

# Decision 2016:

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# Planning for MACRAnomics

## BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed by Congress and signed by President Obama on April 15, 2015, receiving bicameral, bipartisan support. MACRA replaces the Medicare Sustainable Growth Rate (SGR), the fee-for-service (FFS) method used since 1997 to reimburse physicians for Medicare services, with a much more predictable and sustainable model for the future. MACRA is poised to accelerate change in care delivery across virtually all healthcare sectors, as well as payment changes that push providers increasingly away from fee-for-service reimbursement and toward value-based payment.

On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) published a final rule that implements key features of this law through the Quality Payment Program (QPP), creating two new methods of payment: the Merit-based Incentive Payment System (MIPS) and a bonus program for Advanced Alternative Payment Models (APMs). The QPP applies to eligible clinicians that Medicare pays under the Physician Fee Schedule (PFS).

Regardless of whether providers choose to participate in MIPS or APMs, MACRA represents an inflection moment in healthcare. The law puts significant revenue at stake under MIPS for clinicians and the health systems that employ them, and uses incentive payments to draw clinicians toward the assumption of risk under coordinated care models. This could create opportunities for health systems and health plans to enter into new, aligned arrangements with independent physicians under Medicare. Providers must take advantage of the rules and requirements to build measurement collection and management systems that will ensure success in the QPP, and as a healthcare system over time.

## ELIGIBLE CLINICIANS (ECs)

Although the QPP in MACRA is limited to Part B professional payments, and does not affect hospital reimbursement directly, it does affect payment to clinicians practicing at acute-care facilities and also includes many other provisions of high strategic importance to health systems.

Starting in 2019, the QPP payment adjustments will apply to all “eligible clinicians” (ECs), beginning with physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurses anesthetists. New Medicare-enrolled ECs with no prior experience with Medicare claims, as well as those with low-volume charges (defined as billing less than \$30,000 a year to fewer than 100 Medicare Part B beneficiaries), are excluded. Similarly, clinicians practicing in rural health clinics or Federally Qualified Health Clinics (FQHCs) are also exempt.

Over time, the number and types of ECs covered in the QPP will expand. By 2021, for instance, the QPP may expand to include therapists, social workers, psychologists, audiologists and dietitians, among other clinicians that submit Medicare Part B claims. These clinicians are, however, eligible for Advanced APM bonus payments starting in 2019.

## TWO TRACKS FOR PAYMENT: MIPS VERSUS ADVANCED APMs

Starting in July of 2016, physicians and other ECs will receive a 0.5 percent payment update through 2019. Then, in 2019, MACRA freezes payment rates and creates the QPP, which consists of two separate paths that will more closely align reimbursement with the goals of population health.

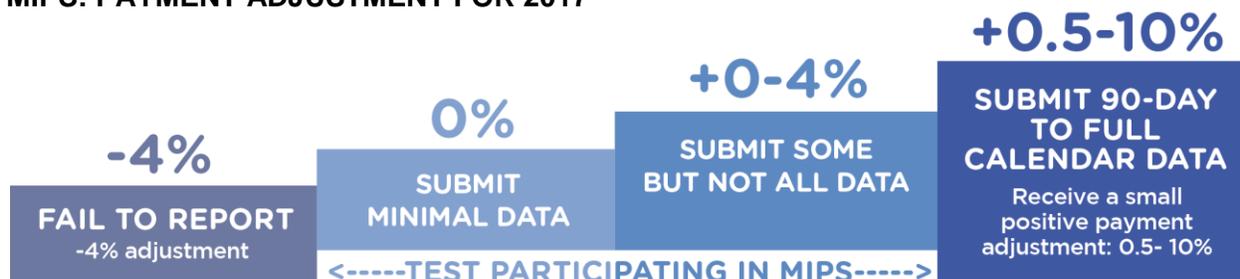
**MIPS:** MACRA sunsets three historic payment adjusters for physicians (the Physician Quality Reporting System (PQRS), Value-based Modifiers (VM) and Meaningful Use/EHR incentive program) and consolidates them under a single program called MIPS.

Under MIPS, the eligible clinician can earn a penalty or incentive. A portion of an eligible clinician’s payments are put at risk, beginning at 4 percent in 2019 and increasing to 9 percent by 2022. In addition to the payment adjustment, the law designates an additional \$500M to be distributed as an exceptional performance adjustment of up to 10 percent in the years 2019-2024.

Under the MIPS option, individual clinicians will be measured and given a final score based on performance across four performance categories. The reporting requirements are as follows:

*Transition Year-* The first performance year (CY2017, Jan. 1-Dec. 31, 2017) has been structured to serve as a transition period that allows eligible clinicians to “pick their pace” for getting started with the QPP. Eligible clinicians that do no reporting whatsoever will be subjected to the full negative payment adjustment under MIPS, while those who submit at least a minimal amount of data (e.g., one measure) will receive neither a penalty, nor a bonus. Clinicians who submit at least some data (e.g. a subset of measures for at least 90 days) are eligible for a small upward adjustment, while those who submit all the required data for at least one continuous 90-day period will be eligible for higher bonus payments.

### MIPS: PAYMENT ADJUSTMENT FOR 2017



It is at the MIPS eligible clinician’s discretion whether to submit data for the same 90-day period for the various measures and activities, or for different time periods for different measures and activities. During the 2017 transition year, minimal participation to avoid a negative payment adjustment is considered a minimum of a single measure in the quality performance category, a single activity in the improvement activities performance category or all five required measures in the advancing care information performance category.

*Quality Performance-* CMS proposes to use a total of seven measures to assess clinician performance. Six of these measures will be reported and one is calculated from claims data for large groups. The six reported measures are largely consistent with the PQRS system, utilizing the same reporting mechanisms and a similar list of measures. In addition, clinicians can now

choose to report a specialty-specific set of measures. At least one selected measure must be an outcome measure. If no outcome measure is available, then the clinician can choose a high-priority measure as designated by CMS (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). Alternatively, large groups can choose to report all the measures in the GPRO web interface. Additionally, the CAHPS survey is optional for all groups, and would count as one of the six required measures. The 30-day all-cause readmission measure calculated by CMS from claims data will be waived for those clinicians with fewer than 200 potential cases and those groups with fewer than 15 ECs. By combining reported and claims based measures, CMS’s proposal is analogous to the Quality Composite of the VM program. As with PQRS and the VM, clinicians can report as individuals or as a group.

**Cost** – CMS proposes to largely reuse the Cost Composite of the VM program for the first year of the MIPS program. For payment year 2019, CMS will include total per capita costs for attributed patients and Medicare Spending per Beneficiary. CMS will continue to push for more episodes as called for in the VM program, with ten new episode-based payment measures finalized for payment year 2019 and more than 30 additional episode-based measures planned for future payment years. MACRA also includes new required information that is expected to improve the attribution of patients for resource use performance. By January 1, 2018, MACRA requires that 1) ordering clinician NPI, 2) care episode and patient condition codes and 3) patient relationship codes be included on all claims.

Cost measures do not require reporting of any data by MIPS eligible clinicians to CMS.

