Advisory Board | Physician Practice Roundtable

Medical Group Success under MACRA

Rethinking Risk Strategy and Maximizing Performance in MIPS

Road Map

1 The Law That Shook the Physician Payment World

2 Rethinking Your Risk Model Strategy

3 Playbook for Maximizing Your Performance in MIPS

A Few Choice Words About MACRA

Unnecessarily complex

Do your best to keep it simple

No to MACRA. Just No.

Nothing more than a larger patch on top of smaller patches.

This is much too fast

It is all crap

Too many metrics with unproven ties to outcomes

Please stop hurting us

MACRA is an abomination, unconstitutional...recklessly takes the entire nations populace and forces them into databases, using physicians as the financial scapegoat for a bankrupt economy.

When I get a Starbucks coffee, I pay for the coffee, not my perceived value of the coffee, how it made me feel and if it was delivered to me in a nice way. I want it, I pay for it, I get it and I move on.

This will never work. It is doomed to fail

Move to global risk!

CMS grow a pair!

Good basis, but forces us to affiliate with higher cost partners. We cannot make it in this environment.

NOOOOOOOOOO!!!!!!

Source: 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," Apr. 27, 2016, available at: qpp.cms.gov. Physician Practice Roundtable 2016 MACRA Pulse Check Survey. Advisory Board interviews and analysis.

MACRA: Executive Summary

Legislation in Brief

- Medicare Access and CHIP Reauthorization Act (MACRA) passed with bipartisan support in April 2015
- Final rule issued October 14, 2016
- Repeals the Sustainable Growth Rate (SGR)
- Locks Medicare Physician Fee Schedule reimbursement rates at near-zero growth:
  - 2016-2019: 0.5% annual increase
  - 2020-2025: 0% annual increase
  - 2026 and on: 0.25% annual increase, or 0.75% increase, depending on payment track
- Stipulates development of the Quality Payment Program (QPP)
- Programs to be implemented on January 1, 2019 based on annual performance period starting January 1, 2017

The Quality Payment Program (QPP): Two New Medicare Physician Fee Schedule Payment Tracks

1 Merit-Based Incentive Payment System (MIPS)

- Rolls existing Medicare Physician Fee Schedule payment programs[1] into one budget-neutral pay-for-performance program
- Clinicians will be scored on quality, cost, clinical practice improvement activities, and EHR[2] use—and assigned a positive or negative payment adjustment accordingly

2 Advanced Alternative Payment Models (APM)

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

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

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Advancing Risk Through Physician Reimbursement

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

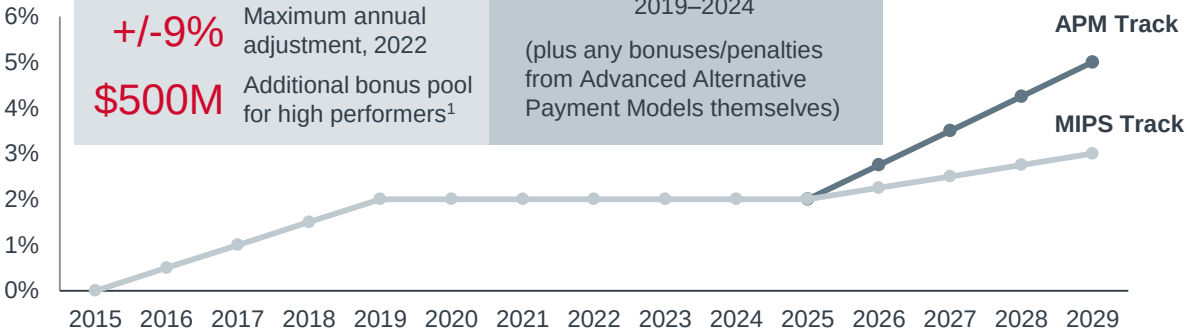
1. MIPS Bonuses/Penalties

+/-4%	Maximum annual adjustment, 2019
+/-9%	Maximum annual adjustment, 2022
$500M	Additional bonus pool for high performers[1]

2. APM Bonuses/Penalties

5% Annual lump-sum bonus from 2019–2024

(plus any bonuses/penalties from Advanced Alternative Payment Models themselves)



Baseline payment updates[2]:

2015 – 2019:
0.5% annual update (both tracks)

2020 – 2025:
Payment rates frozen (both tracks)

2026 onward:
0.25% annual update (MIPS track)
0.75% annual update (APM track)

1) Clinicians with a threshold final score of 70 or higher eligible for additional bonus.
2) Relative to 2015 payment.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Groups Fall into One of Three Scenarios

Differences in Criteria, Scoring, and Payment Under MACRA

	MIPS	MIPS-APM	APM
Criteria	Eligible clinicians (ECs) that exceed low volume threshold and don't participate in an APM	ECs that participate in an APM but don't qualify for the APM track Specialists: Must be listed on participant list of APM	ECs that: • Participate in an advanced APM • Use CEHRT[1] • Meet patient count or revenue threshold[2]
Scoring (in 2018)	In 2018, Quality is 50%, Cost is 10%, IA is 15%, and ACI is 20%.	Quality is 50%, IA is 20%, and ACI is 30%. Not scored on cost.	Exempt from MIPS (Not scored)
Payment (in 2020)	• Max. of 5% positive or negative payment adjustment in 2020, based on 2018 performance year	• Max. of 5% positive or negative payment adjustment • Better poised to be high performers	• Eligible for 5% bonus in first five years of program. • No positive or negative payment adjustment based on performance.

1) Certified EHR Technology.
2) For 2017 performance period APM entities must have 26% of payments through advanced APMs or 20% of patients in advanced APMs.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

For MIPS Reporting, 2017 a Transitional Year

Flexible Reporting Requirements Ease Providers into MIPS

MACRA Implementation Timeline

Three Options for MIPS Reporting in 2017[1]

1 Full Measure Set Across All Categories

Report required MIPS measures for 90 days or more

→ Eligible for moderate positive payment adjustment

2 More than One Measure

Report more than one measure for 90 days or more

→ Eligible for small positive payment adjustment

3 One Measure in Any Category

Report any measure in any category for any period of time

→ Avoid penalty

Organizations only penalized for non-reporting

Cost category not scored

1) For payment in 2019.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

But Not the Only Change

CMS Reduces Reporting Requirements Across All Categories

MIPS Performance Category	Top Reporting Takeaways for 2017
Quality (*Replaces PQRS[1], VBPM[2]*)	• Nearly 300 measures to choose from, 80% of which are tailored to specialists • Eligible Clinicians only required to report six measures; in addition, all-cause readmissions will be calculated based on claims • Cross-cutting measure will no longer be required
Cost *(Expands VBPM cost metrics)*	• Total per capita costs for all attributed beneficiaries and Medicare spending per beneficiary • Adds 10 episode-based measures, rather than 41 • No longer a component of MIPS performance in program year 2017; weighted at 10% in 2018, 30% in 2019
Improvement Activities (IA) *(New category)*	• Over 90 activities to choose from; some activities weighted higher than others • Full credit requires 40 points, rather than 60 • Preferential scoring for small practices, PCMH[3], and MIPS-APM participants
Advancing Care Information (ACI) *(Replaces Meaningful Use for physicians)*	• Applies to all clinicians, not just physicians • Clinicians given opportunity to report as group or individual • No longer requires all-or-nothing EHR measurement • Reporting minimum: Four Modified Stage 2-equivalent measures or five Stage 3-equivalent measures in 2017, rather than 11 required measures

1) Physician Quality Reporting System.
2) Value Based Payment Modifier.
3) Patient-Centered Medical Home.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Fundamentally Changing the Physician Payment Game

Ups the ante on physician
Pay-for-Performance

Payment tied to physician performance versus peers, with no “held harmless” zone

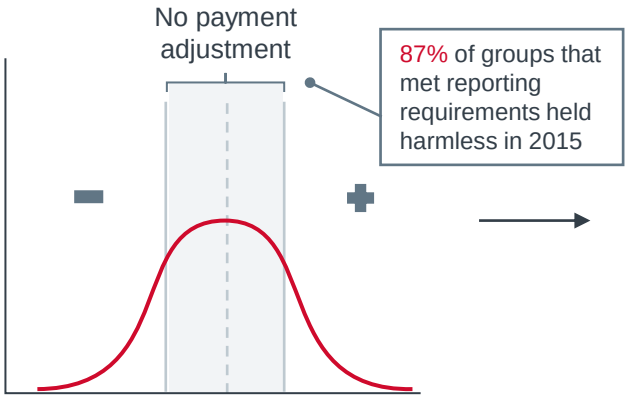
Introduces significant
Incentives to Take on Risk

Incentives include payment bonus and reduced physician reporting burden

Source: Advisory Board interviews and analysis.

