr>
<td></td>
<td>• Increase eligibility age to 67</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Create a “Medicare Exchange” with traditional and private plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeal IPAB, CMMI, and ACA-mandated cuts to MA</td>
<td></td>
</tr>
<tr>
<td>Affordability</td>
<td>• Expand availability of HSAs</td>
<td>Supports low-income beneficiaries through tax credits instead of subsidies and supports greater consumer-driven health care</td>
</tr>
<tr>
<td></td>
<td>• Provide tax credits toward purchase of coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cap tax exclusion of employer-provided health benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Allow purchase of insurance across state lines</td>
<td></td>
</tr>
<tr>
<td>Innovation</td>
<td>• Reform FDA processes</td>
<td>Largely consistent with Obama-era initiatives</td>
</tr>
<tr>
<td></td>
<td>• Boost NIH funding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Encourage interoperability</td>
<td></td>
</tr>
</tbody>
</table>

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### Unclear Future for CMMI

#### Reviewing CMMI’s Role

- **Test new payment and service delivery models**
- **Evaluate results and advance best practices**
- **Upon validation and proven cost savings, expand to broader Medicare program**

#### Congress Seeking Control

“The broad powers vested in CMMI, and the agency’s interpretation of that authority, have the potential to further degrade Congress’s lawmakers’ authority by shifting decision-making away from elected officials into the hands of unelected bureaucrats.”

*Representative Tom Price (R-GA)*

*Chairman of the House Budget Committee*

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Approaching a Critical Decision Point

Congress Choosing Between Payment Reform and Payment Cuts

**Continue Payment Reforms**
Providers accept alternative payment models and move rapidly away from fee-for-service status quo

**Shift to Payment Cuts**
Providers remain in fee-for-service but face ever-more stringent reimbursement cuts

**Strategic Imperatives**
- Radical cost-efficiency
- Asset and service rationalization
- Fixed cost restructuring

The Next Era of Health Care Reform

Four Key Principles Likely to Guide GOP Reform Efforts

1. **Reduce Federal Entitlement Spending**
   More assertive focus on reduction in federal health care spending

2. **Devolve Health Policy Control to States**
   Reduce federal role in health care, provide states more autonomy to make decisions, cut spending

3. **Embrace Free Markets and Consumer Choice**
   Usage of free-markets to promote private sector competition in payer, provider markets

4. **Promote Transparency of Cost and Quality**
   Mandate greater consumer choice and shopping at the point-of-care and point-of-coverage through improved transparency
MACRA Overview

**MACRA\(^1\): The Law That Repealed The SGR\(^2\)**

Law Locks in Low Rates and Creates Two-Track Quality Incentive Program

**New CMS Quality-Based Payment Programs**

<table>
<thead>
<tr>
<th>Merit-based Incentive Payment System (MIPS)</th>
<th>Alternative Payment Models (APM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance based on 4 categories:</strong></td>
<td><strong>Financial incentives:</strong></td>
</tr>
<tr>
<td>Quality, Resource use, ACI(^3), CPIA(^4)</td>
<td>5% annual bonus in 2019-2024, and 0.75% annual payment increase from 2026 on</td>
</tr>
</tbody>
</table>

**MACRA-in-Brief**

- Legislation passed in April 2015 that repealed the Sustainable Growth Rate (SGR)
- Locks Medicare Part B payment rates at near-zero growth
- Stipulates development of two new Medicare payment tracks
- Extra $500M for exceptional performers under MIPS; APM bonuses estimated from $146M-$429M

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\(^1\) Medicare and CHIP Reauthorization Act.
\(^2\) Sustainable Growth Rate.
\(^3\) Advancing Care Information (i.e., EHR use).
\(^4\) Clinical Practice Improvement Activities.
Strong Bipartisan Support for MACRA Persists

Repeal or Perpetual Delays Unlikely—Safest Bet on Implementation

Legislation Enjoyed Bipartisan Support

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

Legislation Enjoyed Bipartisan Support

Senate vote in favor of MACRA

92-8

House vote in favor of MACRA

392-37

A Sweeping Impact Across Providers

Who’s Included and Who’s Exempt

Included

Medicare Physician Fee Schedule

Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists

Groups that include any of the above clinicians

Excluded

Inpatient Prospective Payment System, Outpatient Prospective Payment System (mostly Medicare Part A)

Clinicians, groups that fall under low volume threshold:
• $30,000 or less in Medicare charges, OR
• 100 or fewer Medicare patients

Providers in their first year billing Medicare

MACRA is to care delivery reform what the ACA\(^1\) was to coverage reform.”