**MIPS: COST PERFORMANCE CATEGORY**

- 2017 (2019 payment)- 0% Feedback Reports Provided
- 2018 (2020 payment) 10%
- 2019 (2021 payment) and later- 30%

Measure	Description
Medicare Spending per Beneficiary	<ul style="list-style-type: none"> <li>▪ Attribution: TIN providing plurality of Medicare Part B claims</li> <li>▪ Evaluate observed to expected costs at the episode level</li> <li>▪ Measure is average of assigned ratios</li> <li>▪ 35 minimum cases</li> </ul>
Total per Capita Cost	<ul style="list-style-type: none"> <li>▪ Attribution: Two-step process:</li> <li>▪ TIN of PCP providing plurality of primary care services</li> <li>▪ TIN of Non-PCP providing plurality of primary care services</li> <li>▪ 20 minimum cases</li> </ul>
10 Episode-based payment measures	<ul style="list-style-type: none"> <li>▪ 20 minimum cases</li> <li>▪ Included in 2014 and 2015 sQRUR and reliability of 0.4 for majority of clinicians</li> <li>▪ Acute condition: All MIPS eligible clinicians that bill at least 30% of inpatient E&amp;M visits during trigger event; more than one clinician can be attributed</li> <li>▪ Procedural: MIPS eligible clinicians billing a part B claim with a trigger code during the trigger event                             <ul style="list-style-type: none"> <li>– Inpatient- inpatient stay triggering the episode plus day prior to admission</li> <li>– Outpatient Method A- day before triggering claim- two days after triggering event</li> <li>– Outpatient Method B- day of triggering event</li> </ul> </li> </ul>

**Advancing care information (ACI)** – This replaces the Meaningful Use/EHR incentive program with a range of measures designed to evaluate how physicians and other clinicians use EHR in their practice, with a strong push toward interoperability, information security and data exchange. Unlike Meaningful Use, ACI allows for a range of points instead of an all or nothing.

Clinicians can also report as a group instead of as an individual. Clinicians must attest to “Protecting Patient Health Information” in order to receive any points in this performance category. Base points are assigned based on reporting on five measures, and clinicians that successful do so will earn 50 percent of the total in this area. Clinicians can earn higher scores by reporting on optional measures. A bonus point is available for clinicians who use their certified EHR technology (CHERT) to complete an improvement activity or report to an additional public health or clinical data registry.

**MIPS: ACI SCORING STAGE 2 OBJECTIVES AND MEASURES**

Objective	Measure	Base Score Requirement	Performance Score/ Bonus
Protect Patient Health Information	Security Risk Analysis MUST PASS	<input checked="" type="checkbox"/> Must attest “yes”	0
Electronic Prescribing	ePrescribing	<input checked="" type="checkbox"/>	0
Patient Electronic Access	Patient Access ★	<input checked="" type="checkbox"/>	Up to 20%
	View, Download or Transmit (VDT) ★		Up to 10%
Patient-Specific Education	Patient-Specific Education ★		Up to 10%
Secure Messaging	Secure Messaging ★		Up to 10%
Health Information Exchange	Health Information Exchange ★	<input checked="" type="checkbox"/>	Up to 20%
	Medication Reconciliation ★		Up to 10%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting		0 or 10%
BONUS	Syndromic Surveillance Reporting	Bonus	5%
	Specialized Registry Reporting	Bonus	
	Improvement Activities using CEHRT	Bonus	10%

**MIPS: ACI SCORING STAGE 3 OBJECTIVES AND MEASURES**

Objective	Measure	Base Score (50%) Requirement	Performance Score (up to 90%)
Protect Patient Health Information	Security Risk Analysis <b>MUST PASS</b>	<input checked="" type="checkbox"/> Must attest “yes”	0
Electronic Prescribing	ePrescribing	<input checked="" type="checkbox"/>	0
Patient Electronic Access	Provide Patient Access ★	<input checked="" type="checkbox"/>	Up to 10%
	Patient-Specific Education ★		Up to 10%
Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) ★		Up to 10%
	Secure Messaging ★		Up to 10%
	Patient-Generated Health Data ★		Up to 10%
Health Information Exchange	Send a Summary of Care ★	<input checked="" type="checkbox"/>	Up to 10%
	Request/Accept Summary of Care ★	<input checked="" type="checkbox"/>	Up to 10%
	Clinical Information Reconciliation★		Up to 10%
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting ★		0 or 10%
BONUS	Syndromic Surveillance Reporting ★	Bonus	5%
	Electronic Case Reporting		
	Public Health Registry Reporting		
	Clinical Data Registry Reporting		
	Improvement Activities Using CEHRT	Bonus	10%

*Improvement Activities* – This is a new area that includes more than 90 performance improvement measures that track clinician activity in the following areas:

- Expanded access (e.g., same day or weekend appointments)
- Population management (e.g., participation in patient centered medical home)
- Care coordination (e.g., use of patient navigators to manage transitions)
- Beneficiary engagement (e.g., use of shared decision-making and patient portals)
- Patient safety and practice assessment (e.g., use of surgical checklists or electronic infection surveillance systems)
- Social and community involvement (e.g., evidence of partnerships or collaboration with the community and social services)
- Health equity (e.g., high quality for underserved populations)
- Emergency preparedness (e.g., reserve and active duty uniformed services)
- Behavioral and mental health integration (e.g., shared/integrated behavioral health and primary care records)
- Alternative payment model participation (e.g., participation in bundled payment or shared savings programs)

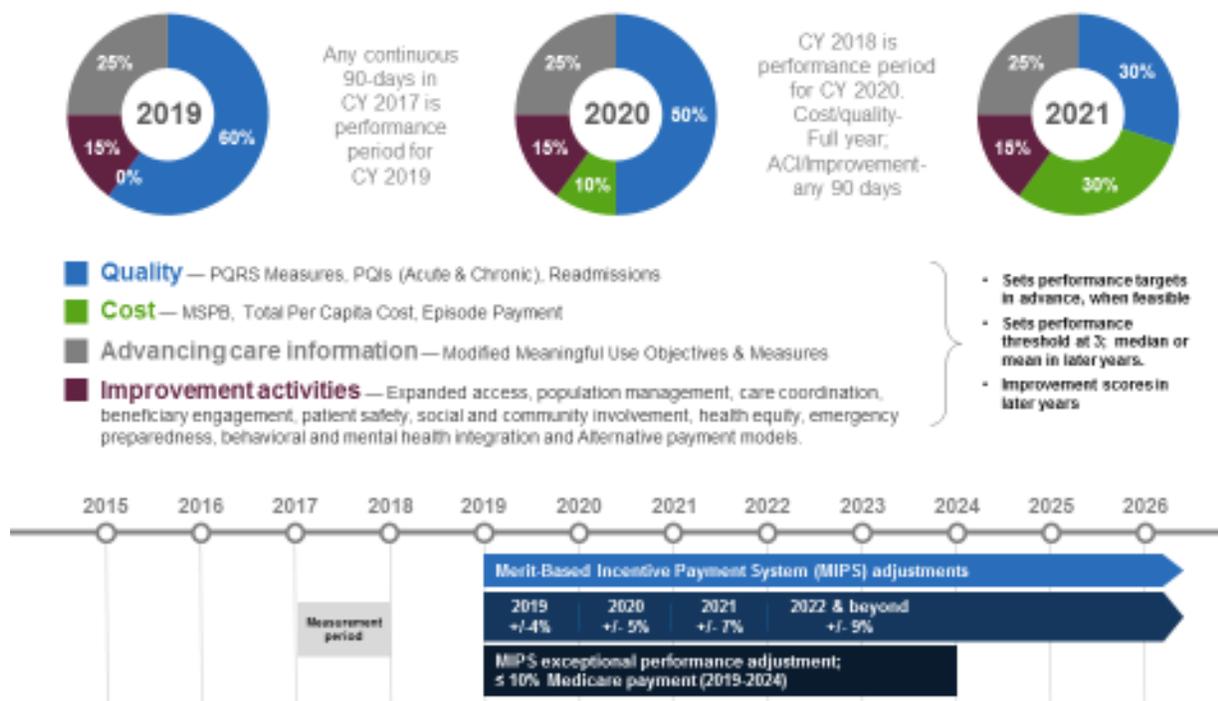
Clinicians must select measures that carry weights of either 10 to 20 points, depending on their priority. To receive full credit in the transition year, clinicians must report four medium-weighted or two high-weighted activities. In subsequent years, full credit will depend upon six medium-weighted or three high-weighted activities. For small practices, rural practices, or practices located in geographic health professional shortage areas (HPSAs), and non-patient facing MIPS eligible clinicians, full participation requires one high-weighted or two medium-weighted activities. Clinicians will receive the full points allotted for this performance category if they

