Medical Group Success under MACRA

Rethinking Risk Strategy and Maximizing Performance in MIPS
The Law That Shook the Physician Payment World

Rethinking Your Risk Model Strategy

Playbook for Maximizing Your Performance in MIPS
A Few Choice Words About MACRA

Unnecessarily complex

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

Too many metrics with unproven ties to outcomes

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.

Do your best to keep it simple

No to MACRA. Just No.

This is much too fast

This will never work. It is doomed to fail

Please stop hurting us

Move to global risk!

CMS grow a pair!

It is all crap

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.

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It is all crap

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

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 programs¹ into one budget-neutral pay-for-performance program
   - Clinicians will be scored on quality, cost, clinical practice improvement activities, and EHR² 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.
Advancing Risk Through Physician Reimbursement

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

1. MIPS Bonuses/Penalties
   - +/-4%
   - +/-9%
   - $500M

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:

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.
Groups Fall into One of Three Scenarios

Differences in Criteria, Scoring, and Payment Under MACRA

<table>
<thead>
<tr>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS: Eligible clinicians (ECs) that exceed low volume threshold and don’t participate in an APM</td>
</tr>
<tr>
<td>MIPS-APM: ECs that participate in an APM but don’t qualify for the APM track</td>
</tr>
<tr>
<td>APM: ECs that:</td>
</tr>
<tr>
<td>• Participate in an advanced APM</td>
</tr>
<tr>
<td>• Use CEHRT¹</td>
</tr>
<tr>
<td>• Meet patient count or revenue threshold²</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoring (in 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS: In 2018, Quality is 50%, Cost is 10%, IA is 15%, and ACI is 20%.</td>
</tr>
<tr>
<td>MIPS-APM: Quality is 50%, IA is 20%, and ACI is 30%. Not scored on cost.</td>
</tr>
<tr>
<td>APM: Exempt from MIPS (Not scored)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment (in 2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS: • Max. of 5% positive or negative payment adjustment in 2020, based on 2018 performance year</td>
</tr>
<tr>
<td>MIPS-APM: • Max. of 5% positive or negative payment adjustment</td>
</tr>
<tr>
<td>APM: • Eligible for 5% bonus in first five years of program.</td>
</tr>
<tr>
<td>• No positive or negative payment adjustment based on performance.</td>
</tr>
</tbody>
</table>


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.
For MIPS Reporting, 2017 a Transitional Year

Flexible Reporting Requirements Ease Providers into MIPS

MACRA Implementation Timeline

- **Transition Year 1**: 2017
- **Transition Year 2**: 2018
- **Payment Year 1**: 2019

Three Options for MIPS Reporting in 2017

1. **Full Measure Set Across All Categories**
   - Report required MIPS measures for 90 days or more
   - Eligible for moderate positive payment adjustment
   - Organizations only penalized for non-reporting
   - Cost category not scored

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

## But Not the Only Change

### CMS Reduces Reporting Requirements Across All Categories

<table>
<thead>
<tr>
<th>MIPS Performance Category</th>
<th>Top Reporting Takeaways for 2017</th>
</tr>
</thead>
</table>
| **Quality** *(Replaces PQRS¹, VBPM²)* | • 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, PCMH³, 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 |

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

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

Prior to MACRA, groups held harmless for average performance

87% of groups that met reporting requirements held harmless in 2015

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

How MACRA Ups the Ante

Game of winners and losers

Annual improvement necessary to stay competitive

9% of payment on the line in 2022

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

1) Value Based Payment Modifier.
2) Merit-Based Incentive Payment System.
Introduces significant incentives to take on risk

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.
Making APM Track Even More Accessible

AAPM¹ Definition, Eligibility Evolving From Proposed to Final Rule

More Clinicians Likely to Qualify for APM Track than Anticipated

Proposed Rule (April 2016):

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

Final Rule (October 2016):

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

Two Key Changes Making APM Track More Accessible

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

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

Succeeding under MACRA Requires Dual Focus

Rethinking Risk Model Strategy

Maximizing MIPS Score

- 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.
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/2016sumitresources

Source: Advisory Board interviews and analysis.
1. The Law That Shook the Physician Payment World

2. Rethinking Your Risk Model Strategy

3. Playbook for Maximizing Your Performance in MIPS
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

<table>
<thead>
<tr>
<th>Strongly Agree or Agree</th>
<th>Disagree</th>
<th>Tend to Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>42%</td>
<td>30%</td>
<td>29%</td>
</tr>
</tbody>
</table>