Andy Slavitt, CMS Acting Administrator


#1: Majority of clinicians impacted, and thus should take notice

712,000

Estimated number of clinicians affected by MACRA changes in first performance year

Source: CMS; Advisory Board Company interviews and analysis.

1) Affordable Care Act.
Regardless of Track, Baseline Payment Holds Steady

Effective Payment Rates Depend on Track, Performance

Annual Provider Payment Adjustments

<table>
<thead>
<tr>
<th>MIPS Bonuses/Penalties</th>
<th>APM Bonuses/Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>+/-4%</td>
<td>5%</td>
</tr>
<tr>
<td>+/-9%</td>
<td></td>
</tr>
<tr>
<td>Annual adjustment, 2019</td>
<td>Annual lump-sum bonus from 2019-2024 (plus any bonuses/penalties from Advanced Payment Models themselves)</td>
</tr>
<tr>
<td>Annual adjustment, 2022</td>
<td></td>
</tr>
<tr>
<td>$500M</td>
<td></td>
</tr>
</tbody>
</table>

Additional bonus pool for high performers

**Baseline payment updates**:
- **2015 – 2019**: 0.5% annual update (both tracks)
- **2020 – 2025**: Payment rates frozen (both tracks)
- **2026 onward**: 0.25% annual update (MIPS track) 0.75% annual update (Advanced APM track)

**Advanced APM Track**

**MIPS Track**

---

**Source**: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.

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Most Providers Will Not Qualify Initially for APM Track

High Bar for Qualification

To Qualify for APM Track, Providers Must do Both:

1. Participate in Advanced Alternative Payment Models
2. Meet Qualifying Participant (QP) targets for revenue or patients included in Advanced Alternative Payment Models

---

Making APM Track Even More Accessible

AAPM1 Definition, Eligibility Evolving From Proposed to Final Rule

More Clinicians Likely to Qualify for APM Track than Anticipated

Proposed Rule (April 2016):

4–12%
ECs projected to qualify for APM track in 2017

Final Rule (October 2016):

10–17%
ECs projected to qualify for APM track in 2017

Two Key Changes Making APM Track More Accessible

1) CMS working to loosen financial risk criteria
   • At-risk revenue-based standard reduced to 8%, or
   • Maximum possible loss reduced from 4% to 3% of spending target

2) CMS adding new AAPM-eligible payment models in 2018
   • MSSP2 ACO Track 1+ model
   • Mandatory bundled payment models including CJR3 and Episode-Based Payment Model

APM Entities Must Meet Percent of Payments or Patient Counts

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments through Advanced APMs</th>
<th>Patients in Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>2021</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2022</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2023</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>2024+</td>
<td>75%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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; Advisory Board interviews and analysis.

1) Advanced Alternative Payment Model.
2) Medicare Shared Savings Program.
3) Comprehensive Care for Joint Replacement.

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APMs That Qualify Largely Unchanged—For Now

Advanced APM-Ineligible Payment Models

- Bundled Payments for Care Improvement Initiative (BPCI)
- Comprehensive Care for Joint Replacement (CJR) Model
- Medicare Shared Savings Program (MSSP) Track 1 (50% sharing; upside only)

Advanced APM-Eligible Payment Models

- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO Model
- Episode-Based Payment Model (currently a proposal; downside risk would begin in 2018)
- The Oncology Care Model Two-Sided Risk Arrangement
- Comprehensive ESRD Care Model (two-sided risk arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Certain commercial contracts with sufficient risk, including Medicare Advantage (starting in 2021)

Limited Returns So Far, But Continued Participation

MSSP ACOs Sharing in Savings, 2015

<table>
<thead>
<tr>
<th>Did Not Reduce Spending</th>
<th>Reduced Spending, Earned Shared Savings</th>
<th>Reduced Spending, Did Not Qualify for Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>48%</td>
<td>30%</td>
<td>21%</td>
</tr>
</tbody>
</table>

ACO Participation by Model

Among groups taking on risk
n=15 independent medical groups

<table>
<thead>
<tr>
<th>MSSP Track 1 ACO</th>
<th>MSSP Track 2 or 3 ACO</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>60%</td>
<td>33%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: 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.
More Opportunity to Participate in Advanced APMs