participate in a certified patient centered medical home or similar program. Clinicians will receive at least half the total point value if they participate in certain APMs.

### MIPS Measures Weighting

The weighting of the performance categories in the MIPS payment equation will evolve over time, with an increasing emphasis on cost, as shown by the graphic below.

### MIPS OVERVIEW

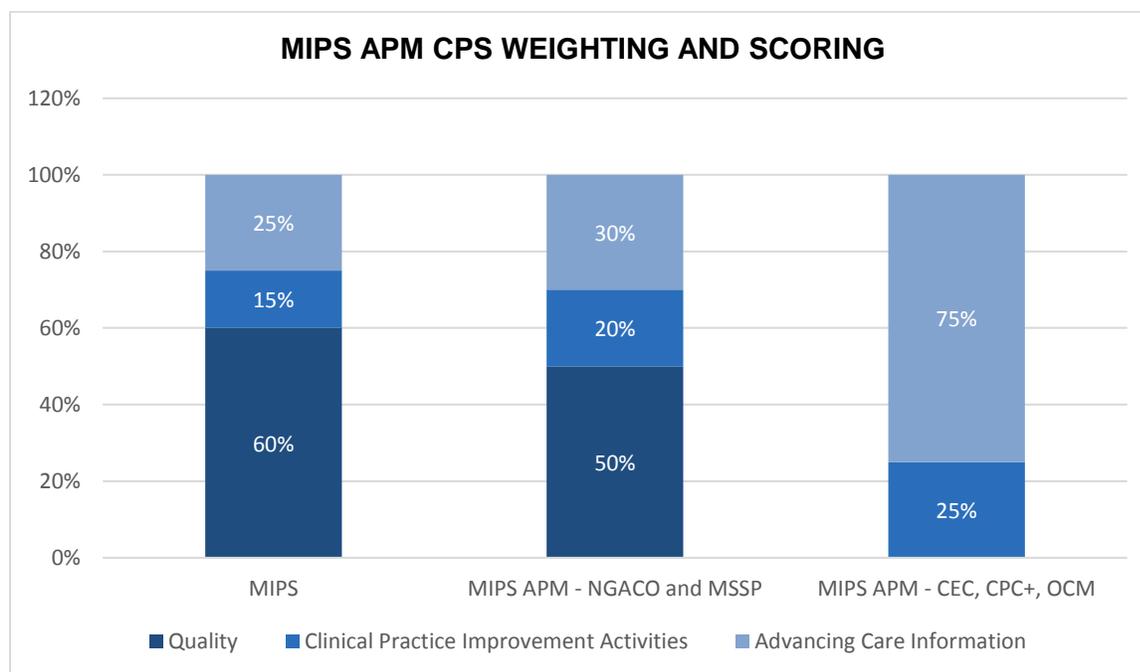


During the transition year, clinicians will not be evaluated on cost, but will receive performance feedback from CMS. In 2020, cost will account for 10 percent of the total scoring. In 2021, cost will account for 30 percent of the total.

**MIPS APMs:** To move providers toward population health, MIPS provides differential scoring for those entities in APMs that do not meet the more stringent requirements for Advanced APMs and the 5 percent bonus. A handful of APMs were designated as MIPS APMs that would offer providers optimal scoring as they prepare to move up the risk continuum and share in savings that are generated through cost and quality improvements. In the final rule, CMS designates these options to include the one-sided risk version track of MSSP (Track 1), the Oncology Care Model and the Comprehensive ESRD Care Model.

Moreover, certain CMS-designated Advanced APMs may still fall into the category of a MIPS APM for scoring purposes if the Advanced APM entity does not meet the payment or patient count thresholds set to become a Qualifying APM Participant (QP), as detailed below.

The weighting for MIPS APM measures changes in this track, with advancing care information and improvement activities weighted more heavily in the MIPS APM than in MIPS only (exact weighting differs by MIPS APM). In addition, clinicians that participate in a MIPS APM, are guaranteed at least an automatic 20 out of 40 points in the improvement activities performance category, with the current models granted the full 40 points for 2017 performance.



**Advanced APMs:** The QPP offers a second option to reward clinicians engaged Advanced APMs. ECs who receive significant shares of their revenue or patient volumes through Advanced APMs beginning in 2017 will be exempt from MIPS and become Qualifying Participants (QPs) eligible for a 5 percent bonus from 2019 through 2024. After 2025, QPs also will receive higher annual pay updates of 0.75 percent a year, compared to 0.25 percent for those that select MIPS.

MACRA regulation establishes three requirements for a model to be considered an Advanced APM: the model must pay based on quality measures comparable to MIPS, use certified Electronic Health Record technology (CEHRT) by at least 50 percent of ECs, expose participants to more than “nominal” risk for losses or serve as a Medical Home model scaled by the CMS Innovation Center.

In the final MACRA rule, CMS further defined “nominal risk” to mean assuming either 1) 8 percent of the average estimated total Medicare Parts A and B revenues of the participating entity or 2) 3 percent of the expected expenditures for which the APM is responsible. This standard represents a very high risk threshold, meaning that very few current programs meet the criteria necessary to qualify for bonus payments. For the 2019 payment year, only Medicare Shared Savings Program (MSSP) Track 2 and 3 ACOs, Next Gen ACOs, the Oncology Care Model (OCM) two-sided risk track, Comprehensive ESRD Care (CEC) two-sided risk and Comprehensive Primary Care Plus (CPC+) programs meet the definition. CMS notes in the final rule, however, that they will develop new requirements within bundled payment arrangements for cardiac and joint replacement care and Track 1 MSSP (to be called Track 1+) that allow these models to be considered an Advanced APM for 2020 payment.

Revenue and patient count requirements for Advanced APMs are expansive, and increase over time to ensure that organizations are fully engaged and committed to the models. Because the requirements rise over time, it is possible for clinicians to start out in an Advanced APM and move back down to MIPS, depending on patient counts and revenues at risk.