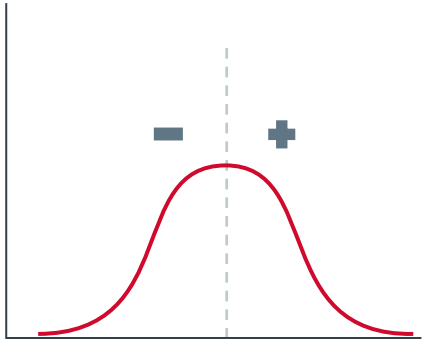
Average Performance No Longer Sufficient

Group Performance under VBPM[1]



Prior to MACRA, groups held harmless for average performance

Group Performance under MIPS[2]



Under MIPS, one point above or below mean or median composite score results in payment adjustment[3]

How MACRA Ups the Ante

- Game of winners and losers
- Annual improvement necessary to stay competitive
- 9% of payment on the line in 2022

1) Value Based Payment Modifier.
2) Merit-Based Incentive Payment System.
3) Beginning in payment year 2020 based on performance in 2018.

Source: Physician Practice Roundtable 2016 MACRA Pulse Check Survey. Advisory Board interviews and analysis.

Offering Multiple Carrots for Risk

Ways CMS Incentivizes Taking on Risk through MACRA

APM TRACK

5% bonus for participation in APM track 2019-2024

0.75% adjustment in 2026 and beyond (vs. 0.25%)

MIPS-APM

Reduced reporting burden in quality category of MIPS

Cost category not scored if MIPS-APM

Automatically given full credit in IA[1] in 2017

1) Improvement Activities.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Making APM Track Even More Accessible

AAPM[1] 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

25%

ECs projected to qualify for APM track in 2018

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

- MSSP[2] ACO Track 1+ model
- Mandatory bundled payment models including CJR[3] and Episode-Based Payment Model

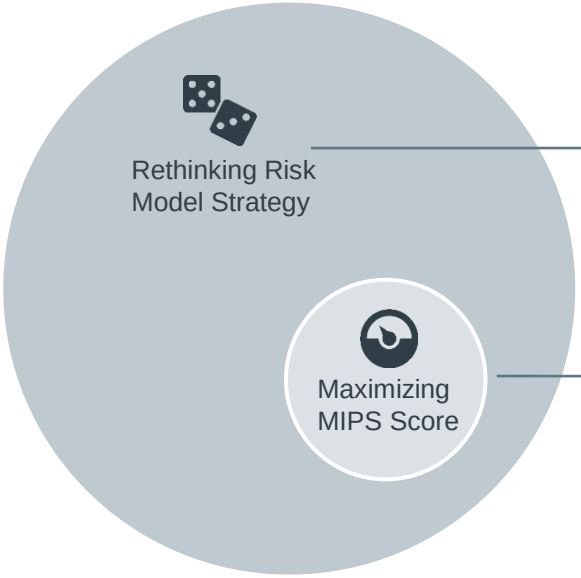
1) Advanced Alternative Payment Model.
2) Medicare Shared Savings Program.
3) Comprehensive Care for Joint Replacement.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Focusing on the Forest and the Trees

Confronting the Push to Risk Amidst Efforts to Optimize Performance

Succeeding under MACRA Requires Dual Focus



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

- 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[1] and ACI[2] categories?

1) Improvement Activities.
2) Advancing Care Information.

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

Source: Advisory Board interviews and analysis.

Road Map

1 The Law That Shook the Physician Payment World

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MACRA Forcing Reevaluation of APMs

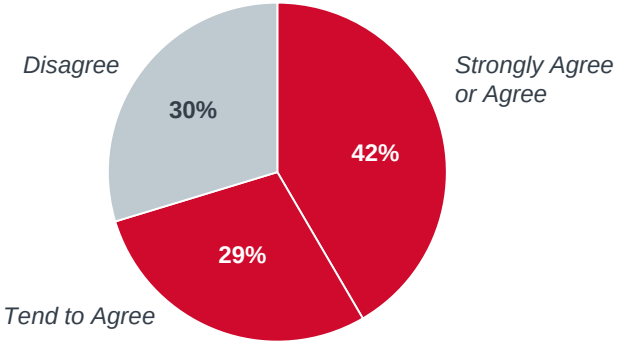
Medical Groups Must Grapple With the Implications for Payment

A Key Set of Strategic Questions

- Is the preferential scoring in MIPS-APM worth it to start to take on risk?
- What would it take for us to participate in an advanced APM vs. MIPS APM? Which—if either—can we achieve given our organization's current capabilities?
- Come 2019, is it critical to secure 5% APM track bonus? Come 2026, could we survive on only 0.25% annual update?

"MACRA is Pushing my Group to Take on More Risk in the Next 3 Years"

n=31 independent medical group leaders



71%

Percent who express some level of agreement

Source: Physician Practice Roundtable 2016 MACRA Pulse Check Survey. Advisory Board interviews and analysis.

But Just One Piece of the Bigger Picture

Stagnant Rates and More Models to Choose From Also Part of the Push

Diminishing FFS[1] Payments

- Misvalued codes initiative
- Rate of inflation growing three times faster than MPFS rates 2004-2013
- Conversion Factor continuing to stagnate

Evolution, Multitude of APM Options

- CMMI[2] continuing to release new voluntary payment models, adapt payment models according to provider feedback
- Implementation of mandatory bundled payment models in some markets

Increasing Portion of Payment at Risk

- **Medicare Access and CHIP Reauthorization Act (MACRA)**

1) Fee for service.
2) Centers for Medicare and Medicaid Services Innovation.

Source: Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2015; Cumulative Inflation Calculator, available at www.inflationdata.com; Advisory Board interviews and analysis.

A Range of On-Ramps to Risk

CMS Expanding Portfolio of Alternative Payment Options

APM Eligible Payment Models

1 Bundled Payment Models[1]

- Comprehensive Care for Joint Replacement Model (mandatory)
- Oncology Care Model
- Episode Based Payment Model (proposed)

2 Total Cost of Care Models

- MSSP Track 1+, 2 and 3[2]
- Pioneer ACO Model[2]
- Next-Generation ACO[2]
- Medicare Advantage (provider-sponsored)[3]
- ESRD Care Model[1]

3 Primary Care Models

- Comprehensive Primary Care + (starting 2017)[2]

1) Will qualify for Advanced APM track in 2018.
2) Currently qualifies for Advanced APM track.
3) Will qualify beginning in 2021.

Source: Centers of Medicare and Medicaid Services; Modern Healthcare, "Slavitt: 'We'll go a fast as the evidence allows us to go," *Modern Healthcare,* July 2016; Health Care Advisory Board interviews and analysis.

Assessing Medicare ACOs in Light of MACRA

An Expanding Set of Medicare ACO Options to Evaluate

MSSP Track 1	MSSP Track 1+	MSSP Track 2	MSSP Track 3	NGACO[2]
Upside-only shared savings with maximum share rate of 50%	New downside risk model introduced in final rule. Details to come from CMS	Downside risk model with max. share/loss rate of 60%	Downside risk model with max. share/loss rate of 75%	Downside risk model with choice of 80% or 100% share/loss rate
411 Participants[1]	0 Participants	6 Participants	16 Participants	18 Participants
MIPS-APM	Eligible APMs for APM Track			

Why Focus on These APMs?

- ☑ Annual application process
- ☑ Both primary-care and specialists can participate
- ☑ Physician-focused, not hospital focused

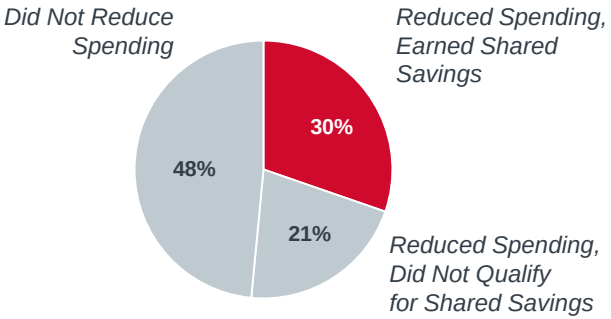
> "We know it's finally time to take on risk. What we don't know is how much, or which model we should choose."
>
> *President, Stars Hollow Group*[3]

1) As of September 2016.
2) Next Generation ACO.
3) Pseudonym.

Source: NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; CMS, "Next Generation Accountable Care Organization Model (NGACO Model)," January 11, 2016, available at: www.cms.gov; CMS, "2016 Medicare Shared Savings Program Organizations," October 2016, available at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt, Advisory Board interviews and analysis.