CMS to Expand List of Qualifying Programs in 2018 and Beyond

Anticipated Additions to Advanced APM List for 2018 Program Year

Creation of Qualifying New Models

MSSP¹ Track 1+

Two-sided risk track with less upside reward but also less downside risk than Track 2 and Track 3, expected to begin in 2018

Voluntary Bundled Payment Model

CMMI² considering a new voluntary bundled payment model for 2018; would build on BPCI³

Inclusion of Existing Models

CJR⁴ Payment Model (CEHRT⁵ Track)

Proposed rule allows for qualification as an Advanced APM if participating hospitals are using CEHRT

EPM⁶ Track 1 (CEHRT Track)

Proposed rule creates two tracks; participants required to use CEHRT in Track 1 of each EPM to qualify as Advanced APM

Vermont Medicare ACO Initiative

CMS expects the Vermont Medicare ACO program (part of Vermont’s new All-Payer ACO Model) to be an Advanced APM

Qualifying Participant Status the Next Requirement

How to Determine If APM Entity Meets QP Status

APM Entities Must Meet Percent of Payments or Patient Counts

Example of Payment Qualification

<table>
<thead>
<tr>
<th>Year</th>
<th>APM Entity 1</th>
<th>APM Entity 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>Payments = 15%</td>
<td>Payments = 33%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2021</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>2022</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>2023</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>2024+</td>
<td>75%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Payments through Advanced APMs

Patients in Advanced APMs

Source: 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 Company interviews and analysis.

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The Math Behind QP Thresholds

25% Payment threshold for QPs in 2019

Numerator: All payments for services\(^1\) furnished by ECs in the APM Entity to attributed beneficiaries\(^2\)

Denominator: All payments for services\(^1\) furnished by the ECs in the APM Entity to attribution-eligible beneficiaries\(^3\)

20% Patient count threshold for QPs in 2019

Numerator: Unique number of attributed beneficiaries to whom ECs in the APM Entity furnish services\(^1\),\(^2\)

Denominator: Number of attribution-eligible beneficiaries to whom ECs in the APM Entity furnish services\(^1\),\(^2\)

Attribute-Eligible Beneficiary Criteria

<table>
<thead>
<tr>
<th></th>
<th>Medicare Part B covered professional services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not enrolled in Medicare Advantage nor Medicare Cost Plan</td>
</tr>
<tr>
<td>2</td>
<td>Medicare not a second payer</td>
</tr>
<tr>
<td>3</td>
<td>Medicare Parts A and B enrollment</td>
</tr>
<tr>
<td>4</td>
<td>At least 18 years old</td>
</tr>
<tr>
<td>5</td>
<td>US Resident</td>
</tr>
<tr>
<td>6</td>
<td>At least 1 E&amp;M(^3) claim within the APM entity</td>
</tr>
</tbody>
</table>

1) Certified Electronic Health Records Technology

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APM Track

Key Takeaways for Medical Group Leaders

1. CMS proposed rule sets a strict standard for qualification of Advanced Alternative Payment Models, Most ACO participants are excluded

2. Partial qualifiers and participants in non-qualifying APMs have options for exclusion from MIPS or preferential scoring within MIPS

3. APM bonus is attractive, but should not be sole basis for taking downside risk

4. Long-term strategy should focus on developing capabilities to control unnecessary clinical and cost variation

Sources: CMS Quality Payment Program, Source: Advisory Board research and analysis.
Ultimately, Advance Overall Risk Strategy

ACO Participation Should Not Distract From Broader Ambitions

Three Key Considerations

Number of Lives in Traditional Medicare
ACO programs have minimum population size requirements and will likely require even larger numbers to see an ROI

Medicare Advantage (MA) Growth Strategy
Current focus on shifting lives to MA contracts could be jeopardized by ACO participation and would make getting to critical mass in all contracts more difficult

Overarching Enterprise Goals for Population Health
Organizations that have capitation targets and require a narrow network may find that current options don’t satisfy their needs

MIPS
Despite Flexibility, MIPS Still A Zero-Sum Game

Annual Evaluation Likely to Create Volatility

Payment Adjustment Determination
1 Clinicians assigned score of 0-100 based on performance across four categories

Score compared to CMS-set performance threshold; non-reporting groups given lowest score

A score above performance threshold results in upward payment adjustment; a score below results in a downward adjustment

Maximum Clinician Penalties and Bonuses

Highest performers eligible for up to 10% additional incentive

Budget neutrality adjustment: Scaling factor ranging from 0.0 to 3.0 may be applied to upward adjustment to ensure payout pool equals penalty pool

Non-reporting participants given lowest score

1) Return on investment.