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)

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

A Range of On-Ramps to Risk

CMS Expanding Portfolio of Alternative Payment Options

APM Eligible Payment Models

1. Bundled Payment Models¹
   - 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 3²
   - Pioneer ACO Model²
   - Next-Generation ACO²
   - Medicare Advantage (provider-sponsored)³
   - ESRD Care Model¹

3. Primary Care Models
   - Comprehensive Primary Care + (starting 2017)²

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

¹ Will qualify for Advanced APM track in 2018.
² Currently qualifies for Advanced APM track.
³ Will qualify beginning in 2021.
Assessing Medicare ACOs in Light of MACRA

An Expanding Set of Medicare ACO Options to Evaluate

**MSSP Track 1**
Upstate-only shared savings with maximum share rate of 50%

411 Participants\(^1\)

**MSSP Track 1+**
New downside risk model introduced in final rule. Details to come from CMS

0 Participants

**MSSP Track 2**
Downside risk model with max. share/loss rate of 60%

6 Participants

**MSSP Track 3**
Downside risk model with max. share/loss rate of 75%

16 Participants

**NGACO\(^2\)**
Downside risk model with choice of 80% or 100% share/loss rate

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

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

Limited Returns So Far, But Continued Participation

MSSP ACOs Sharing in Savings, 2015¹

Did Not Reduce Spending

Reduced Spending, Earned Shared Savings

Reduced Spending, Did Not Qualify for Shared Savings

ACO Participation by Model

Among groups taking on risk
n=15 independent medical groups¹

<table>
<thead>
<tr>
<th>Model</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP Track 1 ACO</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>MSSP Track 2 or 3 ACO</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>Next Gen ACO</td>
<td>20%</td>
<td>33%</td>
</tr>
</tbody>
</table>

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.

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
- Potentially eligible for 5% bonus in APM track

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

Source: Advisory Board interviews and analysis.
Getting into Risk for the First Time

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

No Risk Model Participation → Taking on Limited, Upside-only Risk → Taking on Significant, Downside Risk

- MIPS track
- MIPS-APM scoring
- MIPS-APM or APM track

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

<table>
<thead>
<tr>
<th>Agreement Length</th>
<th>Three year agreement period¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Size</td>
<td>5,000 beneficiaries</td>
</tr>
<tr>
<td>Attribution</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>FFS with reconciled shared savings</td>
</tr>
<tr>
<td>Sharing Rate</td>
<td>Up to 50%</td>
</tr>
<tr>
<td>First Dollar Savings</td>
<td>MSR² based on size, between 2-3.9%</td>
</tr>
<tr>
<td>Maximum Gain</td>
<td>10% of benchmark</td>
</tr>
<tr>
<td>Maximum Loss</td>
<td>0%, upside only</td>
</tr>
</tbody>
</table>

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

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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.

MSSP Track 1 Supports MIPS Success in Near Term

<table>
<thead>
<tr>
<th>MIPS Score Components</th>
<th>Advantages of MSSP ACOs under MACRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>ACO quality measures qualify for MIPS reporting</td>
</tr>
<tr>
<td>Cost</td>
<td>Medicare ACOs exempt from cost category¹</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Automatically awarded all possible points in this category²</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>ACOs are more familiar with EHR and IT requirements easing reporting burden by leveraging past experience</td>
</tr>
</tbody>
</table>

$500M Extra pool of incentives for high-performing MIPS eligible clinicians³

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

Decision 2: Should we shift to downside risk?

Shifting From Upside-Only to Downside

No Risk Model Participation

Taking on Limited, Upside-only Risk

MIPS-APM scoring

Taking on Significant, Downside Risk

MIPS-APM or APM track

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

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

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

Sorting Through a Variety of Options

Two Questions Central to Decision-Making Process

Financial Continuum of Downside Models

Maximum Risk

Maximum Earnings

MSSP Track 2

MSSP Track 3

NGACO

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.
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

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\(^1\) Return on investment.