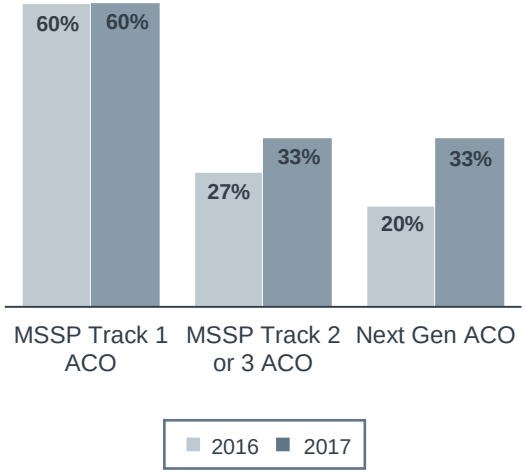
Limited Returns So Far, But Continued Participation

MSSP ACOs Sharing in Savings, 2015[1]



ACO Participation by Model

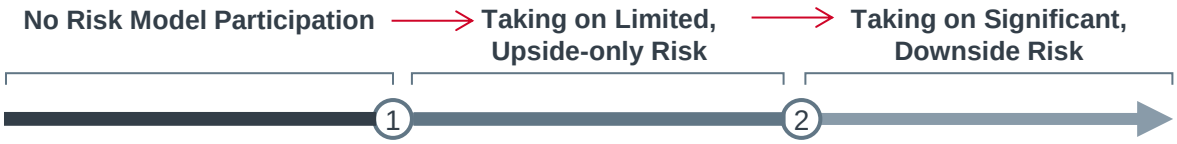
Among groups taking on risk
n=15 independent medical groups[1]



1) Results reflective of Track 1 MSSP ACOs only.
2) Respondents were allowed to select more than one model for participation, so percentages do not equal 100.

Source: CMS, available at: data.cms.gov, accessed October 3, 2016; Physician Practice Roundtable MACRA Pulse Check Survey. Advisory Board interviews and analysis.

Two Decisions at Hand



Decision 1: Should we take on upside-only risk?

- Eligible for preferential scoring in MIPS
- Still protected from payment penalty in risk model

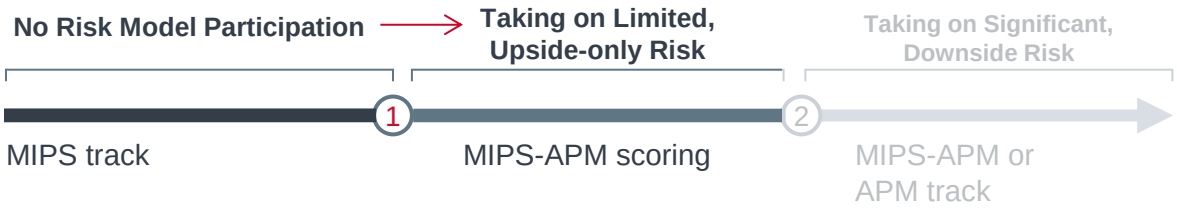
Decision 2: Should we shift to downside risk?

- Eligible for preferential scoring in MIPS
- Potentially exempt from MIPS reporting[1]
- Potentially eligible for 5% bonus in APM track[1]

1) So long as revenue and patient count thresholds met.

Source: Advisory Board interviews and analysis.

Getting into Risk for the First Time



Reasons Groups Hesitant to Jump into Risk

Limited Population Health Experience

Many operating largely on FFS, haven't made large scale investments in population management

A Laundry List of Options

With so many options to choose from, it can be difficult to evaluate risk models

Difficulty Comparing Costs and Benefits

Taking on risk requires investment, and it can be difficult to fully understand incentives

Key Questions

For Decision Point One

Groups with Primary Care:

- Have we invested in a population health infrastructure in order to be successful in a risk model?
- If not, how can we develop these capabilities?

Specialty Groups:

- Do we have primary care partners to take on risk with?
- Do our current partners plan to take on risk? Are we official participants?

Source: Advisory Board interviews and analysis.

MSSP Track 1 May Be Ideal Starting Point

Upside-only, FFS Reimbursement Attractive for First Movers

Agreement Length	Three year agreement period[1]
Minimum Size	5,000 beneficiaries
Attribution	Retrospective
Reimbursement	**FFS** with reconciled shared savings
Sharing Rate	Up to 50%
First Dollar Savings	MSR[2] based on size, between 2-3.9%
Maximum Gain	10% of benchmark
Maximum Loss	0%, **upside only**

Two Key Strategic Benefits

1. Supports success under MIPS in the near-term:
   - Preferential scoring
   - Economies of scale
   - Reporting experience

2. Provides on-ramp to downside risk in the long-term:
   - Time limits on participation in track before downside required
   - Creates opportunity to cultivate infrastructure for population health, essential to downside risk strategy

1) Allowed to renew for a second three-year period or to apply for an additional year in the first period to delay move to downside track.
2) Minimum Savings Rate.

Source: NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

MSSP Track 1 Supports MIPS Success in Near Term

MIPS Score Components		Advantages of MSSP ACOs under MACRA
Quality	→	ACO quality measures qualify for MIPS reporting
Cost	→	Medicare ACOs exempt from cost category[1]
Improvement Activities	→	Automatically awarded all possible points in this category[2]
Advancing Care Information	→	ACOs are more familiar with EHR and IT requirements easing reporting burden by leveraging past experience

$500M Extra pool of incentives for high-performing MIPS eligible clinicians[3]

1) Cost doesn't apply to MIPS scoring for all participants in 2017.
2) In 2017.
3) Clinicians with a threshold final score of 70 or higher eligible for additional bonus,

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, 81 FR 28161," https://federalregister.gov/a/2016-10032; Advisory Board interviews and analysis.

Providing On-Ramp to Downside in the Long Term

Three Primary Strategic Aims in Track 1 Participation

Establish Key Relationships

First-mover advantage in securing partnerships in market before competitors; allows time for alignment of network with ACO's population health goals

Build Population Health Infrastructure

Investments in care delivery transformation to transition to value-based care model; incentivize behavior change in new model with potential for shared savings

Analyze Valuable Data

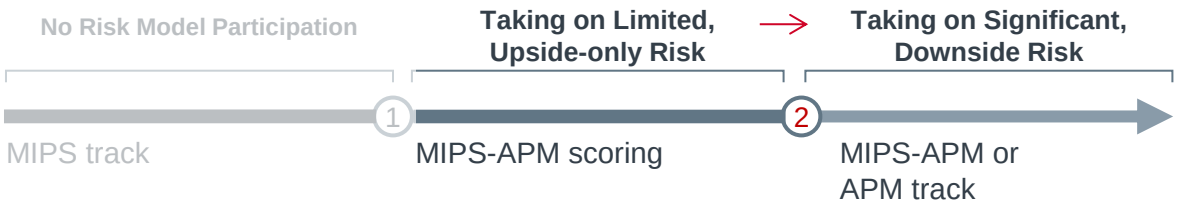
Transparency into areas of spending opportunity, leakage; potential to use Track 1 performance data to evaluate performance in future contracts

6 Years Maximum time allowed for participation in Track 1 before transition to downside risk

63% Percent of ACOs with downside risk that started in MSSP Track 1

Source: NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; Advisory Board interviews and analysis.

Shifting From Upside-Only to Downside



Reasons Groups Hesitant to Jump into Downside

Interpreting Mixed Financial Results

Many evaluating risk despite unremarkable results in first agreement period

No Clear Indicators of Success

Measures of success vary by model; success in Track 1 doesn't guarantee success in Track 2

Uncertainty of Investments

Difficult to know if group has made enough of the right investment in care management

Key Questions

For Decision Point Two

Groups with Primary Care:

- Is there a model that makes transition from upside-only in Track 1 to downside risk a viable option?
- Which model provides us with the most favorable benchmark?

Specialty Groups:

- Do our current ACO partners want to shift to downside risk? If so, when? How might that change our arrangement?
- Is there a bundled payment model to consider for APM track eligibility in future?

Source: Advisory Board interviews and analysis.

Overview of Medicare Downside ACO Models

Comparing Three Advanced APM Options

	MSSP Track 2	MSSP Track 3	NGACO
Sharing Rate	Up to 60%	Up to 75%	Choice of 80% or 100%
Maximum Gain[1]	15%	20%	15% + applied discount
Maximum Loss[1]	5%, 7.5%, 10% in years 1, 2, 3 respectively	15%	15% + applied discount
First-Dollar Sharing?	Optional	Optional	Yes
Payments	FFS, reconciled shared savings/losses	FFS, reconciled shared savings/losses	Four options including FFS or population-based payments
Beneficiary Attribution	Retrospective	Prospective	Prospective
Waivers	None	3-day SNF[2]	3-day SNF, telehealth, post-discharge home visit

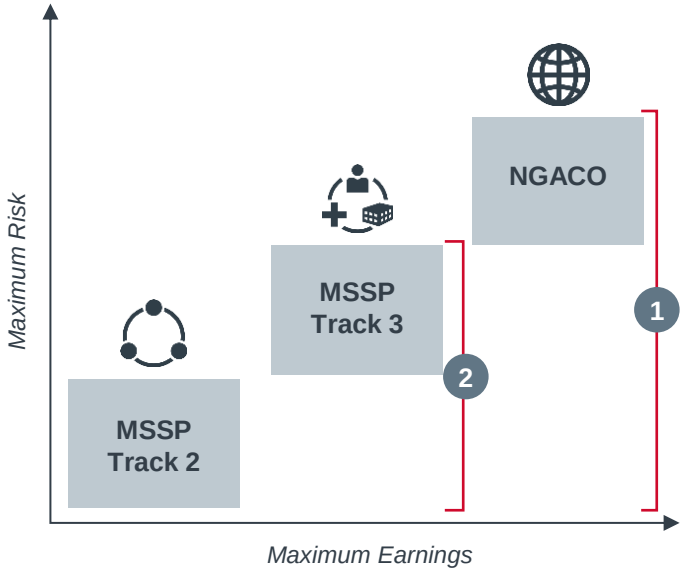
1) Expressed as percentage of benchmark expenditure target.
2) Skilled nursing facility.

