The Third MACRA Reporting Track and Why Now is the Time for a Medicare ACO

May 2017

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INTRODUCTION

When it comes to the new physician payment system, the Medicare Access and CHIP Reauthorization Act's (MACRA's) Quality Payment Program (QPP), there's one option that simplifies reporting and has less downside risk. Health systems should consider this option before it is too late.

With the new administration bringing changes to healthcare, and specifically the Affordable Care Act (ACA), the lack of clarity around what is to come has left the industry uncertain. However, MACRA's QPP and the support of value-based payment models are major bipartisan shifts in healthcare policy that are already affecting providers today and will continue.

The QPP represents an inflection point in healthcare for clinicians, hospitals and health systems, placing significant revenue at stake and incentivizing an additional assumption of risk under alternative payment models (APMs). To date, most of the discussion around the QPP has focused on two primary reporting tracks that clinicians must select.

1. **The Merit-based Incentive Payment System (MIPS),** in which providers remain in fee-for-service (FFS) under Medicare but become eligible for either bonus payments or penalties based on their performance score in the QPP (including the four domains – cost, quality, clinical improvement activities and advancing care information).
2. **Advanced APMs**, which reward eligible clinicians (ECs) who receive significant shares of their revenue or patient volumes through Advanced APMs bonuses (requiring downside risk) and higher annual pay updates than MIPS participants.

Choosing between these two options is difficult. Based on the risks and rewards put forward in MACRA and a financial analysis conducted by Premier, while a good alternative to MIPS, Advanced APMs are the least advantageous choice for health systems that do not have successful experiences with two-sided risk arrangements or are not ready to manage a downside risk potential that is multiple times the MIPS risk level.

MIPS also has its challenges, including a risk of offsetting any QPP bonus payments because it incents the decreased use of acute care services and lower overall revenues for the health system. This option can also create significant flight risks for independent physicians.

Unbeknownst to many is the third option in the QPP, which may be the most palatable for providers not ready to take on downside risk. Known as the MIPS-APM option, this track provides incentives for a movement toward population health for organizations that are not prepared to assume the downside actuarial risk required to qualify for an Advanced APM. An example of a MIPS-APM with no downside risk is Track 1 of the Medicare Shared Savings Program (MSSP).

There are additional advantages to choosing the MIPS-APM option. While technically still considered part of the MIPS program for the purposes of the QPP, MIPS-APMs reduce the administrative burden and qualify for preferential scoring within the program.

Additionally, MSSP Track 1 participants are able to reap all the benefits of a Medicare ACO program, including the ability to earn shared savings payments and access to full Part A, B and

D claims data for their aligned population. Lastly, this option involves significantly less risk than moving to an Advanced APM (i.e., no downside risk).

Before moving forward with one of the three QPP tracks, it is important to understand the alignment across the various federal ACO programs and MACRA. This is especially true for providers choosing MSSP Track 1, as the deadline is May 31 at noon ET for sending a **nonbinding Notice of Intent to Apply** to join the program's 2018 performance year (beginning Jan. 1, 2018).

This paper discusses:

- How the Medicare ACO model aligns with MACRA (and why it's important);
- The advantages of the MIPS-APM and MSSP Track 1 options; and
- Steps to assess if it's the right fit for your organization.

Still analyzing your options for MACRA and participation in a Medicare ACO?

Consider sending a nonbinding Notice of Intent to Apply to the MSSP program.

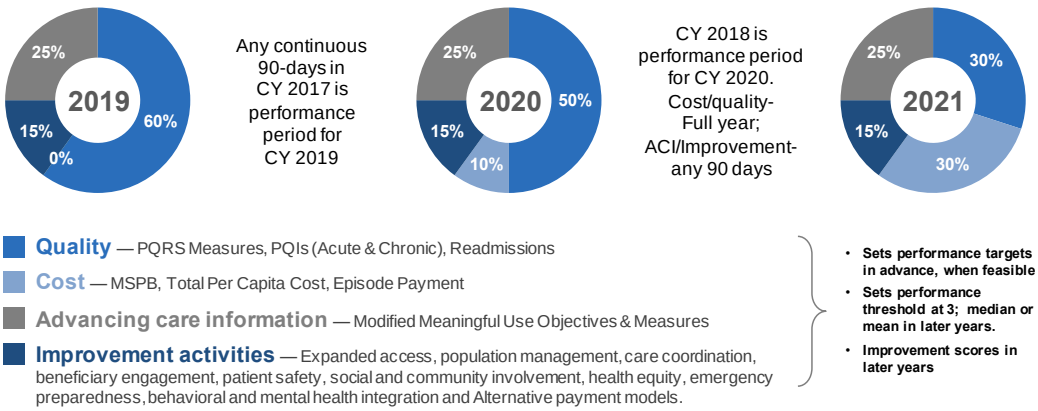
A Notice of Intent to Apply is required prior to applying for 2018 period. It takes less than an hour to complete and submit online. It is due on May 31, 2017 at noon ET.