Source: Advisory Board interviews and analysis.
Defining an Intentional Medicare Risk Strategy

New Study From the Health Care Advisory Board

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

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

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

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

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

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

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 Clinic¹

<table>
<thead>
<tr>
<th>Approach</th>
<th>Best Case</th>
<th>Worst Case</th>
<th>Most Likely Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS Only</td>
<td>$5.6M</td>
<td>-$1.2M</td>
<td>$0.3M</td>
</tr>
<tr>
<td>MSSP 1 + MIPS</td>
<td>$20.4M</td>
<td>-$1.6M</td>
<td>$4.2M</td>
</tr>
<tr>
<td>MSSP 2 + APM</td>
<td>$28.5M</td>
<td>-$13.2M</td>
<td>$9.5M</td>
</tr>
<tr>
<td>MSSP 3 + APM</td>
<td>$47.3M</td>
<td>-$44.4M</td>
<td>$11.7M</td>
</tr>
</tbody>
</table>

¹ Pseudonym.

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.

Source: Advisory Board interviews and analysis.
The Advisory Board’s MACRA Intensive

One-Day Intensive to Prepare for MACRA Success

**On-Site Agenda**

**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 I**

**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 II**

**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

**PART III**

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

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

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The Law That Shook the Physician Payment World

Rethinking Your Risk Model Strategy

Playbook for Maximizing Your 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

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
Not All Clinicians Equal Under MACRA

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

2018 Weighting for 2020 Payment by clinician

- **MIPS-Only**: 50%<br>  - 10%<br>  - 15%<br>  - 25%
- **Non-Patient Facing**: 75%<br>  - 10%<br>  - 15%
- **Hospital-Based**: 75%<br>  - 10%
  - 15%

---

**Finalized Definitions of Non-Patient Facing Clinicians and Groups**

- **Non-Patient Facing Clinician**<br>Performing fewer than 100 procedures with patient facing codes annually

- **Non-Patient Facing Group**<br>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 is 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.

---

## Identify Which Tips Apply to Your Group

<table>
<thead>
<tr>
<th>Group type</th>
<th>Reporting mechanics</th>
<th>Quality</th>
<th>Cost</th>
<th>IA</th>
<th>ACI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MSSP ACO participant</strong></td>
<td>1. Use transition year to your advantage</td>
<td>Use web interface reporting mechanism N/A (must do 14 web interface measures)</td>
<td>Not scored, but imperatives also serve ACO well</td>
<td>Automatic full credit given</td>
<td>9. Focus efforts on performance score</td>
</tr>
<tr>
<td><strong>Multi-specialty with primary care</strong></td>
<td>Consider web interface reporting</td>
<td>N/A (must do 14 web interface measures)</td>
<td>5. Unpack attribution and episodic cost</td>
<td>8. Map your easiest path to 40</td>
<td></td>
</tr>
<tr>
<td><strong>Multi-specialty, no primary care</strong></td>
<td>2. Choose reporting mechanism wisely</td>
<td>3. Review MIPS quality measures and create a target list 4. Aim to earn bonus points</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Single specialty (not part of ACO)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital-Based</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EXEMPT</td>
</tr>
<tr>
<td><strong>Non-patient Facing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EXEMPT</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Tip 1: Use the transition year to your advantage

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

- Non-reporting only way to incur payment penalty—maximum penalty is 4%
- Three flexible reporting period options
- Cost weighted at 0%
- Two options for reporting in ACI

2017

- Poor performance can incur payment penalty—maximum penalty is 5%
  - Must report full year
  - Cost weighted at 10%
  - Must report Stage 3-equivalent measures in ACI

2018

- Poor performance can incur payment penalty—maximum penalty is 7%
  - Must report full year
  - Cost weighted at 30%
  - Must report Stage 3-equivalent measures in ACI

2019

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

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](#)

**EHR¹**
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

**CAHPS² 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

<table>
<thead>
<tr>
<th>Submission Methods</th>
<th>Expected % of Providers</th>
<th>Annual Labor Cost Estimate (per provider)</th>
<th>Minimum Number of Metrics</th>
<th>Unique Selection of Metrics</th>
<th>End-to-End Reporting Bonus</th>
<th>Ability to Submit all Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group or Individual Reporting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>QCDR or Qualified Registry</strong></td>
<td>27%</td>
<td>$1,127</td>
<td>6</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>EHR</strong></td>
<td>11%</td>
<td>$1,206</td>
<td>6</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Group-Only Reporting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CMS Web Interface</strong></td>
<td>28%</td>
<td>$19</td>
<td>15</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Individual-Only Reporting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>34%</td>
<td>$997</td>
<td>6</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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).