Source: Centers for Medicare and Medicaid Services, "Accountable Care Organizations: A Final Rule," *The Federal Register*, June 9, 2015; Advisory Board interviews and analysis.

Sorting Through a Variety of Options

Two Questions Central to Decision-Making Process

Financial Continuum of Downside Models



Two Key Questions for Your Group

1. Do we want to participate in NGACO or MSSP?
2. If we stay in MSSP, is participation in Track 2 or Track 3 more beneficial to our group?

Source: Advisory Board interviews and analysis..

Key Insights to Include in Evaluation

1 NGACO vs. MSSP

Key takeaway:
NGACO offers larger pay-off for groups that are confident they can outperform their targets

Benchmark Calculation a Key Distinction:

- MSSP benchmark based on past three years' expenditures; NGACO based on 2014 only
- MSSP baseline trended forward using national growth rate[1] or regional growth rate[2]; NGACO trended using national growth rate with regional pricing adjustments[3]
- In high-growth regions, MSSP more attractive; In high-cost areas, NGACO more attractive

NGACO Removes MSR[4]/MLR[5] Buffer Zone:

- MSSP first dollar savings/losses start at target amount; NGACO savings/losses start at target minus discount[6]
- MSSP generally the safer option

2 MSSP Track 2 vs. Track 3

Key takeaway:
For most ACOs, Track 3 offers higher reward and lower risk than Track 2

Track 3 offers higher reward:

- Track 3 has a maximum sharing rate of 75%; Track 2 has maximum sharing rate of 60%
- Track 3 ACOs can earn up to 20% of benchmark compared to 15% in Track 2

Track 3 offers lower risk for most:

- Track 3 becomes lower risk when quality score meets/exceeds 55%
- 98% of MSSP ACOs received quality score above 55% in PY2015

1) First performance period.
2) Subsequent performance periods.
3) i.e. area wage index, geographic practices cost index.
4) Minimum savings rate.
5) Minimum loss rate.
6) Size of discount varies from .5% to 4.5% based on ACO's quality and efficiency.

Source: Source: CMS, "Next Generation ACO Model: Review of Alignment/Benchmarking Methodology," April 5, 2016, available at: https://innovation.cms.gov; CMS, "Final Medicare Shared Savings Program Rule (CMS-1644-F)," June 6, 2016, available at: www.cms.gov; CMS, "Medicare Shared Savings Program Accountable Care Organizations Performance Year 3 Results," September 2015, available at: https://data.cms.gov. Advisory Board interviews 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[1]

Medicare Advantage 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

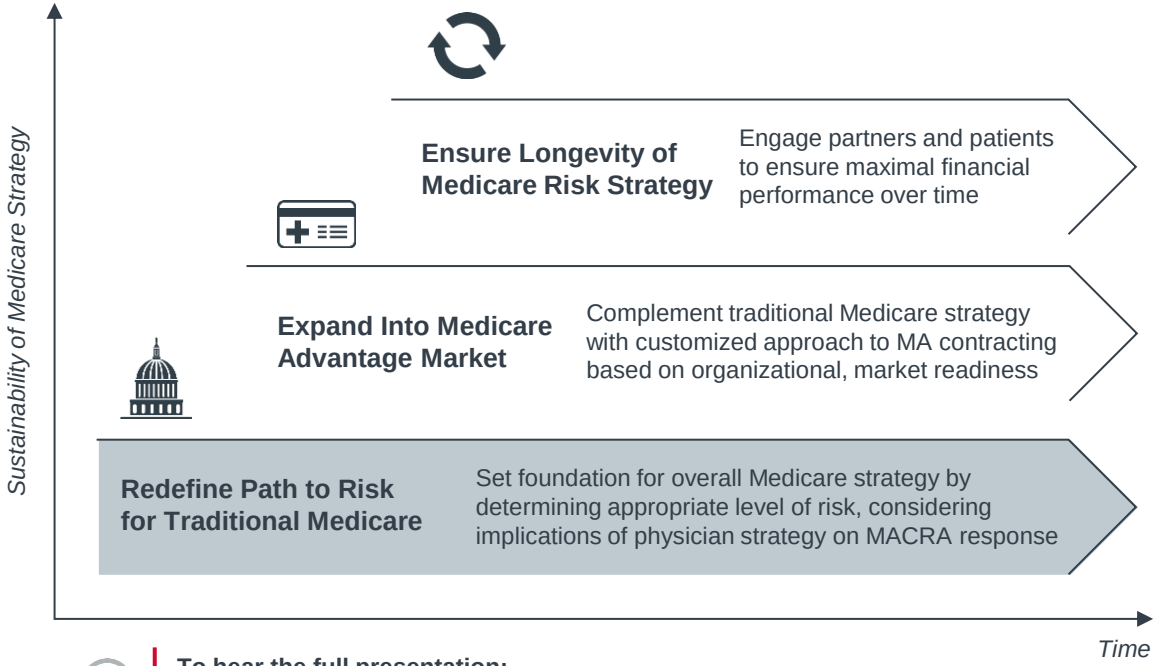
Organizations that have capitation targets and require a narrow network may find that current options don't satisfy their needs

1) Return on investment.

Source: Advisory Board interviews and analysis.

Defining an Intentional Medicare Risk Strategy

New Study From the Health Care Advisory Board



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

Source: Advisory Board interviews and analysis.

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

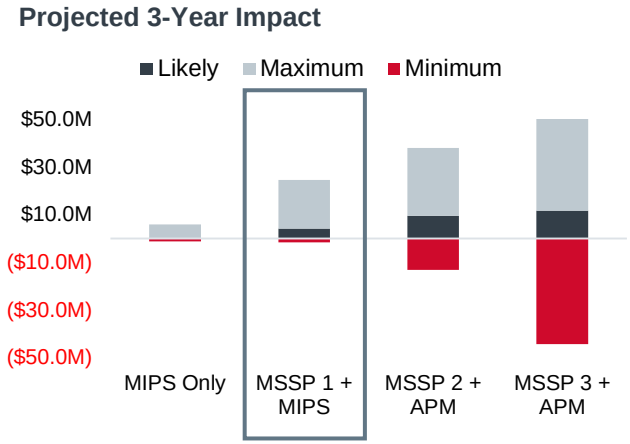
MIPS Score Diluted by Adding ACO Partners

- 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

Source: Advisory Board interviews and analysis.

Don’t Be Blinded by the 5% APM Upside

Example of MACRA Track Scenarios at Weaver Clinic[1]



Necessary to Weigh Benefit and Risk

The MSSP 1 + MIPS track highlights the best scenario because it offers 43% to 71% of maximum potential benefit combined with minimal downside exposure.

Approach	Best Case	Worst Case	Most Likely Case
MIPS Only	$5.6M	-$1.2M	$0.3M
MSSP 1 + MIPS	$20.4M	-$1.6M	$4.2M
MSSP 2 + APM	$28.5M	-$13.2M	$9.5M
MSSP 3 + APM	$47.3M	-$44.4M	$11.7M

1) Pseudonym.

Source: Advisory Board interviews and analysis.

The Advisory Board's MACRA Intensive

One-Day Intensive to Prepare for MACRA Success

Pre-Meeting Analysis

Our team will complete the following tasks to create a customized , three-part agenda for our on-site:

- Interview 3-5 physician and administrative leaders to discuss priorities and objectives
- Request, review, and analyze your Medicare-specific data
- Review your risk-based contracts, and other cost and quality data

On-Site Agenda

PART I

MACRA Policy Education *(open invite)*

- Learn the emerging Medicare policies and protocols under MACRA
- Educate executives and physicians on how these changes will impact their practice

PART II

Performance Assessment

- Review readiness assessment and see a high-level gap analysis of various track scenarios
- Discuss if AAPM is a worthwhile future pursuit

PART III

Strategy Discussion with Senior Leadership

- Outline goals for realizing full potential of reimbursement based on organizational capacity and capabilities
- Discuss areas of focus and tactical next steps for successful performance

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

Road Map

1 The Law That Shook the Physician Payment World

2 Rethinking Your Risk Model Strategy

3 Playbook for Maximizing Your Performance in MIPS

Playbook for Maximizing Performance in MIPS

9 Tips to Elevate Your Performance Score

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
9. **Focus** efforts on performance score

Mechanics

Quality

Cost

Improvement Activities

Advancing Care Information

Source: Advisory Board interviews and analysis.