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Source: Advisory Board interviews and analysis.
CMS Makes 2017 a MIPS Transition Year

Three Options For MIPS Participation in 2017

1. Minimal Reporting to Avoid Penalties
   - Submit any single metric under quality or clinical improvement or the required ACI\(^1\) measures
   - No minimum time period required
   - Will avoid a negative payment adjustment

2. Report Partial Data, Potential for Small Bonus
   - Submit more than one quality or clinical improvement metric or more than the required ACI measures
   - Must report for a full 90-day continuous reporting period
   - Possibility of qualifying for positive payment adjustment, but likely to be small

3. Report Full Data for Chance of Larger Bonus
   - Submit all required data in all categories
   - Must report for a full 90-day continuous reporting period
   - Potential for full payment adjustment
   - Highest performers still earn additional positive adjustment

What this Means for Eligible Clinicians
- Flexibility in MIPS participation in 2017, not all or nothing
- Clinicians will only see negative penalty if fail to report, but strong performers see reduced rewards
- **Important:** Providers should not slow MACRA preparations in light of new options

1) Advancing Care Information.

Ease of Avoiding Penalties May Mean Light Bonuses

But Low Bar Rises Quickly After 2017

Hypothetical 2019 Payment Adjustments
Based on CMS Example of 2017 Provider Score Distribution

$199M
Penalties anticipated from non-reporting ECs in 2017

$336
Estimated net upward base adjustment per clinician subject to MIPS

$500M
Additional funds to be distributed to ECs above Additional Adjustment Threshold

Performance Threshold met or exceeded by reporting a single metric
Additional Adjustment Threshold met by full reporting, strong performance
CMS Simplifies Each of the MIPS Categories

Quality
- Removed two of three proposed population-based metrics
- Only requiring ACR\(^1\) measure for groups of more than 15 (instead of the proposed 10)
- Dialed back, phasing in data completeness requirements

Cost
- Reduced category weight to 0% in 2019, 10% in 2020
- Decreased number of episode-based measures from 41 to 10

Improvement Activities
- Total points possible is now 40, rather than 60
- Full credit through 4 medium-weighted or 2 high-weighted activities, instead of 6 medium-weighted or 3 high-weighted activities

Advancing Care Information
- Reduced number of required measures from 11 to 4 modified Stage 2-equivalent measures or 5 Stage 3-equivalent measures

Source: 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.

1) All-Cause Readmissions.
MIPS Standards Rapidly Become More Challenging

Full-Year Reporting, Weighting for Cost Category, Outcomes Metrics Loom

Weights of MIPS Score Components in Final Rule

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

Key MACRA Reporting Trends Looking Forward

Resource Use Measurement Intensifies Post-Transition Year
Resource use reporting not considered for 2017 performance year, but still increased to 30% by 2019; CMS expects to add more episode-based measures over time

Quality Scoring to Center on Outcomes Metrics
To keep the emphasis on such measures in the statute, we plan to increase the requirements for reporting outcome measures over the next several years through future rulemaking, as more outcome measures become available.

Centers for Medicare and Medicaid Services

Larger Practices Expected to Fare Better

Reporting Flexibility, Data Submission Experience Helps Smaller Groups

Percentage of Eligible Clinicians Projected to Receive MIPS Penalties, Bonuses¹

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Penalty</th>
<th>Neutral or Positive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9 Actual²</td>
<td>41.8%</td>
<td>58.2%</td>
</tr>
<tr>
<td>1-9 Projected³</td>
<td>20.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>10-24</td>
<td>16.3%</td>
<td>83.7%</td>
</tr>
<tr>
<td>25-99</td>
<td>7.4%</td>
<td>92.6%</td>
</tr>
<tr>
<td>100+</td>
<td>1.5%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

¹) Projections based on 2015 data.
²) Assumes no change in data submission from 2015 to 2017.
³) Assumes 80% of groups with 1 to 9 clinicians will submit data in 2017.