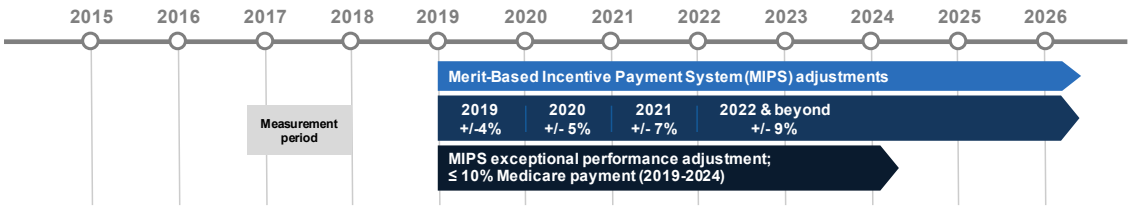
BACKGROUND ON MIPS AND ADVANCED APMs

MIPS

Under MIPS, providers remain in FFS Medicare but become eligible for either bonus payments or penalties based on their performance in the four domains of the QPP. The QPP sunsets three historic payment adjusters for physicians and consolidates them under a single program that places significant proportions of Part B revenue at risk. This includes the Physician Quality Reporting System (PQRS), Value-based Modifiers (VM) and the Meaningful Use/EHR incentive program.

MIPS participant performance is evaluated based on dozens of reported measures in the areas of quality, cost, advancing care information and clinical improvement activities. However, through the cost measure domain, MIPS incents reduced utilization of acute care services and lower overall revenues for the health system, which runs the risk of offsetting any QPP bonus potential.





Moreover, MIPS can create significant flight risks for independent physicians, particularly those that are likely to score better in an MIPS-APM or Advanced APM. This is especially true for independent physicians who may choose to align with a competing health system that offers more favorable options. Up to 15 percent of a physician's take-home compensation can be at risk under the QPP, and Advanced APM participants could see a 5 percent bonus by 2022 – more than enough to motivate a physician to go to a local competitor with different options and support for MACRA. This could lead to a significant loss of hospital volume.

For MIPS participants, Part B revenue is at risk beginning at 4 percent in 2019 (based on 2017 as the metric year) and increasing to 9 percent by 2022 (based on 2020 as the metric year).

Advanced APMs

ECs who receive a significant share (at least 25 percent of Medicare FFS revenue) of their revenue through Advanced APMs beginning in 2017 will be exempt from MIPS and become Qualifying Participants (QPs) eligible for a 5 percent bonus from 2019 through 2024. After 2025, QPs will also receive higher annual pay updates of 0.75 percent a year, compared to 0.25 percent for those that select MIPS.

The QPP establishes three requirements for a model to be considered an Advanced APM. It must:

1. Pay based on quality measures comparable to MIPS.
2. Use Certified Electronic Health Record Technology (CEHRT) across at least 50 percent of ECs.
3. Expose participants to more than "nominal" risk for losses.

Revenue and patient count threshold requirements for Advanced APMs are expansive, and increase over time to ensure that organizations are fully engaged and committed to the models.

In general, Advanced APMs carry significant downside risk potential that is usually multiple times the risk level of MIPS. It is possible to make this option work, but health systems need to be confident in managing the actuarial risk associated with Advanced APMs to avoid having to repay Medicare for cost overruns. This is something very few health systems are prepared to achieve with the exception of those having successful two-sided risk experience or the tools, processes and team in place to manage an effective at-risk arrangement.