**Advanced APM Participation Requirements - Payment**

	2019	2021	2023
Medicare-Only	25% of all Part B payment	50% of all Part B payment	75% of all Part B payment
All-Payer Option	Not available	50% of all payment, 25% Part B payment	75% of all payment, 25% Part B payment

**Advanced APM Participation Requirements - Patients**

	2019	2021	2023
Medicare-Only	20% of all Medicare patients	35% of all Medicare patients	50% of all Medicare patients
All-Payer Option	Not available	35% of all patients and 20% Medicare beneficiaries	50% of all patients, 25% Medicare beneficiaries

*Calculating Payments*

For MIPS and MIPS APMs, all measures carry a point value that is converted to a final score, which this then converted to a payment adjustment. This process is driven by the “performance threshold.” The performance threshold for 2019 payment is a final score of 3, which translates to submitting one quality measure or one improvement activity. Starting in 2021, it will be set at the mean or median of all final scores from a prior period.

The final score will range from 0-100 and every eligible clinician will be provided a score. Clinicians who practice in more than one setting will receive the score of the highest performing entity with its own tax identification number (TIN) in 2019, and will have a weighted average final score across the organizations they work within later years. For 2020 and beyond, eligible clinicians with a score below ¼ of the performance threshold will receive the maximum downward adjustment. Payment adjustments are then distributed in a linear fashion between those that score above ¼ of the performance threshold and 100.

There are two adjustments to the final payment. The first is the budget neutrality scalar (range of 0 to 3) for all upward adjustments, determined based on the balance between upward and downward adjustments. For 2019, CMS anticipates that the scaling factor would be less than 1.0 and the payment adjustment for clinicians with a perfect final score would be less than 4 percent. The second adjustment is for exceptional performance. This additional adjustment is also applied in a linear fashion for all eligible clinicians with a final score above the 25<sup>th</sup> percentile of all upward adjusted ECs. The exceptional performance adjustment is applied with the lowest bonus being 0.5%, and the ECs with the highest final score receiving 10%. A 0-1 scalar may be applied if total additional adjustments are projected to be over \$500M. Only those clinicians with a final score at the performance threshold will receive no payment adjustment.

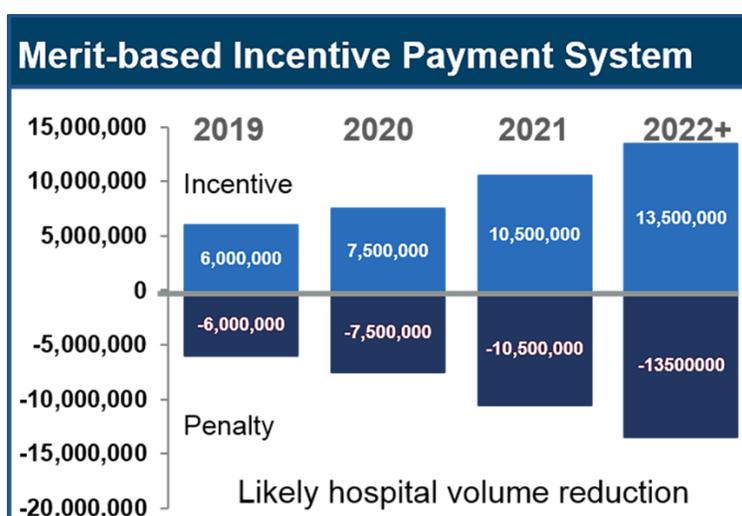
It is important to note that in a given year, clinicians are judged against this pre-determined scale. There is nothing that stops all clinicians from avoiding a downward adjustment if they are all above the performance threshold that year.

## FINANCIAL IMPLICATIONS FOR HEALTH SYSTEMS

MACRA represents a significant financial challenge for every health system in the country. Not only will a portion of reimbursement be at risk from employed physicians, but MACRA, if it works as intended, will certainly result in decreased hospitalizations and lower utilization of acute care, which translates into significant lost revenues for many health systems.

**MIPS Dollars at Risk:** For the purposes of illustrating the potential MIPS impact, Premier modeled the finances for a five hospital system that employs 250 physicians. Assuming that each clinician brings in \$1.5 million in total revenue, 40 percent of which is from Medicare Part B, MACRA alone can affect finances by \$6 million in 2019, scaling up to \$13.5 million in 2022. That figure could potentially increase in future years if MACRA-type payments are employed by other payers in the future.

### MIPS FINANCIAL IMPLICATIONS

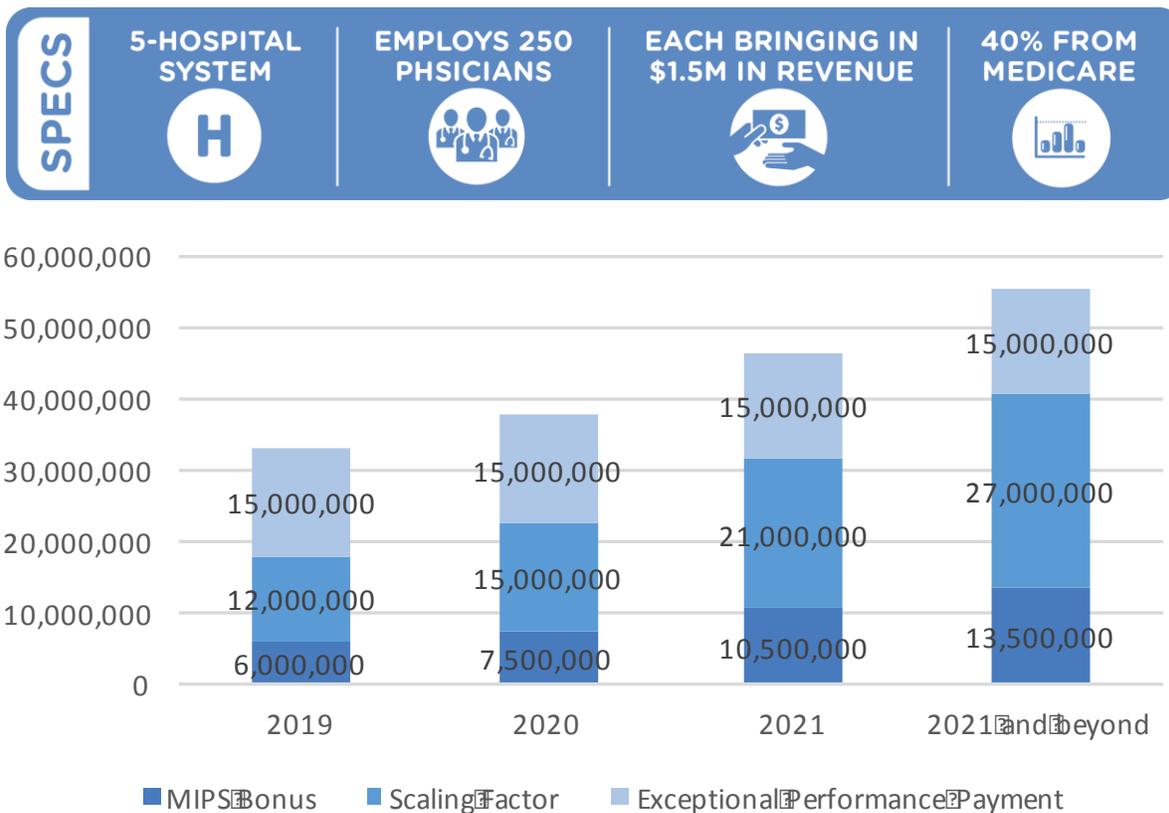


Moreover, health systems need to consider likely reductions in acute-care utilization as physicians become more proactive about managing and preventing illnesses in the primary care setting. Based on assessments conducted by Premier, we have found that for every 1 percent reduction in utilization, health systems can expect to lose 0.2-0.4 percent in revenues. The amount may be more in higher-cost areas of the country.

