INTRODUCTION TO MACRA

Key Strategic and Operational Considerations

September 13, 2016

DISCUSSION DOCUMENT

ASCENSION

Disclaimer

- This summary does not purport to be all-inclusive or contain all of the information regarding MACRA.
- May also contain forward-looking statements and projections that may be impacted by future CMS announcements and other developments.
- All attendees are advised of the need to conduct their own ongoing review and due diligence to prepare and plan for MACRA.

Objectives

- **Overview of Medicare Access and CHIP Reauthorization Act (MACRA).**
  - Nearly half of U.S. physicians are unfamiliar with the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA, according to a new survey by Deloitte.

- **Begin to understand some of the potential key strategic and operational considerations under the proposed rules.**

  The law will fundamentally change how Medicare pays physicians and other clinicians who participate in the program and is expected to be one of the most disruptive regulatory changes in recent years.

  - ❑ Immediate: All should plan and prepare for tactical changes and/or enhancements associated with MIPS readiness.
  - ❑ Beginning Q4 2016: Make informed, strategic choices around moving towards Advanced APMs and Other Payer Advanced APMs.

- **Continued partnership and dialogue - how to collaborate and mutually support each other to enable highest possible performance under these new programs.**

Introduction to the Medicare Access and CHIP Reauthorization Act (MACRA)

Signed into law last year on a bipartisan basis which permanently repealed the Sustainable Growth Rate (SGR) formula and imposed a new payment methodology for Medicare Part B Professional Services payments starting in 2019.

- On April 27, 2016, CMS released the notice of proposed rulemaking ('NPRM') outlining how it plans to implement the Medicare payment changes stipulated in the law. In summary, the new payment methodology includes two key components:

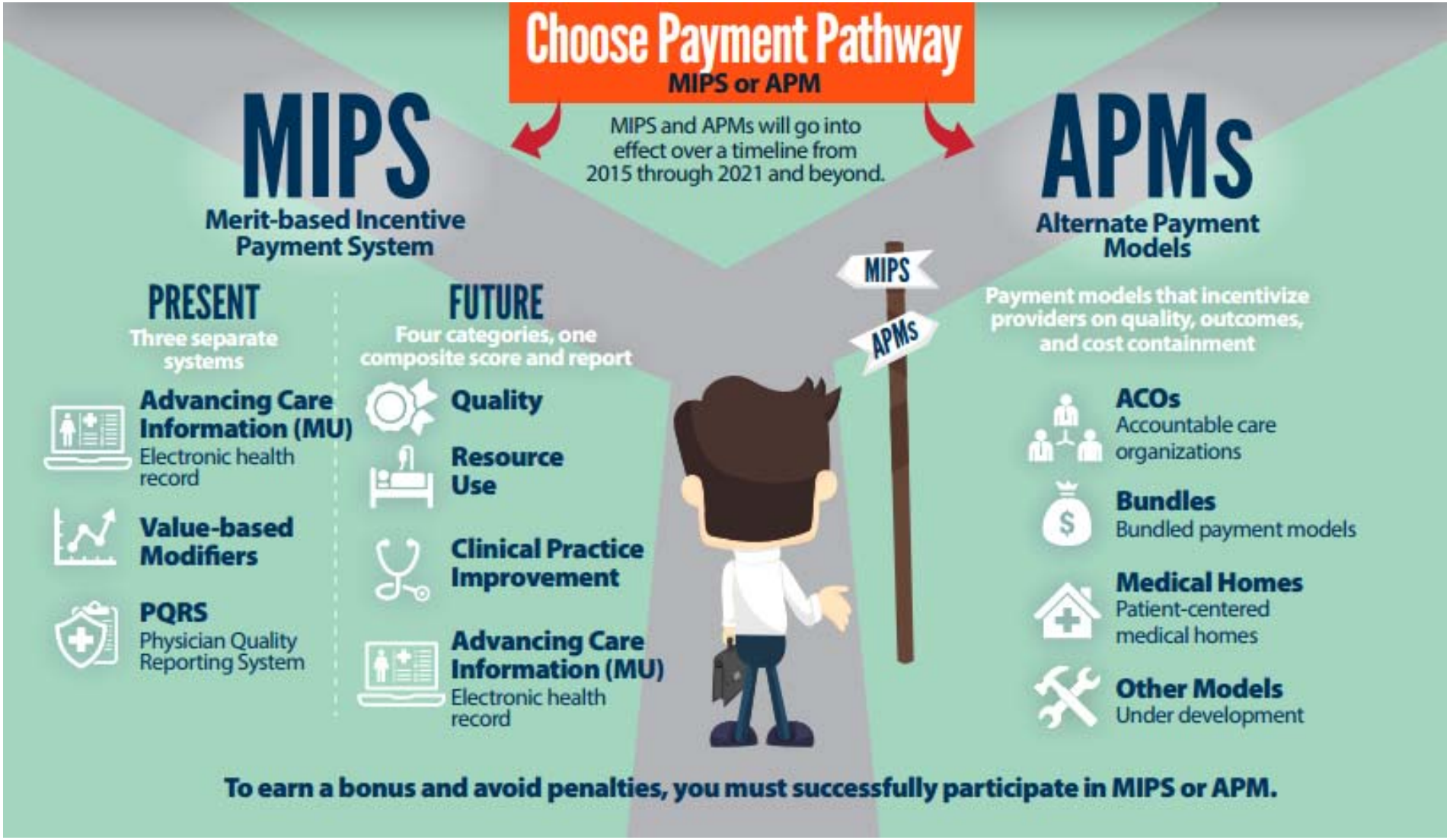
Locks Medicare Part B reimbursement rates at near-zero growth.