How to Use this Playbook

Nine Tips Plus Associated Appendix Included

Who in the medical group should use this playbook?

We recommend medical groups assemble a "MACRA dream team." Bring together staff with expertise in IT, claims submission, regulatory policy, and clinical quality (as well as anyone currently responsible for CMS physician pay-for-performance programs) to implement the tips in this playbook.

How should the MACRA team use this playbook?

Though most medical groups will fall into the MIPS track of MACRA, there are still a range of category weights and scoring scenarios within the MIPS tracks for various clinician and group types. While there is relevant guidance for all group types in this playbook, not every tip will apply to all groups. To identify which tips are most relevant to your group, see the chart on the following page.

When should the MACRA team use this playbook?

The first performance year for the Quality Payment Program (MACRA) begins on January 1, 2017. While requirements for 2017 are relatively minimal, this playbook can help groups ensure they're meeting requirements for 2017 and prepare for full-year reporting and higher standards in 2018.

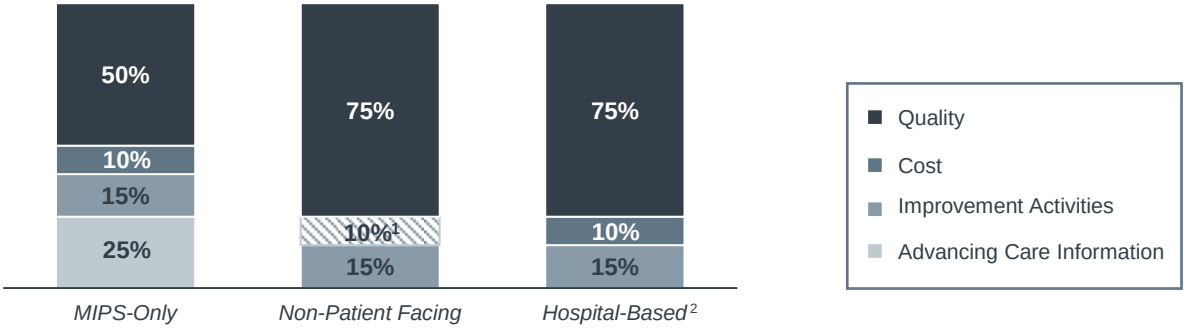
Find an appendix of related resources for this playbook at:
at: advisory.com/PPR/2016summitresources

Source: Advisory Board interviews and analysis.

Not All Clinicians Equal Under MACRA

CMS Provides More Clarity on Non-Patient Facing, Other Definitions

2018 Weighting for 2020 Payment
by clinician



Finalized Definitions of Non-Patient Facing Clinicians and Groups

Non-Patient Facing Clinician

Performs fewer than 100 procedures with patient facing codes[2] annually

Non-Patient Facing Group

At least 75% of eligible providers in the group are designated non-patient facing

1) Non-patient facing ECs get scored on cost measures if they have enough case volume to meet the required case minimum. If case minimum is not met, cost category reweighted to quality making quality 85% of non-patient facing clinician score.
2) Defined as an eligible clinician who furnishes 75% or more of covered professional services in sites of service identified by the Place of Service codes as an inpatient hospital, on campus outpatient hospital or emergency room.
3) Patient-facing services will include general office visits, outpatient visits, and procedures. Specific codes will be released on CMS website.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Identify Which Tips Apply to Your Group

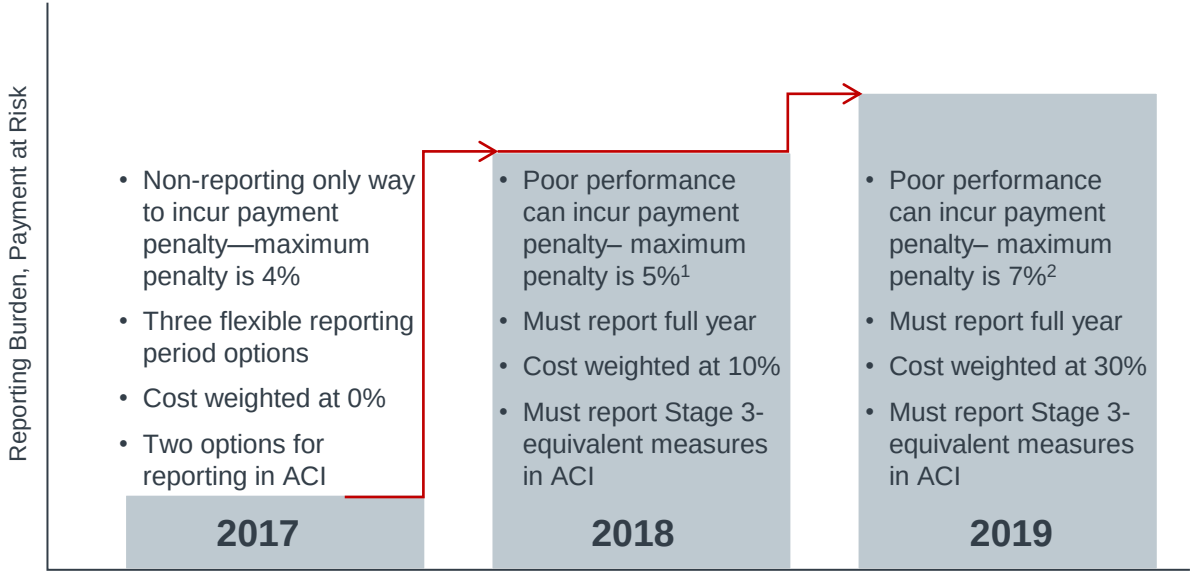
Group type	Reporting mechanics		Quality	Cost	IA	ACI
MSSP ACO participant	*1. Use transition year to your advantage*	Use web interface reporting mechanism	N/A (must do 14 web interface measures)	Not scored, but imperatives also serve ACO well	Automatic full credit given	*9. Focus efforts on performance score*
Multi-specialty with primary care		Consider web interface reporting	N/A (must do 14 web interface measures)	*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*	
Multi-specialty, no primary care		*2. Choose reporting mechanism wisely*	*3. Review MIPS quality measures and create a target list* *4. Aim to earn bonus points*			
Single specialty (not part of ACO)						
Hospital-Based						EXEMPT
Non-patient Facing				EXEMPT	Report two activities	EXEMPT

Source: Advisory Board interviews and analysis.

Though Requirements Lax, 2017 is Not a Year Off

Stakes Get Dramatically Higher in 2018 and Beyond

Progression of Reporting Requirements, Payment at Risk by Performance Year



1) For payment in 2020.
2) For payment in 2021.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Three Ways to Take Full Advantage of 2017

1 Report for Full Year of Data

- In 2018, full year reporting is required--get into the practice immediately
- Maximize your return on reporting by qualifying for modest positive payment adjustment in 2019

2 Report on Full 2018 Requirements

- Use 2017 as practice for full QPP requirements
- Identify any operational challenges early in time to work out kinks
- Enhance performance for 2018 when payment is on the line

3 Use Data to Inform Performance

- CMS will provide a wealth of feedback after groups report each year
- Performance will be calculated even for measures that aren't scored in 2017 performance period
- Feedback valuable for reformulating strategy, maximizing score long-term

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

ABCs of Reporting Mechanisms in MIPS

Six Core Options Available

Qualified Clinical Data Registry (QCDR)

Meets specific CMS qualifications but scope of registry is *not* limited to PQRS measures

For more: QCDRs available

EHR[1]

Office of the National Coordinator-certified EHR submits data directly to CMS

For more: certified EHRs available

Qualified Registry

Meets specific CMS qualifications and scope of registry is limited to PQRS measures

For more: registries available

CMS Web Interface

Group practice reporting option via CMS' QualityNet web site

For more: see QualityNet

Attestation or Claims

Attestation: TBD, CMS may utilize existing MU attestation portal

Claims: Coded data inputted through claims

CAHPS[2] Vendor

CMS certified vendor used for combined CAHPS and PQRS reporting

For more: see approved vendors

1) Electronic health record.
2) Consumer Assessment of Health Providers and Systems.

Sources: CMS QCDRs; CMS EHR Reporting; CMS Qualified Registries; CMS Web Interface Group Reporting Option; CAHPS Vendor; Advisory Board interviews and analysis.