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," October 2016; Health Care Advisory Board interviews and analysis.
Competition Will Intensify with Smaller MIPS Track

Expanded Exemptions and APM Growth Reduce MIPS Participants

**Distribution of Clinicians Billing Medicare in 2017**

<table>
<thead>
<tr>
<th>Eligible Clinicians</th>
<th>Ineligible clinician type/newly enrolled Below volume threshold</th>
<th>Estimated Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exempt Clinicians</td>
<td>~284,000 (20%)</td>
<td>~384,000 (28%)</td>
</tr>
<tr>
<td>Eligible Clinicians</td>
<td>~617,000 (45%)</td>
<td>~95,000 (7%)</td>
</tr>
<tr>
<td>MIPS Track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APM Track</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Low-Volume Threshold**
- Clinicians, groups with:
  - ≤ $30,000 in Medicare charges
  - OR
  - 100 or fewer Medicare patients

**Final Rule Expands Low-Volume Exemptions, Reducing Number of ECs**

<table>
<thead>
<tr>
<th>Estimated Number of ECs¹ Subject to MACRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Rule: 836,000</td>
</tr>
<tr>
<td>Final Rule: 712,000</td>
</tr>
</tbody>
</table>

**MIPS Expected to Shrink Further as APM Track Grows**
- 25% ECs projected to qualify for Advanced APM incentives in 2018

**Key Takeaways for Medical Group Leaders**

1. Most providers will be paid under MIPS in 2019
2. Providers will earn most of the points in the CPIA and ACI performance categories, eventually
3. Quality and Resource Use categories will be where providers compete for bonuses
4. Resource Use will become much more significant in later years
5. Must focus immediately on quality reporting and CEHRT¹ implementation and performance for 2017
6. Opportunity exists to strengthen alignment with small and independent practices

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¹ Certified Electronic Health Records Technology.
Election 2016 and the Emergence of TrumpCare

MACRA: The End of Fee For Service?

New Pathways to Risk in Specialty and Primary Care

Consider alignment strategy in light of MACRA

Seeking Company to Weather Together?

An Array of Partners and Alignment Options

"If we’re going to take risk with you, no more of this discussion of whether you are willing to do patient satisfaction surveys or get your medical home application into NCQA. You have to do it now, or you’re not in. That’s been our intent all along, but MACRA is allowing us to speed it up."

President, Jacobs Health Care

Your To Do Steps for Alignment

- Engage provider partners to determine requirements for entry into alignment model
- Consider referral relationship and value of more formal partnership
- Evaluate how alignment affects reporting strategy

1) Clinically integrated network
2) Independent practice association
3) Skilled nursing facility
4) Pseudonym

Source: Physician Practice Roundtable 2016 MACRA Pulse Check Survey. Advisory Board interviews and analysis.
**More Layers to Alignment Decisions than Before**

Critical to Understand Impact of Potential Partners on MACRA Performance

Alignment Efforts May Have Inadvertent Outcome

Partnering to Form ACO
- Expand options for beneficiaries
- Fulfill service line deficits

**Intended Result**

Alignment Efforts Improve Network Scale
- Growth in physician network increases number of attributed beneficiaries, ability to manage risk
- Improves transparency into physician performance, ability to shift practice patterns

**Unintended Result**

Possibility MIPS Score Diluted by Adding ACO Partners
- All ACO participants receive same aggregate score
- New additions to ACO might have lower quality performance
- Takes time to align goals of participants

**MACRA: Your New Tool for Growth**

Creating New Urgency for Larger Group Employment

Alignment Requests Likely Coming from Smaller, Medicare-Heavy Practices

Your To Do Steps for Growth
- Carefully evaluate physicians that approach you
- Consider re-approaching those you’ve been casually courting
- Crystallize your value proposition

61%
Percent of physicians in practices of 10 physicians or less

Not Quite a No-Regrets Decision

Understand Who You’re Getting in Bed With to Avoid Dilution

Alignment Efforts May Have Inadvertent Outcome

Partner with Other Organizations to Form ACO Participant List
- Expand options for beneficiaries
- Fulfill service line deficits

Intended Result
Alignment Efforts Improve Network Scale
- Growth in physician network increases number of attributed beneficiaries, ability to manage risk
- Improves transparency into physician performance, ability to shift practice patterns

Unintended Result
MIPS Score Diluted by Adding ACO Partners
- All ACO participants receive same aggregate score
- Independent groups have higher overall quality, could score better on their own
- Takes time to align goals of participants

Focusing on the Forest and the Trees

Confronting the Push to Risk Amidst Efforts to Optimize Performance

Succeeding under MACRA Requires Dual Focus

Rethinking Risk Model Strategy
- Should we take on upside-only risk?
- Should we shift to downside risk?