Creates two new payment tracks:

1. The Merit-Based Incentive Payment System (MIPS) for clinicians who are reimbursed largely through fee-for-service.

2. The Alternative Payment Model (APM) for clinicians who take on a significant amount of risk-based arrangements.

MACRA's Payment Tracks



Source: American College of Rheumatology, 2016.

Some Details Still Subject to Change

These two payment programs under MACRA, which CMS has named as the Quality Payment Program (QPP), are scheduled to be implemented on January 1, 2019, with calendar year 2017 to be the first performance period that CMS will use to determine a clinician's payment track and their payment adjustment under the MIPS in 2019. **Final rule is scheduled to be released by November 2016.**

May Change

- Given the NPRM is proposed, not final, CMS could change the timing of performance period (e.g., for MIPS, may delay implementation by six months, from 1/1/2017 to 7/1/2017).

As of 9/8, CMS said it will not delay the payment reforms' start date.

More Challenging to Change

- Only Congress can change the timing of payment adjustments (beginning 2019), the types of clinicians subject to MACRA, and the range of penalties and bonuses.

Additional Flexibility: CMS Update as of Sept. 8th

Instead of delaying the payment reforms' start date, CMS will implement new MACRA compliance options that would allow physicians to pick their pace and level of participation for the first performance period. **More details on these options will become available when CMS releases its final rule by November 1st.**

Option 1

Test the Quality Payment Program

- *Submit some data, including data from after January 1, 2017, avoid a negative payment adjustment.*
- *Designed to ensure that the providers' system are working and that are prepared for broader participation in 2018 and 2019 as they learn more.*

Option 2

Participate for Part of the Calendar Year

- *Submit quality information for a reduced number of days.*
- *This means providers' first performance period could begin later than January 1, 2017 and their practice could still qualify for a small positive payment adjustment.*

Option 3

Participate for the Full Calendar Year

- *Practices that are ready to start on Jan. 1 could submit quality information for a full year.*
- *Thus could qualify for a "modest" payment adjustment.*