In addition, when modeling the MIPS financial effect, health systems need to evaluate their independent ECs, and assess their flight risk. To do this, systems should pull independent EC Medicare Part B payments, and flag those who are non-reporting (and therefore likely to perform poorly under MIPS), as well as those that have high dollars at stake assuming average performance in the program. Based on assessments Premier has conducted, those with more than 20 percent of their average annual salary at risk represent potential flight risks, or those who are likely to leave and affiliate with a competing organization that offers an APM option to avoid independent MIPS reporting. Should these ECs leave, health systems need to understand the revenue contributions that would go with them in order to truly understand the MIPS impact.

On the positive side, MIPS does offer additional upside potential. For instance, the law is budget neutral, so if a large percentage of physicians performs poorly, the others have the potential to earn more. In this case, there is a multiplier included in the calculation that could be as high as three. So, in the MIPS financial scenario, if a large number of physicians do poorly through MIPS, but the health systems’ employed physicians do very well, the payments can swell from \$6 million to \$18 million (4 percent bonus, multiplied by three). While a budget neutral scalar is not anticipated for 2019 payment, it is likely to increase positive payment adjustments in 2020 and beyond. Additionally MIPS includes a separate bonus, called an “exceptional performance payment,” that can be as high as 10 percent, bringing the full bonus pot up to 22 percent in the 2019 payment year.

Turning back to our 5-hospital health system, the total maximum bonus through MIPS could be as high as \$33 million in 2019, \$37.5 million in 2020, \$46.5 million in 2021 and \$55.5 million in 2022 and beyond – although maximum payments such as these are highly unlikely.



However, it’s important to note that MIPS funds will be variable. Because MACRA mandates that bonus payments through MIPS be budget neutral, upward adjustments are contingent upon the number of physicians that do poorly. So, while the maximum payouts in MIPS may be tempting, it is unlikely that they will be realized each year. Moreover, although the exceptional performance bonus is not subject to the budget neutrality clause, it is limited to \$500M each year between 2019-2024.

Through on-the-ground assessments of performance, Premier analysts have found that the larger the physician group, the more likely performance tends to regress to the mean. In other words, when reviewing performance data, there are typically an equal number of top and bottom performers, meaning that the potential to earn MIPS maximum payments will most likely be remote.

APM Dollars at Risk: For health systems already in an Advanced APM, it is relatively straightforward to project future performance based on the results that have been achieved to date. For those not already in an Advanced APM, modeling should assume average performance based on publicly-reported results. A range can be developed that assumes health systems' two-sided risk runs all the way up to the capped loss amount specified in the program (for instance, 15 percent of all Part A and B payments for the attributed population in MSSP Track 3), and a likely outcome of about -5.5 percent of Part A and B payments (the average results to date from two-sided risk programs). The total dollars at stake can then be determined by applying those results to the population that would most likely be attributed to the APM.

Each Advanced APM entity is assessed to determine if they meet the patient count or payment amount thresholds. If the entity is determined to have met the threshold, then all participants are deemed to be Qualified Participants. If the entity meets the partial qualifier thresholds, then the entity can elect for all participants to be subject to MIPS or to waive participation.

Also to be considered is the likely "halo effect" from change. Care delivery changes necessary to qualify as an Advanced APM benefit all patients, not just the Medicare population. Unless the health system has shared savings agreements with all payers, some of the savings they achieve will not be captured, and will instead flow back to the payer, resulting in lost revenue. For most systems, the default halo effect assumption is 1:1, with every change in utilization matched by the non-covered population.

On the upside, some of these likely loss levers may be offset by the Advanced APM bonus of 5 percent of all Part B payments for all participating ECs. However, the 5 percent bonus is only applied to the part B payments made to the clinician, while the potential losses of a two-sided model will include both the part A and part B payments made to *all* clinicians and providers for the attributed population.

Choosing Tracks: Based on the risks and rewards put forward in the MACRA final rule, Advanced APMs are the least advantageous for health systems. Health systems often bear the responsibility for the downside risk of Advanced APMs, but will only see the APM bonus for employed ECs. This makes the Advanced APM path much more attractive to independent clinicians, and less attractive for healthcare systems. A two-sided Advanced APM also carries significant downside risk potential that is about 3-10 times the risk level in MIPS. It is possible to make this option work, but health systems need to be confident that they can outperform the average results achieved through these programs to date in order to avoid having to repay Medicare for cost overruns. In general, this is an option that should be reserved for those that already have extensive experience in population health efforts, and a consistent track record of high performance in those programs.

Choosing MIPS is generally much more beneficial. With this option, providers that consistently achieve high performance in the MIPS measure domains can expect to out-earn those in qualifying APMs for many future years. Moreover, health systems can use the program to offer support to independent clinicians in reporting, as well as final score buffering (in past programs, large groups of physicians tend to be near the performance threshold similar to a regression to the mean phenomena). However, MIPS only (i.e., MIPS without an APM), incents decreased utilization of acute-care services and lower overall revenues for the health system. This option can also create significant flight risks for independent ECs, particularly those that are likely to score better in an APM.

Likely the most advantageous option is to pursue an APM that is still scored in MIPS – or a MIPS APM. For the most part, this option involves significantly less risk than an Advanced APM, while also ensuring more favorable scoring in the MIPS program, as well as an opportunity to capture shared savings that are generated by the APM. For instance, a Track 1 MSSP ACO carries no downside risk, may enable higher MIPS scoring and a shared savings opportunity.

As such, it may make the most financial sense for ECs, including those already in a qualifying APM who can assume high scores in the measure domains, to be scored under MIPS – at least for the foreseeable future.

## STRATEGIC CONSIDERATIONS FOR MIPS, MIPS APMs OR ADVANCED APMs

Before selecting between the various tracks, all health systems need to understand their potential exposure to MACRA payments, and model the finances based on their unique market characteristics.

**Eligible Clinicians:** It's important for health systems to understand who among their employees is considered an EC, and therefore subject to MACRA payment. The number of ECs and the amount of Medicare revenue they bring in will determine the health system's overall exposure to MACRA risk.

**Practice Characteristics:** Health systems should have an understanding of their EC's practice characteristics, including their patient populations and volumes (percent of patients in Medicare), and their participation in APMs. For instance, if a large number of health system ECs participate in population health programs already, it may make sense to organize them within an Advanced or MIPS APM in order to capture shared savings. Similarly, if ECs don't meet the APM volume requirements, health systems may have no choice but to default to MIPS. For non-employed ECs, it will also be important to understand all the affiliated organizations where the EC practices, as they will receive weighted average scores across settings, as determined by the taxpayer ID numbers (TINs).