Offers greatest flexibility in measure selection

Not appropriate for specialty groups: requires standard ACO reporting metrics, heavily primary care focused
Comparing CMS Web Interface and QCDR Options

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

<table>
<thead>
<tr>
<th>CMS Web Interface</th>
<th>Qualified Clinical Data Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td>![Folder Icon] May be lowest cost option</td>
<td>Ability to view performance in time to make changes</td>
</tr>
<tr>
<td>![Calendar Icon] Automatically earns 9 bonus points by reporting</td>
<td>More choices available in measure selection</td>
</tr>
<tr>
<td>![People Icon] Same set of measures required in ACO, can serve as on-ramp period</td>
<td>QCDR participation can help groups carry out IA activities</td>
</tr>
<tr>
<td><strong>Drawbacks</strong></td>
<td><strong>Drawbacks</strong></td>
</tr>
<tr>
<td>![Groups Icon] Groups are competing against ACOs on quality measures</td>
<td>![Checkmark Icon] May require significant investment</td>
</tr>
<tr>
<td>![People Icon] Metric performance based on 248 randomized Medicare beneficiaries, not all-payer data</td>
<td></td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
# 2017 Web Interface Quality Measures

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

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

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.

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

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
- ECs¹ 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

<table>
<thead>
<tr>
<th>10 Pts</th>
<th>10 Pts</th>
<th>10 Pts</th>
<th>10 Pts</th>
<th>3 Pts</th>
<th>10 Pts</th>
<th>10 Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Measure</td>
<td>Class 2 Measure²</td>
<td>All-Cause Readmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 Measures

1 Population-Based Measure³

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 requirement⁴ is met, so the total possible points can vary between ECs

Tip 3: Review MIPS quality measures and create target list

Standing Out in a Crowded Room

Focus on Metrics Where Performance is Likely to Exceed Peers

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?

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

MIPS Target List

- List of the six quality measures your group will submit
  - List should include one outcomes measure, 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.
Two Ways to Earn Bonus Quality Points

Tip 4: Aim to earn bonus points

Additional High-Priority Measures

Medical Group Leader’s To-Do List
- Identify high-priority measures¹ applicable to your group
- Submit extra high-priority measures in addition to required outcome measures

End-to-End Electronic Reporting

Data Recording
Data must be collected using an EHR certified by the ONC² (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

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

---

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.

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

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021+</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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
  - 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/NPI level

How Scoring Works: Total Measures Vary

<table>
<thead>
<tr>
<th>10 Pts</th>
<th>10 Pts</th>
<th>10 Pts</th>
<th>10 Pts</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total per Capita</td>
<td>MSPB</td>
<td>Up to 10 Episode-based measures</td>
<td>Below Case Threshold</td>
<td>No Attributed Cases</td>
<td></td>
</tr>
</tbody>
</table>

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.

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### Tip 5: Unpack attribution and episodic cost

#### Understanding the Three Cost Measures

**Breaking Down Attribution, When Your Group is Accountable**

<table>
<thead>
<tr>
<th><strong>Total Cost per Capita</strong></th>
<th><strong>Medicare Spending per Beneficiary</strong></th>
<th><strong>Episode-Based Measures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty-adjusted measure that evaluates overall efficiency of care. Includes all payments under Medicare Parts A and B</td>
<td>Cost of Medicare Part A and B services during an episode defined as three days before and 30 days after inpatient hospitalization</td>
<td>Cost for 10 high cost, high variability conditions/procedures. Includes all Medicare Part A and B payments for services related to trigger condition/procedure</td>
</tr>
<tr>
<td>• Medical group must have minimum 20 cases or not scored</td>
<td>• No longer specialty-adjusted</td>
<td>• Medical group must have minimum 20 cases or not scored</td>
</tr>
<tr>
<td>• Medical group must have minimum 35 cases or not scored</td>
<td>• Medical specialty must have minimum 35 cases or not scored</td>
<td></td>
</tr>
<tr>
<td><strong>Attribution Methods:</strong></td>
<td><strong>Attributed to TIN that provides plurality of claims for Medicare Part B Services during inpatient hospitalization</strong>¹</td>
<td><strong>• Acute Conditions: Attributed to all ECs that bill at least 30% of inpatient E&amp;M² visits during trigger event</strong></td>
</tr>
<tr>
<td>Two step process</td>
<td></td>
<td><strong>• Procedures: Attributed to EC that bills Medicare Part B claim with a trigger code; costs included in episodes vary</strong></td>
</tr>
<tr>
<td>#1: Attributed to group with largest share of primary care services provided by PCPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#2: If beneficiary didn’t visit PCP, attribution applied to specialist with plurality of services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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

Understanding Cost per Capita Attribution

Specialists Can Be Caught Off Guard by Attribution

CMS Analyzes Share of Services
- Based on largest share of primary care services provided

Attributed Costs
- Specialist responsible for total cost of care
- Imaging ............... $450
- Endocrinology .... $200
- Cardiology .......... $710
- Total ................ $1360

68 year old female

Patient

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

Conditions
- AF
- Diabetes

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.