Numerous Considerations to Take Into Account

Prioritize Mechanism Benefits, Vendor Capabilities

Certain mechanisms provide additional benefits including bonus points, data tracking, and supplemental measures

Financial and labor costs can vary dramatically across reporting mechanisms

The ability to streamline reporting across categories can decrease reporting burden

Vendor Assessment Checklist

- ☑ Has an established track record of several years?
- ☑ Able to provide consistent feedback?
- ☑ Experience working with your type of group?
- ☑ Knowledgeable on MACRA requirements?
- ☑ Offers a MIPS reporting guarantee?
- ☑ Can provide documentation to support audits?

Source: Advisory Board interviews and analysis.

A Mechanism by Mechanism Analysis

Features of MIPS Approved Reporting Mechanisms

Submission Methods	Expected % of Providers[3]	Annual Labor Cost Estimate (per provider) [3]	Minimum Number of Metrics[4]	Unique Selection of Metrics	End-to-End Reporting Bonus	Ability to Submit all Categories
Group or Individual Reporting						
QCDR or Qualified Registry	27%	$1,127	6	✓	✓	✓
EHR	11%	$1,206	6	✓	✓	✓
Group-Only Reporting						
CMS Web Interface[1]	28%	$19	15		✓	✓
Individual-Only Reporting						
Claims[2]	34%	$997	6	✓		

Offers greatest flexibility in measure selection

Not appropriate for specialty groups: requires standard ACO reporting metrics, heavily primary care focused

1) Available for groups of 25 or more only.
2) Claims submission through attestation. Must include 50%+ of Medicare Part B patients in 2017.
3) Based on Final Rule (Oct. 2016). Does not include infrastructure cost.
4) Plus one claims-based population measure, All –Cause Readmissions, (no reporting required).

Source: CMS, "CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Comparing CMS Web Interface and QCDR Options

Web Interface Ideal for Primary Care, QCDR Best Choice for Specialists

CMS Web Interface

Benefits

- May be lowest cost option
- Automatically earns 9 bonus points by reporting
- Same set of measures required in ACO, can serve as on-ramp period

Drawbacks

- Groups are competing against ACOs on quality measures
- Metric performance based on 248 randomized Medicare beneficiaries, not all-payer data

Qualified Clinical Data Registry

Benefits

- Ability to view performance in time to make changes
- More choices available in measure selection
- QCDR participation can help groups carry out IA activities

Drawbacks

- May require significant investment

Source: Advisory Board interviews and analysis.

2017 Web Interface Quality Measures

Set of Metrics Primary Care Focused, one Claims-Based Measure Included

Measure Description	Method	Measure Type
Medication reconciliation post-discharge[1]*	CMS WI[2]	Process
Falls screening for future fall risk*	CMS WI	Process
Influenza immunization	CMS WI	Process
Pneumonia vaccination status for older adults	CMS WI	Process
Body Mass Index (BMI) screening and follow-up	CMS WI	Process
Tobacco use: screening and cessation intervention	CMS WI	Process
Screening for depression and follow-up plan	CMS WI	Process
Colorectal cancer screening	CMS WI	Intermediate Outcome
Breast cancer screening	CMS WI	Process
Statin therapy for the prevention / treatment of cardiovascular disease	CMS WI	Process
Depression remission at twelve (12) months**	CMS WI	Outcome
Diabetes Composite (1/2): hemoglobin A1c poor control and eye exam[3]**	CMS WI	Intermediate Outcome
Hypertension: controlling for high blood pressure**	CMS WI	Intermediate Outcome
Ischemic Vascular Disease: use of aspirin or another antiplatelet	CMS WI	Process
Hospital Readmissions: All-Cause Hospital Readmissions	Claims Data	Population-Based
Hospitalization per 1,000 beneficiaries (ACSA): Acute Composite Score[4]	Claims Data	Population-Based
Hospitalization per 1,000 beneficiaries (ACSA): Chronic Composite Score[4]	Claims Data	Population-Based

1) Asterisk indicates high priority measure (1 point per *).
2) Web Interface.
3) Two-part composite measure.
4) Indicates tracked for feedback in 2017, not scored.

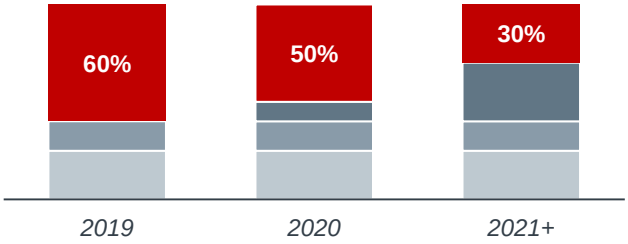
Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

A Critical Performance Differentiator From the Start

Quality Category Demands Significant Attention

Relative Weight of Quality Category

by Payment Year[1]



Our Take

- Dominant component of score where medical groups will likely focus most effort
- ECs have flexibility to strategically choose measures
- Likely critical performance differentiator in early years

Two Tips for Quality

3 Review MIPS quality measures and create target list

4 Aim to earn bonus points

1) Payment based on performance two years prior.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

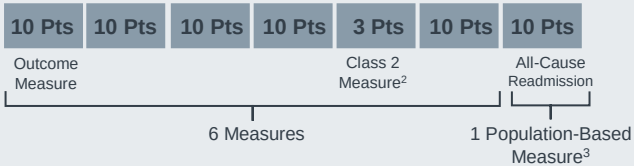
MIPS Quality Performance Category

Dominant Component of Score, Significant Flexibility in Measures

MIPS Category In Brief: Quality

- Nearly 300 measures to choose from, 80% tailored to specialists
- ECs[1] required to report six measures
- If reporting as a group, CMS will evaluate one population-based measure: All-Cause Readmissions based on claims data
- 50% all-payer data completeness requirement for 2017, rises to 60% in 2018
- Reporting a cross-cutting measure no longer required
- Two ways to earn bonus points

How Scoring Works



Scoring Takeaways

- In general, each measure is worth a maximum of 10 points
- Generally, performance points assigned for a measure based on performance against peer benchmark
- Measures without previously established benchmark receive automatic score of 3 points
- In 2017 CMS will also assign 3 points if measure is reported, even if it doesn't meet data completeness, case minimum threshold, or has 0% performance
- A measure is included in the scoring only if minimum case requirement[4] is met, so the total possible points can vary between ECs

1) Eligible clinician.
2) Defined as measures that do not have an established benchmark and therefore cannot be scored based on performance. Automatically assigned 3 points regardless of performance.
3) Based on claims, no reporting required.
4) General case requirement is 20 cases. Case requirement for All-Cause Readmissions is 200 cases.

Sources: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Standing Out in a Crowded Room

Focus on Metrics Where Performance is Likely to Exceed Peers

List of All Measures

- Measures currently submitting under PQRS
- List of additional measures group could submit based on review of 2017 proposed MIPS measures
- Measures from registry (if applicable)
- Track these measures over the course of year

Questions to Consider Across Year

1. Are there specific measures in which high performers could "carry" the group?
2. Will our performance on this exceed our peers based on available data?
3. How likely is it that other groups will submit this measure?

MIPS Target List

- List of the six quality measures your group will submit[1]
- List should include one outcomes measures, emphasize high-priority measures
- Choose additional metrics where strong performance expected to potentially improve score

Start With Your QRUR

Access your 2015 Quality and Resource Use Report (QRUR) on the CMS Enterprise Portal. Please note you'll need an Enterprise Identity Management (EIDM) account to access your reports.

1) Measures must be 50% all-payer data completeness threshold in 2017. Threshold increases to 60% in 2018.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Two Ways to Earn Bonus Quality Points

Additional High-Priority Measures

Medical Group Leader's To-Do List

- ❑ Identify high-priority measures[1] applicable to you group
- ❑ Submit extra high-priority measures in addition to required outcome measure

166 Number of high-priority measures across all specialties to choose from

End-to-End Electronic Reporting

Data Recording
Data must be collected using an EHR certified by the ONC[2] (CEHRT)

Data Exporting
CMS must receive the data electronically from the CEHRT

Third-Party Submission
CMS allows third-party intermediaries, but they must use automated software

1) High-priority domains are: appropriate use, patient safety, efficiency, patient experience, and care coordination.
2) Office of the National Coordinator for Health Information Technology.