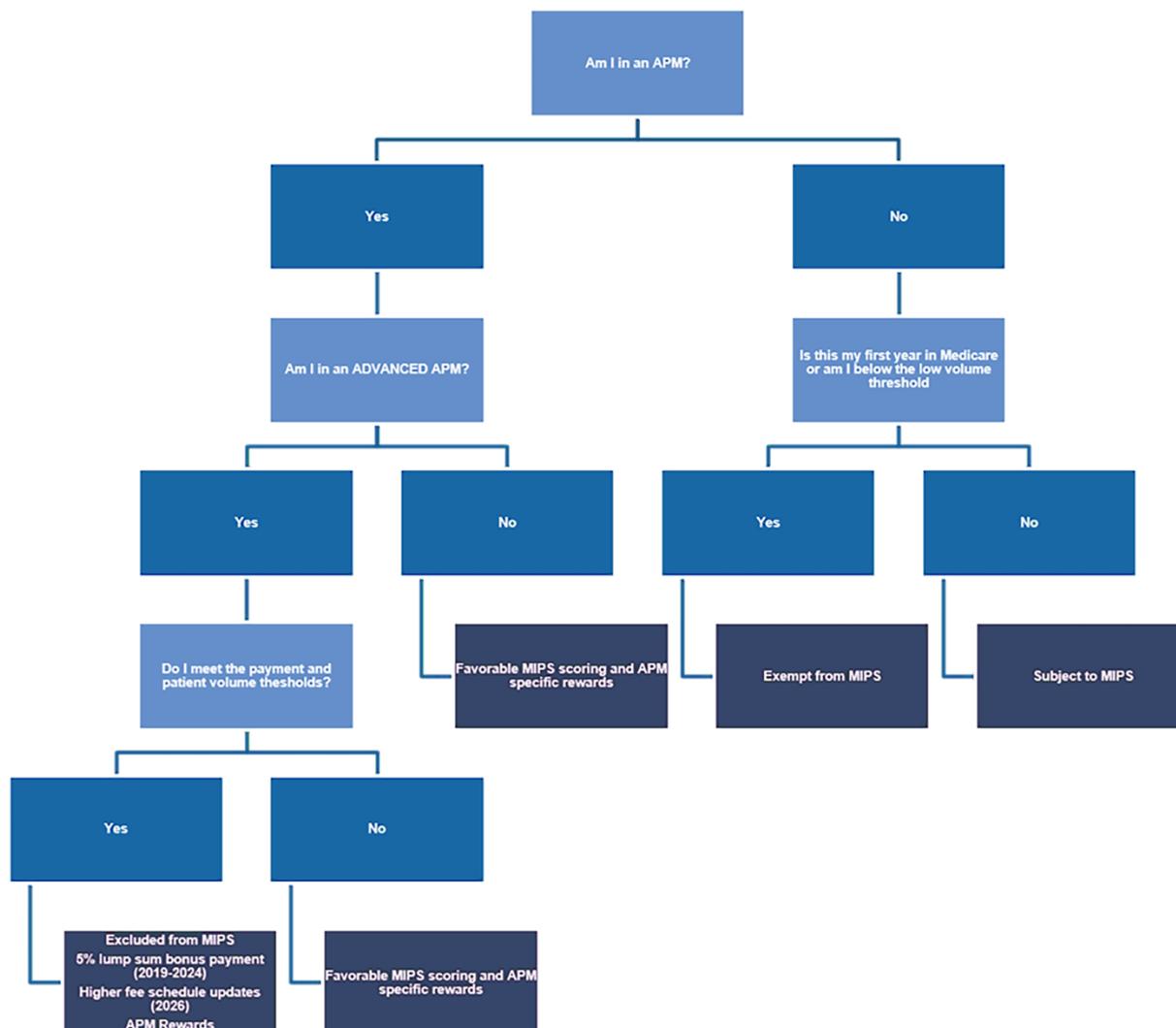
**Past Performance:** Health systems need to understand how their ECs perform in terms of cost and quality in order to determine the payment tracks, and/or initiate improvement efforts, if necessary. Health systems can evaluate performance by examining Physician Quality Reporting System (PQRS) and quality and resource use reports (QRUR) to understand how their ECs have chosen to be measured, as well as their aggregate performance. Understanding past performance will be a powerful indicator of potential risk under both MIPS and Advanced APM tracks.

**Medical Homes:** Medical homes are keys to success under any track. These enhanced primary care practices perform much of the yeoman's work within an Advanced APM, and can enable ECs to qualify for shared savings in addition to QPP bonus payments. Under the improvement activities domain within MIPS, ECs earn the full score if they are recognized by a national, accredited patient centered medical home certification program. Additionally, certain medical home payment models (e.g., Comprehensive Primary Care Plus) can qualify as an advanced APM. If few ECs participate in the model today, health systems may want to consider creating one in order to qualify for a future Advanced APM, help ECs earn their full score under MIPS and minimize the potential for losses.

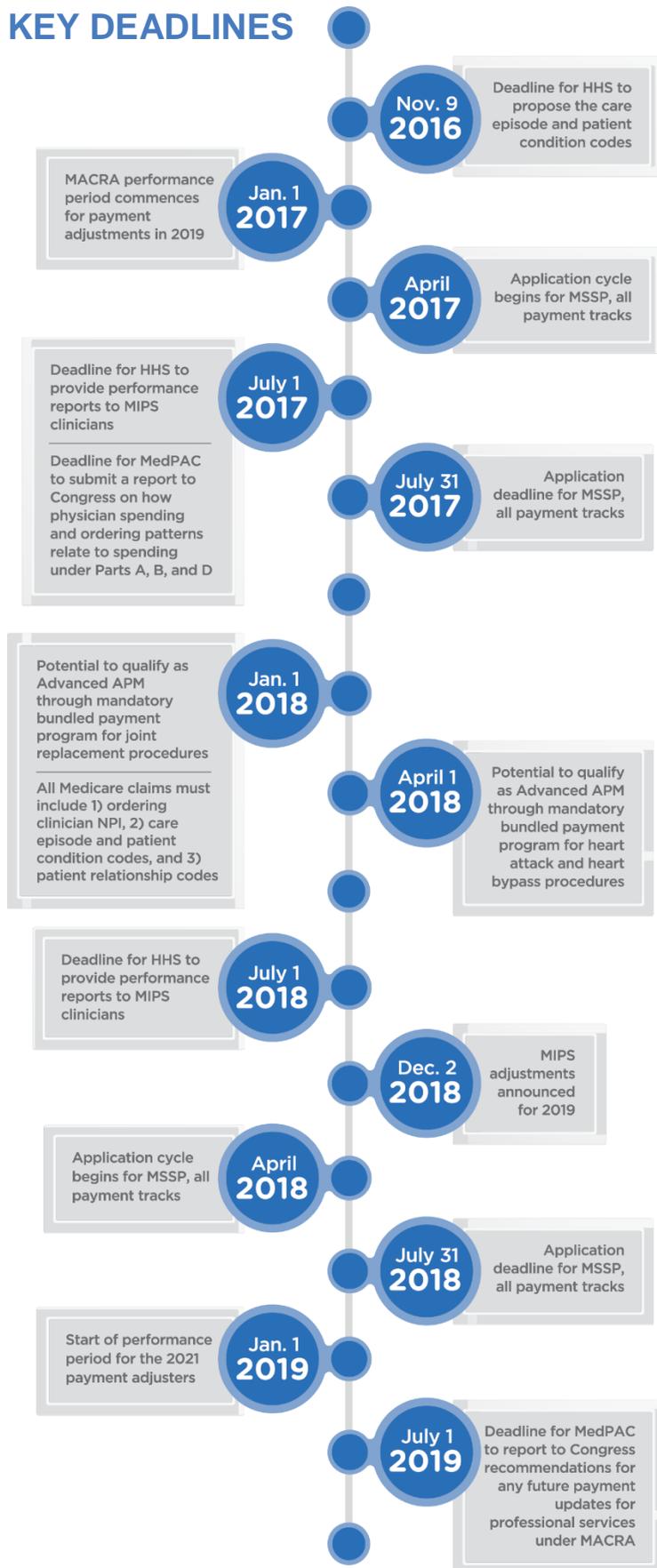
**Technology Use:** Both MIPS and the APM tracks require that large percentages of ECs use certified EHR technology in their practices. Health systems should verify that the versions of the EHR systems used are, in fact, considered “certified,” and also ensure that the system has gotten a thorough security risk analysis. It’s also important to verify that patient engagement systems, such as patient portals or appointment reminders, are in place and used.