MSSP TRACK 1, MIPS-APM ALIGNMENT AND ADVANTAGES

Participating in an MSSP Track 1 provides significant reporting advantages under MACRA's QPP. In addition, participation in an MSSP Track 1 MIPS APM offers:

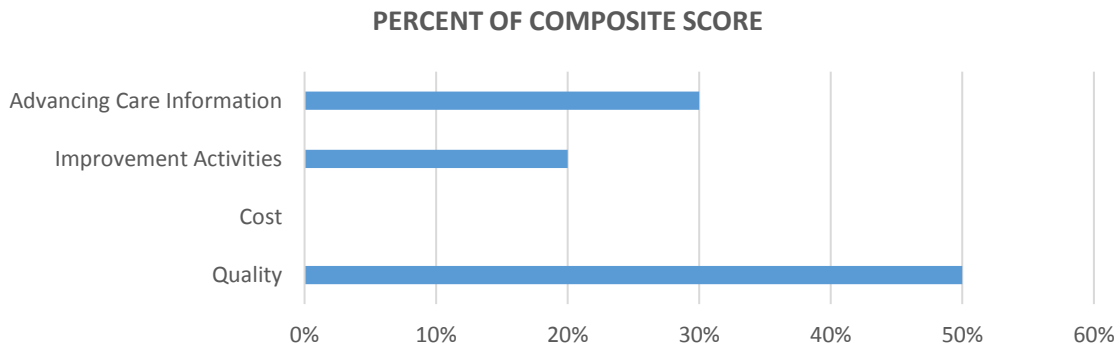
- Access to unblinded and comprehensive claims data to assess performance;
- The ability to better align with clinicians;
- Certain fraud and abuse waivers that support care quality and coordination; and
- The potential to earn shared savings payments with no downside risk.

Reporting Alignment

Rather than reporting individually, ECs can consider most of their QPP reporting completed through the Medicare ACO's group reporting. This obviates the need for individual measures selection, data collection and reporting – all of which significantly reduce administrative burden.

Moreover, MIPS-APMs receive beneficial scoring across each of the four MIPS reporting categories.

MIPS-APM scoring standard for a MSSP Track 1 ACO



Quality: CMS will use the 15 GPRO measures that are already reported for the MSSP 31 quality metrics for this category (50 percent of composite score).

Cost: This category is not included in the assessment, as CMS believes ACOs are already judged on efficiency through the MSSP target.

Improvement activities: The ACO receives full credit for this category (20 percent of composite score).

Advancing care information: Each ACO participant taxpayer ID number (TIN) will report for this category. These scores will be aggregated, and the ACO will receive the weighted average of those scores (30 percent of composite).