Maximizing MIPS Score
- How do I choose the optimal quality measures?
- In cost category, what will my group be scored on?
- What is required to secure full credit under IA\textsuperscript{1} and ACI\textsuperscript{2} categories?

Source: Advisory Board interviews and analysis.
Medical Group Success Under MACRA

Roadmap for Discussion

Rethinking Your Risk Model Strategy

- Should we take on upside-only risk?
- Should we shift to downside risk?

Playbook for Maximizing Performance in MIPS

1. Use the transition year to your advantage
2. Choose reporting mechanism wisely
3. Review MIPS quality measures and create target list
4. Aim to earn bonus quality points
5. Unpack attribution and episodic cost
6. Prioritize risk adjustment
7. Develop a short list of top cost savings opportunities
8. Map your easiest path to 40 points in IA
9. Focus on your performance score in ACI

Find an appendix of related resources to this study at: advisory.com/PPR/2016summitresources

Defining an Intentional Medicare Risk Strategy

New Study From the Health Care Advisory Board

Ensure Longevity of Medicare Risk Strategy
Engage partners and patients to ensure maximal financial performance over time

Expand Into Medicare Advantage Market
Complement traditional Medicare strategy with customized approach to MA contracting based on organizational, market readiness

Redefine Path to Risk for Traditional Medicare
Set foundation for overall Medicare strategy by determining appropriate level of risk, considering implications of physician strategy on MACRA response

To hear the full presentation:
Attend an upcoming Health Care Advisory Board national meeting.
Register for date and location of choice at: advisory.com/hcab/2016nationalmeeting
CMS Expands Onramps to Downside Risk

New Programs for Both Primary and Specialty Care

Continuum of Medicare Risk Models

<table>
<thead>
<tr>
<th></th>
<th>Pay-for-Performance</th>
<th>Bundled Payments</th>
<th>Shared Savings</th>
<th>Shared Risk</th>
<th>Full Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital VBP¹ Program</td>
<td>Hospital Readmissions Reduction Program</td>
<td>Medicare Shared Savings Program</td>
<td>MSSP³ Track 1 (50% sharing)</td>
<td>MSSP³ Track 2 (60% sharing)</td>
<td>Next-Generation ACO (optional full performance risk)</td>
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Increasing Financial Risk

CMS Recognizes Potential of Primary Care

New CPC+ Program Expands and Enhances Incentives

Key Features of Comprehensive Primary Care Plus (CPC+)

- Five year performance period (2017-2021)
- Total participation to include up to 5,000 practices across 20 regions
- Shared savings to be replaced with prospective incentive payments (either $2.50 and $4 PBPM) with payback for underperformance
- Higher reward Track 2 pays portion of evaluation and management fees up front and reduces the remainder to remove incentives for face-to-face office visits

“A continuously improving health care system requires ongoing innovation and improvement. Nowhere is that more important than primary care, the foundation of the delivery system.”

Sessums LL et al. Centers for Medicare and Medicaid Services
CPC+ Introduces New Payment Methodology

CPC+ Introduces New Payment Methodology Designed to Enhance Upfront Payment

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>CPCI</th>
<th>CPC+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared Savings:</strong> Opportunity to share in cost savings if quality targets are met</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td><strong>Monthly Care Management Payments:</strong> Per beneficiary per month payment</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td><strong>Performance Based Incentive Payments:</strong> Prepaid at the beginning of a performance year, but returned if quality and utilization performance thresholds are not met</td>
<td>✗</td>
<td>✔</td>
</tr>
<tr>
<td><strong>Comprehensive Primary Care Payments:</strong> A hybrid of fee-for-service and a percentage of their expected E&amp;M(^1) reimbursements upfront</td>
<td>✗</td>
<td>✔</td>
</tr>
</tbody>
</table>

Only available under track two of CPC+ program

Average\(^2\) PBPM\(^3\) Care Management Payments, By Program

- CPCI\(^1\) Years 1-2: $20
- CPCI\(^1\) Years 3-4: $15
- CPC+ Track 1: $15
- CPC+ Track 2: $28

Source: CMS, Advisory Board Company interviews and analysis

1) Evaluation & Management.
2) Based on risk tier, payments range from $6-$30 in track one, $9-$100 in track two.
3) Per beneficiary per month.