**Mandatory Participation:** As of July, CMS has proposed that the mandatory comprehensive joint replacement (CJR) or the pending cardiac care bundles for heart attacks and heart bypass surgery do meet the standards for an Advanced APM if health systems are also able to meet the certified EHR requirements. Health systems that are required to participate in one or all of these bundles should assess the revenue their ECs derive from these procedures, as they may be able to qualify for the MIPS or Advanced APM track.

## MACRA DECISION TREE



## KEY DEADLINES



Although payment changes required by MACRA do not start until 2019, the performance year for clinician measurement and track determination begins in 2017, meaning that clinicians need to decide between MIPS and APMs before the end of the year.

Since very few clinicians are currently in CMS proposed Advanced APMs, and almost all application windows (except for CPC+) have closed for the 2017 participation year, it is likely that the overwhelming majority of clinicians will be paid under MIPS initially.

However, it will be important for clinicians to be mindful of the timetables for subsequent performance years, as there will be annual opportunities to move up the risk continuum and apply for both MIPS and Advanced APM programs, provided that they can meet the new, higher thresholds for patient counts and payment amounts flowing through their APM.

## CHOOSING MIPS

For health systems that choose or must default to MIPS, work should begin now to ensure optimal performance within each of the measured domains.

### MIPS Quality Checklist- Questions for Health Systems to Answer:

- After the transition year, ECs must select at least six quality measures out of a list of nearly 300 choices. At least one must measure an outcome:
  - What measures are your ECs reporting now?
  - Do your ECs currently report outcomes measures?
  - What is their baseline performance on those measures?
  - Should ECs switch to other measures to maximize performance?
  - Do ECs need to add measures?
  
- MIPS will award generous bonus points for additional outcomes or high-priority measures (in 2020 and beyond), and for end-to-end electronic reporting:
  - How do ECs perform in the high-priority categories (appropriate use, patient safety, efficiency, patient experience and care coordination)?
  - Can you persuade ECs to report on additional measures?
  - Can your ECs report all measures electronically?
  - Would it make financial sense for the health system to assist ECs in these efforts in order to ensure higher payments?
  
- ECs have the choice to report quality measures through claims, electronic health record (EHR), clinical registry, qualified clinical data registry (QCDR) or group practice reporting option (GPRO) Web-interface.
  - How do your ECs plan to report?
  - How can you assist them with reporting?
  - Can you offer your ECs use of a QCDR or other IT systems?
  - How can the health system proactively monitor performance in real-time, and intervene, if necessary, on measures that are not meeting standards?
  - What performance improvement programs can you offer your ECs to help them meet the MIPS requirements?

### MIPS Cost Checklist- Questions for Health Systems to Answer:

- Although not measured during the transition year, cost will gradually be phased in to account for 30% of the total MIPS weighting by 2021. Cost evaluates total per capita costs, Medicare spending per beneficiary and spending for certain conditions and care episodes. There is no reporting for this measure; it is automatically calculated by CMS (years 2020 and beyond).
  - Based on QRURs, how are your ECs performing now?
  - Which of the episode group measures will apply to your ECs?
  
- To improve total costs, health systems must be able to help ECs identify the most costly patient populations and conditions.
  - Can you provide reports to your ECs that identify high-cost, heavy users of healthcare services?
  - Do you have programs/workflows in place to help ECs optimize care delivery for these patients?
  - Can you offer additional resources to help ECs provide more effective care for patients with multiple, chronic illnesses?

- Are you staffed appropriately to provide care to these populations using cost-effective interventions, such as home visits or health coaching?
- Can you offer patient engagement tools to your ECs to assist them in caring for this population?
- The Medicare spending per beneficiary measure will incent physicians to help control costs across care settings, not just in their practices.
  - Can you provide assistance to ECs in managing hand offs to other settings of care?
  - Do you have care managers and patient navigators in place to ensure smooth transitions to the right level of care?
  - Can you help ECs create a high-quality, cost effective provider network to ensure referrals go to top performers?
  - Is the health system viewed as a top performing facility for acute care and able to attract high-performing physicians for privileges?

MIPS Improvement Activities Checklist- Questions for Health Systems to Answer:

- ECs must report on a combination of high- and medium-weighted activities out of a potential list of more than 90 different options. The activities must be performed for at least 90 days during the performance period.
  - Which activities will your ECs report?
  - Are the activities already happening, or do they need to be implemented?
  - Can the activities be implemented in time to meet the 90-day minimum in 2017?
- ECs get an automatic 30 points if they participate in alternative payment models, and an automatic full credit if they participate in a patient-centered medical home (PCMH).
  - Should the health system organize an ACO or bundled payment agreement in order to assist ECs in meeting the requirements?
  - Should the health system pursue accreditation for a PCMH in order to assist ECs in meeting the requirements?

MIPS Advancing Care Information Checklist- Questions for Health Systems to Answer:

- ECs must use certified EHR technologies (CEHRT) that meet Meaningful Use stage 2-3 requirements. Systems must be either the 2014 or the 2015 editions, which will determine the measures that ECs must report in 2017.
  - How many of your ECs meet Meaningful Use stages 2-3 requirements using current technology?
  - Which edition of the technology do they use?
  - Do any of your ECs require a systems upgrade in order to comply?
  - What assistance or technologies can you offer your ECs in order to help them meet this requirement?
- CEHRTs must accomplish five measures: protect patient information, facilitate electronic prescribing, allow patients to access their own electronic records, and improve coordination by sending and receiving summaries of care.
  - Do EC systems accomplish all five measures?
  - Should the health system make additional investments in HIT in order to build out these capabilities?
  - Has the health system or the EC conducted a security risk analysis of their CEHRT?
  - Can the health system assist ECs in reporting to a public health registry in order to earn a bonus point?

Other MIPS Considerations - Questions for Health Systems to Answer:

- MIPS only can be a significant threat for health systems, because it incents reduced hospital utilization, with no mechanism for capturing any of the generated savings.
  - Are any of your ECs interested in pursuing alternative payment models that would allow the health system to align around common goals and share savings?
  - If you pursue alternative payment, are you prepared to accept the financial risk?
  - Which alternative payment model will you pursue and which year will you apply for? Note: the Medicare Shared Savings Program (MSSP) application period is closed for 2017, but will reopen in January for the 2018 cycle; Bundled Payments for Care Improvement (BPCI) is also closed, but you can still join through an existing convener.
  - Are any health systems in your area already organized in alternative payment models, and what's the risk that some of your ECs may be attributed to a competitor's APM?
  - Is the health system able to identify and implement operational offsets to decreased revenue that may result from declining use rates?