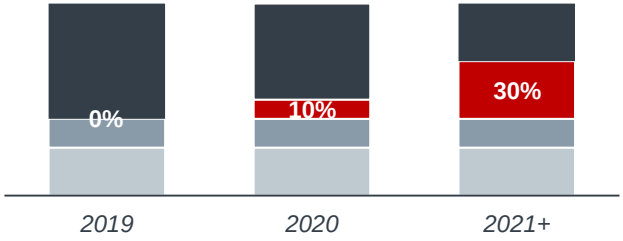
Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Cost Starts At Zero, but Shouldn't Be Ignored

Category to Be Critical Performance Differentiator in 2019 and Beyond

Relative Weight of Cost Category

by Payment Year[1]



Our Take

- Rapidly increasing impact on score may catch some providers off guard
- Inflecting performance takes time; focus on tackling this category from the start
- Groups will quickly master quality category, making this category the most competitive

Three Tips for Cost

5. Unpack per capita cost attribution and determine if any of the 10 episodes apply to you
6. Prioritize risk adjustment
7. Develop a short list of top cost drivers and develop strategies to start to tackle

1) Payment based on performance two years prior.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

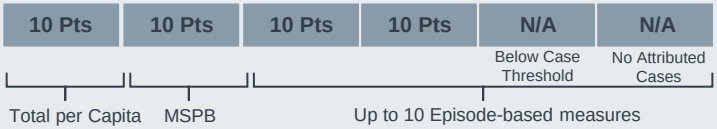
MIPS Cost Performance Category

New Cost Measures; Performance Assessment Based on Claims

MIPS Category in Brief: Cost

- Assesses cost in three categories
  - Total cost per capita
  - MSPB[1]
  - Episode-based measures
- CMS will use data submitted through administrative claims to determine cost performance
- Minimum of 20 cases required for Total cost and episode based measures; 35 for MSPB
- Groups and individuals evaluated at TIN[2]/NPI[3] level

How Scoring Works: Total Measures Vary



Scoring Takeaways

- Measures are equally weighted for a maximum of 10 points each
- A measure is included in the scoring only if minimum case requirement is met, so the total possible points can vary between ECs
- Performance points assigned for a measure based on performance against peer benchmark
- Category will be scored for informational purposes only in 2017

1) Medicare spending per beneficiary.
2) Tax identification number.
3) National provider identification number.

Sources: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Understanding the Three Cost Measures

Breaking Down Attribution, When Your Group is Accountable

Total Cost per Capita

Definitions:

Specialty-adjusted measure that evaluates overall efficiency of care. Includes all payments under Medicare Parts A and B

- Medical group must have minimum 20 cases or not scored

Attribution Methods:

Two step process

#1: Attributed to group with largest share of primary care services provided by PCPs

#2: If beneficiary didn't visit PCP, attribution applied to specialist with plurality of services

Medicare Spending per Beneficiary

Cost of Medicare Part A and B services during an episode defined as three days before and 30 days after inpatient hospitalization

- No longer specialty-adjusted
- Medical group must have minimum 35 cases or not scored

Attributed to TIN that provides plurality of claims for Medicare Part B Services during inpatient hospitalization[1]

Episode-Based Measures

Cost for 10 high cost, high variability conditions/procedures. Includes all Medicare Part A and B payments for services related to trigger condition/procedure

- Medical group must have minimum 20 cases or not scored

- Acute Conditions: Attributed to all ECs that bill at least 30% of inpatient E&M[2] visits during trigger event
- Procedures: Attributed to EC that bills Medicare Part B claim with a trigger code; costs included in episodes vary

1) As measured by allowable charges.
2) Evaluation and management.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Understanding Cost per Capita Attribution

Specialists Can Be Caught Off Guard by Attribution

The Path to Specialist Attribution

Patient

68 year old female

Utilization

- Sees cardiologist occasionally
- No visit to PCP in 2 years

Conditions

- AF[1]
- Diabetes

CMS Analyzes Share of Services

1. Based on largest share of primary care services provided
2. Based on largest share of services provided by specialist physician

Attributed Costs

Specialist responsible for total cost of care

Imaging……...$450
2 x-rays

Endocrinology…$200
1 office visit

Cardiology……..$710
2 office visits
1 stress test

Total…….$1360

CONSIDER: **Driving Patients to Primary Care**

Attribution for cost per capita is based on patient utilization of primary care. Reduce step two attribution by encouraging patients to visit their PCP that year.

1) Atrial Fibrillation.

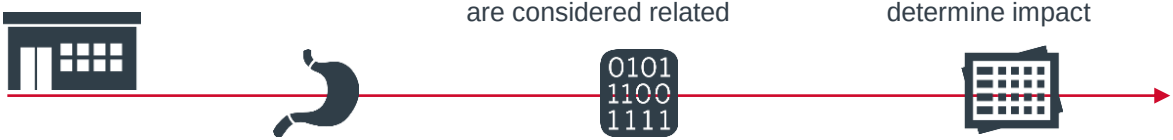
Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Elucidating Episode-Based Measures

How to Determine if Measures May Impact Your Group

Your Three Step Process:

1. Review CMS's proposed list of episode-based measures
2. Determine which trigger codes that open an episode might apply to your patients and identify which services are considered related
3. Using sQRUR[1], evaluate past performance by assessing cost and beneficiary breakdown to determine impact



Applicable Episodes

- Colonoscopy and Biopsy

Trigger Codes

- **CPT 44391**: Colonoscopy through stoma; with control of bleeding
- **ICD 4523**:Colonoscopy
- **HCPCS GO104**: Colorectal cancer screening; flexible sigmoidoscopy

QRUR Essentials

- **Table One**: Includes beneficiary data, names of providers & sites of care involved in episode
- **Table Two**: Includes episode cost breakdown by TIN
- **Table Three**: Includes episode cost breakdown by site of care

1) Supplemental Quality and Resource Use Report.

Source: CMS, "Understanding Your QRUR." 2015. Available at: cms.gov. CMS, "2015 Supplemental QRUR and Episode-Based Payment Measurement. 2016. Available at: cms.gov. Advisory Board interviews and analysis.

10 Episode-Based Measures Finalized for 2017

Method Type[1]	Episode Name	Episode Description
A	Mastectomy	Mastectomy is triggered by a patient's claim with any of the interventions assigned as Mastectomy trigger codes. Mastectomy can triggered by either an ICD procedure code, or CPT codes in any setting (e.g. hospital, surgical center).
A	Aortic/Mitral Valve Surgery	Open heart valve surgery (Valve) episode is triggered by a patient claim with any of Valve trigger codes.
A	Coronary Artery Bypass Graft (CABG)	Coronary Artery Bypass Grafting (CABG) episode is triggered by an inpatient hospital claim with any of CABG trigger codes for coronary bypass. CABG generally is limited to facilities with a Cardiac Care Unit (CCU); hence there are no episodes or comparisons in other settings
A	Hip/Femur Fracture or Dislocation Treatment, IP-Based	Fracture/dislocation of hip/femur (HipFxTx) episode is triggered by a patient claim with any of the interventions assigned as HipFxTx trigger codes. HipFxTx can be triggered by either an ICD procedure code or CPT codes in any setting.
B	Cholecystectomy and Common Duct Exploration	Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MSDRGs.
B	Colonoscopy and Biopsy	Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs.
B	Transurethral Resection of the Prostate (TURP) for benign prostatic hyperplasia	For procedural episodes, treatment services are defined as the services attributable to the MIPS eligible clinician or group managing the patient's care for the episode's health condition.
B	Lens and cataract procedures	Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
B	Hip replacement or repair	Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
B	Knee arthroplasty (replacement)	Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day

1) Method refers to the way in which CMS parses claims information to open episodes and to allocate medical services to one or more episodes during a specified length of time. Episodes can be constructed by Method A or B.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Get to Know HCC[1] Methodology

CMS Announces Intent to Use HCC Coding for Risk Adjustment

!

Risk Adjustment in Cost Category

- To arrive at cost performance score, CMS will risk adjust attributed costs using HCC methodology
- Each HCC code has a score correlated to relative risk
- Level of risk impacts payment

Key Components in Individual Risk Scores

- **Disease Burden** (i.e. 70 possible HCCs, mapped from ICDs)
- **Disease Interactions** (i.e. how a combination of diseases adversely affects a patient)
- **Demographics** (e.g. age, sex, disability, Medicare status)

Four Ways to Improve HCC Documentation and Coding Accuracy

- Prioritize patient problem lists
- Gather baseline data on HCC capture
- Launch provider engagement initiative
- Embed HCC management tools into workflows

Use our Primer on CMS's HCC Coding to improve HCC coding and documentation, at: advisory.com/PPR/2016summitresources

1) Hierarchical care codes.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Four Ways to Improve HCC Documentation and Coding

1 Prioritize Patient Problem Lists[1]

- Keeping problem lists up-to-date and comprehensive for every patient is imperative. This includes re-documenting all chronic conditions every 12 months and diagnosis codes for each patient encounter.
- Accurate problem lists support care, documentation, billing, and HCC credit for conditions that impact risk-adjusted payments while eliminating the need for retrospective chart reviews.

2 Gather Baseline Data on HCC Capture

- Review previous year's billing data and problem lists for patients, keeping a close eye on discrepancies between billing data and documentation, and potential gaps in HCC coding.
- Gathering baseline data will enable medical group leaders to quantify their HCC opportunity and be better positioned to improve HCC complexity, engaging stakeholders as necessary.

3 Launch Provider Engagement Initiative

- Provider engagement is essential to capturing a patient's full complexity, as many clinicians don't fully understand the HCC system of coding and reimbursement.
- Medical groups should proactively educate clinicians around HCCs, highlighting how comprehensive problem lists facilitate more effective care plans and appropriate reimbursement.