CPC+ Offered in Fourteen Regions

Only Practices in Selected States/Counties May Apply

1. Arkansas: Statewide
2. Colorado: Statewide
3. Hawaii: Statewide
4. Kansas and Missouri: Greater Kansas City Region
5. Michigan: Statewide
6. Montana: Statewide
7. New Jersey: Statewide
8. New York: North Hudson-Capital Region
9. Ohio: Statewide and Northern Kentucky Region
10. Oklahoma: Statewide
11. Oregon: Statewide
12. Pennsylvania: Greater Philadelphia Region
13. Rhode Island: Statewide
14. Tennessee: Statewide

Bundles Judged to Offer Great Savings Potential

2008 CBO\(^1\) Estimate of 10-Year Savings Associated with ACOs and Bundled Payments, 2010-2019

<table>
<thead>
<tr>
<th></th>
<th>ACOs</th>
<th>Bundled Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 CBO(^1)</td>
<td>$5.3B</td>
<td>$19B</td>
</tr>
</tbody>
</table>

$47B

2013 CBO estimate of 10-year savings associated with bundle payments, 2014-2023

Analyses in Brief

- 2008 and 2013 Congressional Budget Office analyses of 10-year savings based on savings generated to Medicare from ACOs versus bundled payments
- Both estimates assume bundling across 48 clinical episodes, spanning inpatient admission through post-discharge period. Updated analysis expanded bundle window from 30 to 90 days, ramped up savings estimates
- 2013 calculations estimate overall payouts on bundles to be 5% lower than Medicare’s projected average payments per episode under current law


After Long Buildup, Joint Bundles Now Mandatory

CMS Has Been Building to Mandatory Bundles for Years

**Acute Care Episode (ACE) Demonstration**
- 3-years, 5 participants
- Cardiac, orthopedic MS-DRGs including 469 and 470

**Comprehensive Care for Joint Replacement (BPCI)**
- 2013 – ongoing
- 48 episodes, includes MS-DRGs 469, 470
- First year preliminary results available

**Comprehensive Care for Joint Replacement (CJR)**

- 3-years, 5 participants
- Cardiac, orthopedic MS-DRGs including 469 and 470
- 2013–ongoing
- 48 episodes, includes MS-DRGs 469, 470
- First year preliminary results available

CMS’s CJR Goals

- Assess whether bundled payments reduce costs while maintaining, improving quality
- Test bundling in multiple settings with large, diverse group of providers
- Remove selection bias of voluntary programs

Source: CMS, Financial Leadership Council analysis; Health Care Advisory Board interviews and analysis.
CJR Markets Assume Additional Responsibility

Hospitals Would Take Financial Ownership for Hip/Femur Repair Episode

**Current CJR Program**

- Hospitals within 67 geographically defined MSAs\(^1\)
- Medicare enrollees with parts A and B, discharged with LEJR (DRG 469 or 470)

**SHFFT EPM**

- Medicare enrollees with parts A and B, discharged with SHFFT (DRGs 480-482)

### CJR Expansion by the Numbers

- **109,000** Estimated annual number of potentially eligible SHFFT procedures
- **$308M** Revised estimated episodic cost savings under CJR\(^2\)
- **$130M** Estimated additional episodic cost savings from the SHFFT EPM

---

**Introducing CABG and AMI Episode Payment Models**

Bypass and Heart Attack Would Be First Mandatory Cardiac Bundles

**Cardiac EPMs**

- **CABG**
  - MS-DRGs 231-232
  - All care during index hospitalization through to 90-days post-discharge
  - Hospital would be financially responsible for cost, quality of the episode

- **AMI**
  - MS-DRGs 280-282; 246-251
  - All care during index hospitalization through to 90-days post-discharge
  - Hospital would be financially responsible for cost, quality of the episode

**$40M** Estimate of cost savings to CMS over five years for both cardiac EPMs

---

1. Metropolitan Statistical Area.
2. In the proposed rule, CMS revised its original estimated costs savings for CJR.

Source: CMS, Advisory Board analysis.
Mandatory Bundling in Other Areas Likely to Follow

CMS and State-Level Focus on Episodes Gives Clues to Intentions

**Oncology Care Model**
- Incorporates a two-part payment system with a $160 per-beneficiary-per-month (PBPM) payment for the duration of the episode and the potential for a performance-based payment for episodes of chemotherapy care

**Multi-Payer State Level Initiatives**
- Medicaid and private insurers in Arkansas, Ohio, and Tennessee have launched retrospective bundle for multiple episodes where either the hospital or physician group serves as accountable party

---

1) Smarter Management and Resources Use for Today’s Complex Care Delivery.
2) Center for Medicare and Medicaid Innovation.