## CHOOSING A MIPS APM

APMs that don't qualify as "advanced" by CMS's definition can be an advantageous option. These APMs will still be subject to MIPS, but they are scored preferentially while providers learn how to progress up the risk continuum. In addition, a MIPS APM allows health systems to earn shared savings resulting from the decreased utilization that will naturally occur through the MIPS implementation. Also, participation in an upside-only ACO enables providers to see and understand the cross-continuum data on the patients they serve.

However, many of these programs have a time limit. MSSP Track 1 is only an option for two contracting periods (six years total), after which time providers must either drop out or move up the risk ladder to Tracks 2-3 with downside risk potential.

MIPS APM Checklist - Questions for Health Systems to Answer:

- Putting in place the infrastructure necessary to achieve success in the MSSP requires a significant up-front investment, as well as ongoing operating expenses. Startup costs average at around \$2 million, and yearly operating costs average at \$1.6 million. In addition, health systems must be prepared to "carry" lost utilization revenue for a full year before shared savings funds are distributed.
  - Does the health system have the revenues on hand to cover the costs of participating in alternative payment models?
  - Is the board and leadership team comfortable with taking this much financial risk?
  - What will be the impact on bond ratings or the ability to raise capital?
  - Are there partners that can be brought in to spread the cost?
- Programs such as the MSSP have baseline requirements for applicants that must be achieved in order for participants to be accepted.
  - Does the health system have a minimum of 5,000 Medicare beneficiaries that could be attributed to the ACO?
  - Has the health system formed a legal entity that can receive and distribute shared savings payments and/or pay back losses?
  - Has the health system formed a governing body made up of ACO participants?

- With only two application cycles prior to MACRA payment kicking in, when and how do you plan to prepare your application?
- Participation in APMs requires infrastructure in order to ensure success.
  - Does the health system have technology resources in place to manage population health, such as tools to monitor and report quality measures, risk stratify patient populations and/or support clinical decision making?
  - Does the health system own or affiliate with a patient centered medical home?
  - Has the health system implemented comprehensive disease management care protocols and plans, particularly for high-cost, chronic illnesses?
  - Does the health system have tools in place to reach out and engage beneficiaries and families in health plans?
- APMs require health systems to fundamentally change the way care is delivered in the community. Making this shift requires significant cultural, operational and clinical change.
  - Does leadership understand the magnitude of the change, and are they prepared to drive through a challenging implementation process?
  - Has the health system developed a staffing plan for participation, including hiring for new positions such as care managers, health coaches, patient navigators, social workers, dieticians, etc.?
  - Does the health system have in place a qualified professional who oversees quality and performance improvement?
  - Has the health system established a clinically integrated network of preferred providers?
- Successful APMs require deep relationships across the healthcare continuum in order to ensure appropriate transitions of care and referrals to top-performing partners.
  - Does the health system have a narrowed network of high-performing clinicians across all settings of care (i.e., primary care, specialist care and post-acute care)?
  - Does the health system have processes in place to manage care transitions and follow-up care?
  - Has the health system integrated behavioral health professionals within the PCMH or enhanced primary care practice?
  - Does the health system have relationships with community partners that can meet some of the social challenges that may be preventing good health?
- APMs achieve even greater financial success if they can scale over time to include larger patient populations.
  - When are private payer contracts set to be renegotiated and what's the likelihood of securing alternative payments from them?
  - Are there state alternative payment models you could expand into to reach different populations, such as Medicaid patients or the uninsured?

## CHOOSING AN ADVANCED APM

For organizations that are already in two-sided risk models, or who have long standing experience in the MSSP Track 1, it may be advantageous to organize ECs in an advanced APM. As providers move up the risk continuum, the shared savings percentages increase, and under MACRA, ECs can earn a 5 percent bonus on top of that amount.

However, advanced APMs require assumption of significant risk, and are probably not the right choice for organizations new to population health. In the final rule, CMS estimates that approximately 70,000-120,000 clinicians will participate in an Advanced APM in 2017, and 125,000-250,000 in 2018; of those, about a quarter will take on losses that can be as high as 15% of all Part A and B expenditures – about 3-10 times the amount at risk under MIPS.

Even for organizations that are far along the risk continuum, MACRA imposes some new requirements that could shape strategic decisions.

### Advanced APM Checklist - Questions for Health Systems to Answer:

- Health systems already in a program that CMS considers an advanced APM need to increase their “at risk” dollars in order to meet the requirements of MACRA, moving from 25 percent of all payments in 2019, to 50 percent in 2021 and 75 percent in 2023. Similarly, APMs need to expand their reach to include larger populations over time, moving from 20 percent of patients in 2019, to 35 percent in 2021 and 50 percent in 2023.
  - How many beneficiaries are in the programs now?
  - Are there additional Medicare beneficiaries that the health system could include in the APM by the specified timeline?
  - When are private payer contracts set to be renegotiated and what’s the likelihood of securing alternative payments from them?
  - Are there state alternative payment models you could expand into to reach different populations, such as Medicaid patients or the uninsured?
- Health systems already in a program that CMS considers an advanced APM must expand their use of CEHRTs over time, moving from 50 percent of all ECs in 2017, to 75 percent by 2018.
  - How many of your ECs currently use CEHRTs and is it reasonable to expect that requirements will be met by the deadlines?
  - Will any of your ECs require a systems upgrade over the next two years in order to comply?
  - What assistance or technologies can you offer your ECs in order to help them meet this requirement?
- Health systems in an APM, but not an advanced APM, may determine that the extra incentives in MACRA justify a move up the risk continuum. For instance, MSSP Track 1 can only be an option for two contracting cycles (six years). For providers who have been in the program from the outset, now is the time to decide whether to pursue two-sided risk.
  - Which Advanced APM is right for your organization (i.e., MSSP Tracks 2-3, Next Gen ACO or CPC+)?
  - When is your APM contract expiring, and is the timetable right to submit an application for one of the other programs?
  - Is your organization prepared to scale the program over time to meet the MACRA thresholds?

- Are you in a market that requires the health system to comply with either the mandatory joint or cardiac bundled payment programs, and how many beneficiaries can you expect to add to the APM?
- Is the leadership and board prepared to accept additional downside financial risk, at the pace demanded by MACRA?
- Are there affordable reinsurance options in your market that could protect you from heavy losses?
- Are your ECs prepared to make the progression to higher risk with you?
- If you elect not to move up to higher risk, what are the market implications/risks you face?

## CONCLUSION

With only a few weeks left to make strategic decisions before the MACRA performance period kicks in, ECs are evaluating their options. To avoid being surprised by the outcomes, health systems should engage with their ECs now in order to provide education on the law and the decisions that must be made. Health systems should also convene forums with physicians in order to walk them through their current and expected performance so that adjustments can be made to optimize scoring, highlighting the importance of change using financial modeling tools based on specific, local market data.

Health systems should also be thinking strategically about what assistance they can provide ECs in order to help ensure success through MACRA. Given the payment dollars at risk, it may make sense to speed up alignment efforts or planned investments in order to ensure MACRA preparedness.

Last, health systems need to understand that in order for ECs to perform well, many may need to change clinical practice and referral patterns, which could represent a significant disruption in many markets as ECs transition away from volume and begin embracing value.

### About Premier Inc.

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