4 Embed HCC Management Tools into Workflows

- Appropriate HCC management and support tools are critical, even when providers are engaged.
- These tools should be accessible to providers at the point of care, allowing them to make more informed decisions without adding "clicks", aiding clinician productivity while realizing gains.

1) List of illnesses, injuries, and other factors that affect the health of the patient located within the EHR.

Source: Advisory Board interviews and analysis..

Jump-Start Cost Savings with a Short List

No Shortage of Opportunities to Choose From

Areas of Focus	Sample Opportunities
Post-Acute Care	• Curate SNF[1] network • Curate home health network • Establish nurse, hospitalist rounding at partner sites
Drug Spending	• Standardize physician use of Part B drugs (e.g. retinol injections, macular degeneration drugs) • Encourage use of Part D generics
Outpatient Spending	• Shift care from HOPD[2] to ASCs[3],IDTFs[4] • Curate specialty referral network to direct patients to highest-quality, lowest-cost PCPs[5] and specialists
Hospital Spending	• Shift IP[6] care to PAC[7] setting (e.g. SNF) • Reduce avoidable medical spend (e.g., septicemia,) through care standardization • Shift one-day IP surgeries to OP[8] space

Need Ideas? Dig into your QRUR and sQRUR

What's in My QRUR?

Contains summary of group's overall performance and detailed data on cost per capita and MSPB.

- Cost of services provided for per capita cost (Table 3B)
- Medicare spending per beneficiary (MSPB) costs by episode and service (Table 5D)

What's in My sQRUR?

Contains detailed data on episodic cost.

- Highest cost average billing physicians per episode (Exhibit 3.C)
- Avg. Cost to Medicare for services by episode (Exhibit 3.D); exhibit 4A contains further detail

1) Skilled nursing facility.
2) Hospital outpatient department.
3) Ambulatory surgery center.
4) Independent diagnostic testing facility.
5) Primary care provider.
6) Inpatient.
7) Post-acute care.
8) Outpatient.

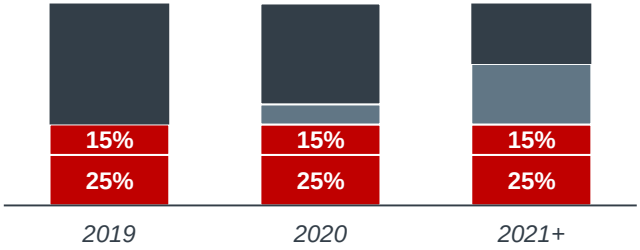
Source: CMS, "Understanding Your QRUR." 2015. Available at: cms.gov. CMS, "2015 Supplemental QRUR and Episode-Based Payment Measurement. 2016. Available at: cms.gov. Advisory Board interviews and analysis.

Check the Box in These Two Categories

No Reason Not to Get Full Credit in Easy Win Categories IA and ACI

Relative Weight of IA and ACI Categories

by Performance Year[1]



Two Tips for IA and ACI

8 Map your easiest path to 40 points in Improvement Activities

9 Focus on your performance score in Advancing Care Information

Our Take

- ACI and IA based solely on personal benchmark; easiest categories to perform well in
- Additional reporting flexibilities in both categories further reduce burden
- Groups should prepare clinicians not previously held accountable for Meaningful Use to report under ACI

Did you know? 83% of Physician Practice Roundtable members successfully attested to Meaningful Use in 2015?

1) Payment based on performance two years prior.

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Physician Practice Roundtable 2016 MACRA Pulse Check Survey. Advisory Board interviews and analysis.

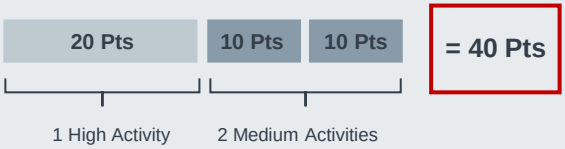
MIPS Improvement Activities Performance Category

Brand New Requirement; More Than 90 Activities to Choose From

MIPS Category in Brief: IA

- New performance category
- Over 90 activities to choose from
- Two measure types:
  - High-weighted: 20 points
  - Medium-weighted: 10 points
- Activity must be performed for at least 90 days
- Yes/No response for all activities

How Scoring Works



Scoring Takeaways

- Maximum score of 40 points
- Any combination of high-weighted or medium-weighted activities

Scoring Flexibility: Certain participants get preferential scoring.

- MIPS APM: **Automatic 40 points**
- Certified PCMH: **Automatic 40 points**
- Small/rural practices: **Report 20 points of activities[1] for full credit**

1) Must be one high weighted or two medium weighted activities.

Sources: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Several Paths to Full Credit Under IA

Differences in Weighting Provide Flexibility

Two Measure Types

H **High**-weighted activity: ***20 points***

M **Medium**-weighted activity: ***10 points***

Sample of High-Weight IAs

- Use of a QCDR to generate regular performance feedback summarizing local practice patterns, outcomes
- 24/7 access to MIPS eligible clinicians

Scoring

Non-patient-facing clinicians can select any two measures to fulfill requirement

Focus on achieving a score of 40 points

- Any combination of high-weighted or medium-weighted activities

Example	Reported Activities	Points Earned
1	H H	40
2	H M M	40
3	M M M M	40

IMPORTANT: **Retain Support Documentation**

IA scoring based on attestation

We recommend that medical groups retain documentation supporting that the IA was performed for at least 90 days during the performance period

Sources: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

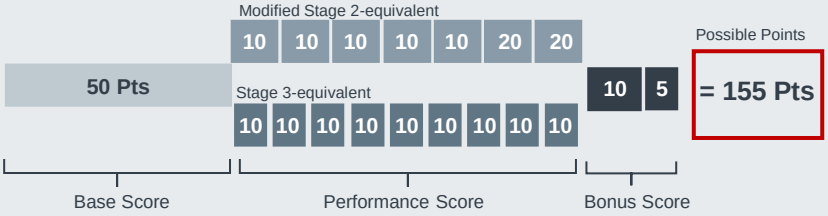
MIPS ACI Performance Category

New Name for MU; Rewards Participation and Performance

MIPS Category in Brief: ACI

- Abandons "all-or-nothing" approach of Meaningful Use, offers flexibility in measure selection
- Option to report ACI measures correlating to Modified Stage 2-equivalent, use of 2014 CEHRT[1] in 2017
- By 2018, all ECs must report ACI measures correlating to Stage 3-equivalent, must use 2015 edition CEHRT

How Scoring Works: Two Paths to 100 in 2017



Scoring

Base Score

- Security risk analysis
- E-prescribing
- Provide patient access
- Send a summary of care
- Request/access summary of care[2]

Performance Score

- Stage 3-equivalent: 9 available measures
- Modified Stage 2-equivalent: 7 available measures

Bonus Score

- 10 points for using CEHRT in IA
- 5 points for public health registry reporting

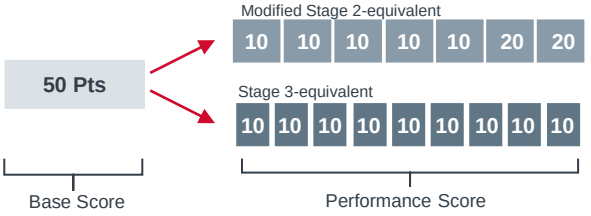
1) Certified electronic health record technology.
2) Request/access summary of care or inbound transition of care is required under "Stage 3-equivalent" option. This specific measure is not included in the Base Score for Modified Stage 2-equivalent option.

Sources: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

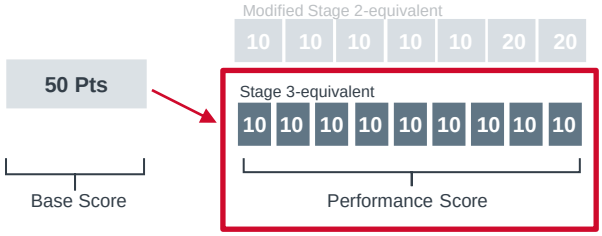
Two Paths to Full Credit in 2017

Focus on Honing Your 2018 Performance Score Strategy

Two Reporting Options in 2017



Only One Reporting Option by 2018



Top Ways Providers Can Excel in ACI

Report on every performance measure in 2017 to maximize potential points scored

Earn 100/155 points for full credit

Invest in 2015 Edition of CEHRT, necessary for reporting Stage 3 measures; prepare for 2018

Earn bonus points by completing certain IA activities with CEHRT and reporting an additional public health or clinical data registry, apart from Immunization

Source: CMS, "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Oct. 14, 2016, available at: qpp.cms.gov. Advisory Board interviews and analysis.

Playbook for Maximizing Performance in MIPS

9 Tips to Elevate Your Performance Score

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
9. **Focus** efforts on performance score

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

1) Improvement Activities.
2) Advancing Care Information.

Source: Advisory Board interviews and analysis.

Physician Practice Roundtable

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