---

Utilization, Not Prices, Key to Episode Cost Variation

**Difference in Per Capita Medicare Spending Between Miami, FL and Salem, OR, Before and After Price Adjustment**

<table>
<thead>
<tr>
<th>Before Adjustment</th>
<th>After Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.1K</td>
<td>$9.4K</td>
</tr>
</tbody>
</table>

$700

Medicare price adjustments (e.g., reflecting local wage costs) explain only a tiny fraction of gap between high and low spend regions

---

**Reduction in Total Geographical Medicare Spending Variance if Variance in Each Category Eliminated**

<table>
<thead>
<tr>
<th>Category</th>
<th>Reduction in Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Acute Care</td>
<td>73%</td>
</tr>
<tr>
<td>Acute Care</td>
<td>27%</td>
</tr>
<tr>
<td>Procedures</td>
<td>14%</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>14%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>9%</td>
</tr>
</tbody>
</table>


1) Categories sum to more than 100% because of covariance terms.
A Focus on PAC Critical for New Joint Episodes

Post-Acute a Major Cost Driver for Hip/Femur Repair

**SHFFT 90-Day Episodic Costs**

*Medicare, 2014*

- Hospital Outpatient: $500
- Physician: $2K
- Readmissions: $3K
- Index Admission: $13K
- Post-Acute Care: $17K

PAC drives nearly half of total episodic costs

---

PAC and Readmissions Drive Cardiac Variation

Cardiac and AMI EPMs Require Tailored Strategies

**Percentage of Total Costs Attributed to Each Setting at 90 Days**

*Medicare, 2014*

- **Index admission** remains a large source of costs at 90 days for CABG
- PAC\(^1\) an important contributor to total episodic costs
- Over a quarter of total costs for AMI\(^2\) attributed to readmissions

<table>
<thead>
<tr>
<th>Setting</th>
<th>Index Admission</th>
<th>Physician</th>
<th>Readmissions</th>
<th>PAC</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG</td>
<td>75%</td>
<td>4%</td>
<td>8%</td>
<td>11%</td>
<td>2%</td>
</tr>
<tr>
<td>PCI</td>
<td>60%</td>
<td>8%</td>
<td>9%</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>AMI</td>
<td>34%</td>
<td>11%</td>
<td>17%</td>
<td>17%</td>
<td>1%</td>
</tr>
</tbody>
</table>

1) Post-acute care
2) Medical treatment of AMI

Source: Advisory Board analysis.
The Advisory Board Company’s MACRA Intensive

One-Day Intensive to Prepare Your Practice for the Coming Transition

New Provider Imperatives Under MACRA

<table>
<thead>
<tr>
<th>Understand Policy</th>
<th>Assess Eligibility, Readiness</th>
<th>Craft Strategic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the emerging Medicare policies and protocols under MACRA?</td>
<td>Which track (MIPS or APM) does my organization qualify for? Is it feasible for us to pursue the APM track?</td>
<td>What organizational changes do we need to implement to effectively make this transition?</td>
</tr>
<tr>
<td>How do I educate executives and physicians on how these changes will impact their practice?</td>
<td>How prepared is my organization to participate in the relevant track?</td>
<td>How can I position my organization for continued success?</td>
</tr>
</tbody>
</table>

The Information & Guidance You Need to Inform Your Strategic Plan

**Policy Update**
Analysis of program requirements and updates released by CMS to get you up to speed on the details of MACRA

**Organizational Briefing**
Discussion examining how MACRA will impact your organization and the major strategic questions to consider

**Eligibility Determination**
Evaluation of organization’s participation in existing quality reporting programs, ability to qualify for APM track

**Readiness Assessment**
Diagnostic designed to identify performance improvement opportunities and direct organizations toward a viable transition strategy

**Strategic Options Discussion**
Best practices for building the infrastructure required to transition; guidance on metric selection and/or strategy for pursuing APMs

**Action Plan Recommendation**
Suggested areas of focus and next steps to implement structural and operational changes required for successful performance

For more information, please contact Anna Hatter at HatterA@advisory.com

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