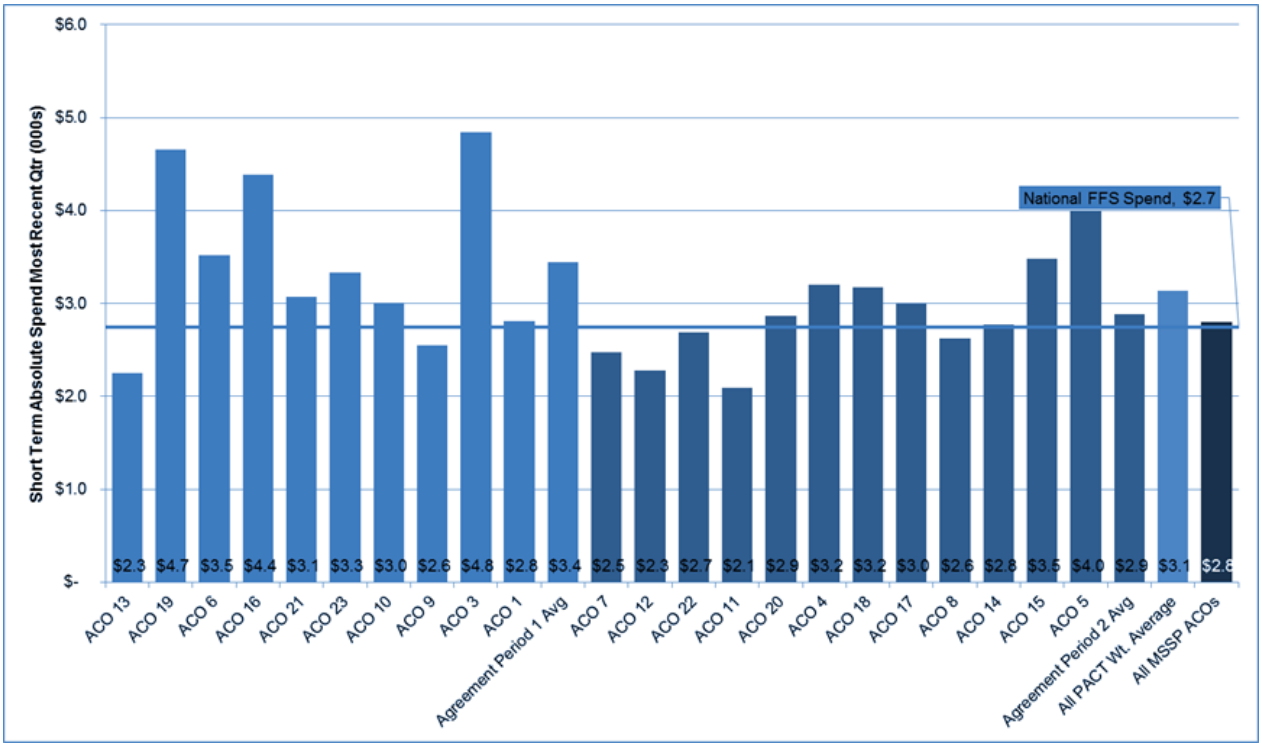
Access to Part A, B and D Claims Data

MSSP Track 1 ACOs have access to full, unblinded claims data for their aligned beneficiaries, allowing ACOs to:

- Identify high-risk and chronically ill populations;
- Manage patient populations;
- Understand gaps and opportunities;
- Measure out-of-network usage; and
- Track performance for future success.

For instance, Medicare ACOs that participate in Premier's Population Health Management Collaborative use a benchmarking database with this information to identify opportunities for improvement (from the top performers in each category), network leakage, and opportunities to grow market share and better manage out-of-network utilization.

Inpatient General Acute Care Spend



*This chart contains mock data. It is an example of quarterly reports that Premier Population Health Management Collaborative Member ACOs receive.

With the inevitable value-based payment movement, developing the skills to succeed under these models, including using claims data and other analytics, is imperative for long-term success in effectively managing a population, as well as tracking all referrals and care to influence market share growth.

No Actuarial Downside Risk

MSSP Track 1 allows organizations to test and gain experience operating under a value-based payment model without taking actuarial downside risk for three-to-six years. It also offers the potential for shared savings and MIPS bonuses**.** This model provides an opportunity for ACOs to gain experience, and share in savings generated without responsibility for losses. Furthermore, providers are already penalized and incentivized based on existing value-based payment measures (such as Medicare VBP, PQRS and Meaningful Use) today. Why not gain savings from making improvements without being at risk for downside losses? If a provider makes improvements but does not participate in a Medicare ACO, it is not able to share in those savings.

Partner with Physicians Before a Disruptor Enters the Market

Many disruptive organizations, financed by venture capital, are entering markets with the goal of financing and organizing primary care providers to develop ACOs. These groups are a threat because they leave health systems out of the ACO. In addition, they view the health system as a cost center and do not share in any savings generated by reducing hospital use rates. Medicare ACOs help facilitate partnerships with community physicians before a venture capital backed, publicly traded firm, a commercial payer, or other competitor APMs are able to. They also maintain and expand physician alignment. This allows health systems to build and implement physician partnerships and avoid being seen as a subcontractor/cost center to competitor models.

Broad Fraud and Abuse Waivers

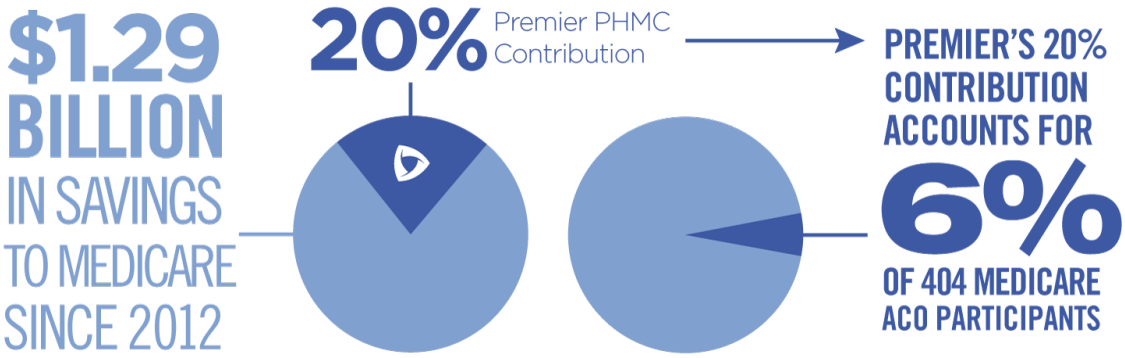
Medicare ACOs are exempted from Stark/anti-kickback, antitrust and civil monetary penalty rules, which allow for innovative, aligned financial relationships with physicians. Use of waivers, which exempt Medicare ACOs from fraud and abuse, antitrust and civil monetary penalties, allow them to more effectively achieve high-quality care. These waivers include the following:

- The ACO is deemed to be clinically integrated by FTC and DOJ for anti-trust purposes.
- ACOs can provide start-up items and services reasonably related to the purposes of the ACO to the participants.
- ACOs are able to distribute shared savings to physicians and their participants based on performance.
- ACOs are able to provide free or below fair-market value items and services to Medicare beneficiaries.