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 sQRUR¹, 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.
### 10 Episode-Based Measures Finalized for 2017

<table>
<thead>
<tr>
<th>Method Type</th>
<th>Episode Name</th>
<th>Episode Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Mastectomy</td>
<td>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).</td>
</tr>
<tr>
<td>A</td>
<td>Aortic/Mitral Valve Surgery</td>
<td>Open heart valve surgery (Valve) episode is triggered by a patient claim with any of Valve trigger codes.</td>
</tr>
<tr>
<td>A</td>
<td>Coronary Artery Bypass Graft (CABG)</td>
<td>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.</td>
</tr>
<tr>
<td>A</td>
<td>Hip/Femur Fracture or Dislocation Treatment, IP-Based</td>
<td>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.</td>
</tr>
<tr>
<td>A</td>
<td>Cholecystectomy and Common Duct Exploration</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>Colonoscopy and Biopsy</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>Transurethral Resection of the Prostate (TURP) for benign prostatic hyperplasia</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>Lens and cataract procedures</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>Hip replacement or repair</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>Knee arthroplasty (replacement)</td>
<td>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.</td>
</tr>
</tbody>
</table>

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.

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.
Four Ways to Improve HCC Documentation and Coding

1. **Prioritize Patient Problem Lists**
   - 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

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

#### 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

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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.

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 Year¹

<table>
<thead>
<tr>
<th>Year</th>
<th>IA</th>
<th>ACI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>15%</td>
<td>25%</td>
<td>40%</td>
</tr>
<tr>
<td>2020</td>
<td>15%</td>
<td>25%</td>
<td>40%</td>
</tr>
<tr>
<td>2021+</td>
<td>15%</td>
<td>25%</td>
<td>40%</td>
</tr>
</tbody>
</table>

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.
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

20 Pts | 10 Pts | 10 Pts | = 40 Pts

1 High Activity | 2 Medium Activities

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.

Tip 8: Map Your Easiest Path to 40 Points

Several Paths to Full Credit Under IA

Differences in Weighting Provide Flexibility

Two Measure Types

<table>
<thead>
<tr>
<th>H</th>
<th>High-weighted activity: 20 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Medium-weighted activity: 10 points</td>
</tr>
</tbody>
</table>

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

- Focus on achieving a score of 40 points
- Any combination of high-weighted or medium-weighted activities

<table>
<thead>
<tr>
<th>Example</th>
<th>Reported Activities</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H H</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>H M M M</td>
<td>40</td>
</tr>
<tr>
<td>3</td>
<td>M M M M M</td>
<td>40</td>
</tr>
</tbody>
</table>

IMPORTANT: Retain Support Documentation

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

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

IA scoring based on attestation

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 CEHRT¹ 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

<table>
<thead>
<tr>
<th>Modified Stage 2-equivalent</th>
<th>10 10 10 10 10 20 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 3-equivalent</td>
<td>10 10 10 10 10 10 10 10</td>
</tr>
<tr>
<td>Possible Points</td>
<td>10 5</td>
</tr>
<tr>
<td>= 155 Pts</td>
<td></td>
</tr>
</tbody>
</table>

Scoring

Base Score
- Security risk analysis
- E-prescribing
- Provide patient access
- Send a summary of care
- Request/access summary of care²

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

Two Paths to Full Credit in 2017

Focus on Honing Your 2018 Performance Score Strategy

Two Reporting Options in 2017

- **Modified Stage 2-equivalent**:
  - Base Score: 50 Pts
  - Performance Score: 10 10 10 10 10 20 20

- **Stage 3-equivalent**: (Same as Modified Stage 2-equivalent)
  - Base Score: 50 Pts
  - Performance Score: 10 10 10 10 10 10 10 10

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**

Only One Reporting Option by 2018

- **Modified Stage 2-equivalent**: (Same as Modified Stage 2-equivalent)
  - Base Score: 50 Pts
  - Performance Score: 10 10 10 10 10 20 20

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

Source: Advisory Board interviews and analysis.
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