Position Your Organization for Success in a Value-Based Payment Environment

Medicare ACOs provide opportunities to develop capabilities and gain experience managing value-based agreements that can be applied across all payers. With rapid growth in ACOs and other APMs, the continued development and expansion of payment models that support value-based care is inevitable. Providers and payers have made significant investments in these models, and they have been proven to work. They're saving Medicare millions of dollars while continuing to improve quality.

In fact, Medicare ACO members of Premier's Population Health Management Collaborative, which make up just 6 percent of the participants in the program, have realized 20 percent of the nearly $1.3 billion in savings the program has achieved. If every ACO performed at this level, Medicare would save billions of additional dollars.



Moving from FFS to value-based payment models is the path healthcare has been on for nearly 20 years and the path it will continue to pursue. In an industry where value is the economy and measurement is the currency, health systems need to continue creating care delivery and population-based models that are efficient, effective, and add value for both patients and payers.

GETTING STARTED: MIPS-APM AND MSSP TRACK 1 MODELS

The MIPS-APM option and the MSSP Track 1 are aligned and a wise choice for innovative providers that aren't ready to take on downside risk. However, time is of the essence. Health systems must consider a few key elements to effectively model their finances based on their unique market characteristics and strategic goals, such as:

- Eligible clinicians;
- Practice characteristics;
- Past performance;
- Medical homes; and
- Technology use.

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

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

Past Performance: Health systems need to understand how their ECs perform in terms of cost and quality to determine the payment tracks, and/or initiate improvement efforts, if necessary. Health systems can evaluate performance by examining PQRS and quality and resource use reports to understand how their ECs have chosen to be measured, as well as their aggregate performance. Understanding past performance will be an important indicator of potential risk.

Medical Homes: Medical homes are one key to success in both MACRA and the MSSP. These enhanced primary care practices help ECs qualify for shared savings in addition to QPP bonus payments. Under the improvement activities domain within MIPS, ECs earn the full score if they are recognized by a national, accredited patient-centered medical home certification program. If few ECs participate in the model today, health systems may want to consider creating one to optimize MIPS-APM scoring and minimize the potential for losses. Effective medical homes implement robust team-based care models that require significant process changes in a primary care practice.

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

MSSP Application Deadlines Looming

- The deadline for filing a nonbinding Notice of Intent to Apply for a MSSP Track 1 is noon on **May 31, 2017**.

- Sample Notice of Intent to Apply Questions:
  1. What is your application type for the January 1, 2018 program start date? (Select one of four types)
  2. What is your ACO Taxpayer Identification Number?
  3. What is the ACO's date of formation (date noted on the Certificate of Incorporation or other formation documentation)?
  4. What type of ACO are you? (Select all that apply in list of choices)
  5. What is your ACO's Type of Legal Entity? (Select one of six choices)
  6. Is your ACO's Tax Status "For Profit" or "Not-for-Profit"?
  7. Select the Shared Savings Program track you are applying to. (Select one of four tracks)
  8. Do you intend to apply for a SNF 3-Day Rule Waiver? Y/N or N/A (Available to Medicare ACO Track 1+ Model and Track 3 Applicants only)
  9. What is your ACO's full Legal Business Name and location?
  10. Who is your primary application contact?
  11. Who is your secondary application contact?

- The MSSP application deadline is **July 31, 2017** at noon ET.

- Application approval or denial decisions are sent in late fall.

CONCLUSION

The significant strategic and economic impact that MACRA will have on clinicians, hospitals and health systems is inevitable. Regardless of whether providers choose to participate in MIPS, an Advanced APM or the MIPS-APM option, significant revenue is at stake for clinicians and the health systems that employ or are aligned with them.

However, with this challenge comes great potential and opportunity, especially for providers that are already taking steps to redesign care, implement value-based care models, and expand their clinical integration capabilities through Medicare ACOs. Providers must take advantage of the rules, opportunities and requirements to build APMs that will ensure success, both in the QPP and as a healthcare system overtime.

MACRA is complex, but there is clearly a streamlined and effective way to avoid significant additional risk and be successful in this transformation to value-based care and payment.

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