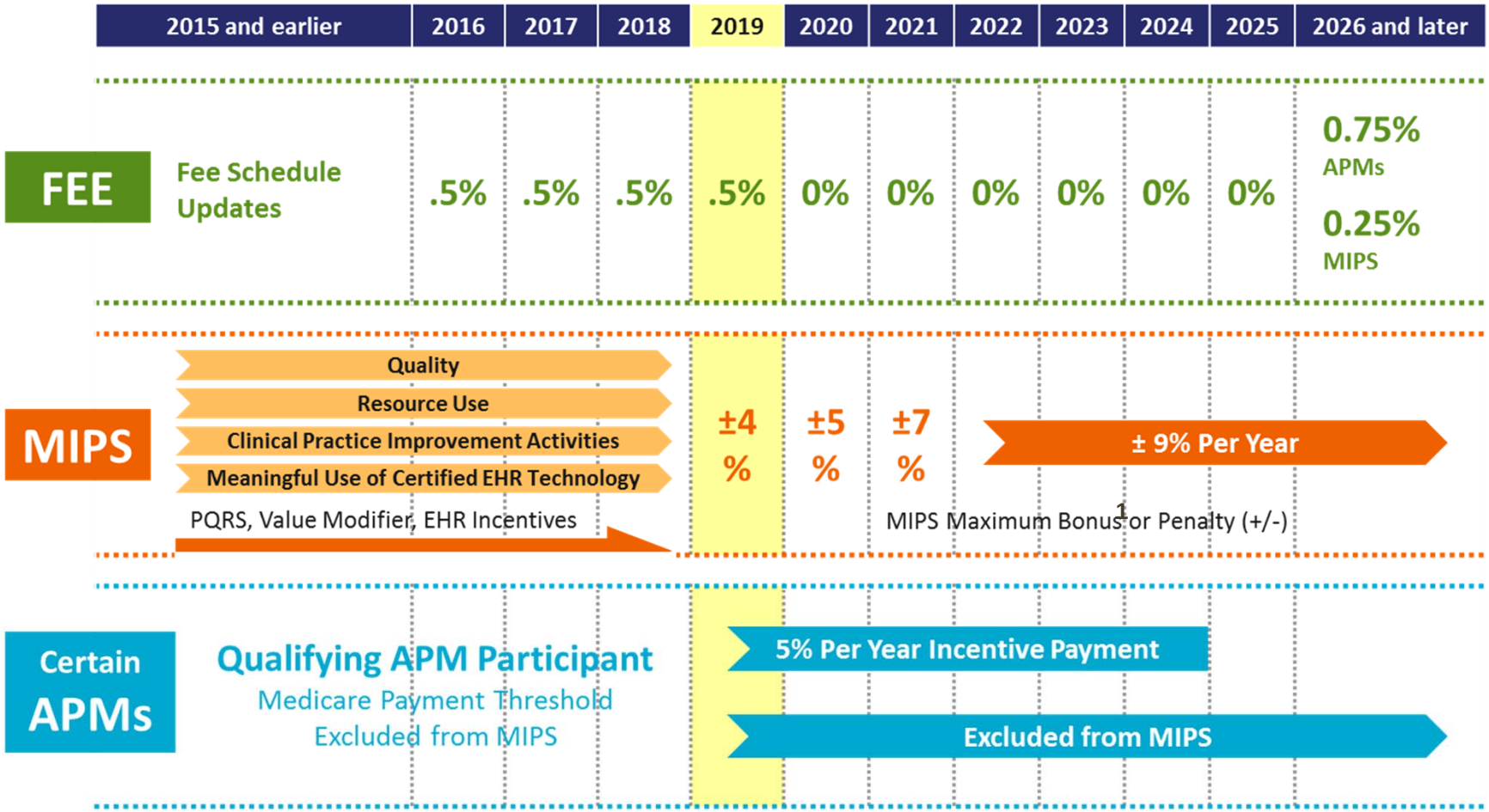
Option 4

Participate in an Advanced Alternative Payment Model in 2017.

- *Practices that choose not to report quality data could instead join an advanced alternative payment model, such as a Medicare Shared Savings program.*

What elements of Medicare payment are impacted by MACRA?

Medicare Part B Professional Payments.



Source: Centers for Medicare & Medicaid Services : www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

MIPS and APMS begin operating *Payment Adjustments*

[1]Under MIPS, a scaling factor up to 3x may be applied to upward adjustment to exceptional performers.

What clinicians are impacted by MACRA? A broad array of clinicians who receive Medicare payments (2017+) and other eligible, all-payer advanced alternative payment models (2019+).

Alternative Payment Models (APMs)

- Physicians*
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional
- Physical or occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist

Merit-Based Incentive Payment System (MIPS), 2019-2020

- Physicians*
- Physician assistants
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

Participation may be expanded to other professionals paid under the physician fee schedule in subsequent years.

Excluded Providers:

- *Providers in their first year of billing Medicare*
- *Clinicians , groups that fall under low volume threshold ($10,000 or less in Medicare charges and 100 or fewer Medicare patients.)*

*Physician, as defined under current law, include: a doctor of medicine or osteopathy; a doctor of dental surgery or of dental medicine; a doctor of podiatric medicine; a doctor of optometry; and a chiropractor.

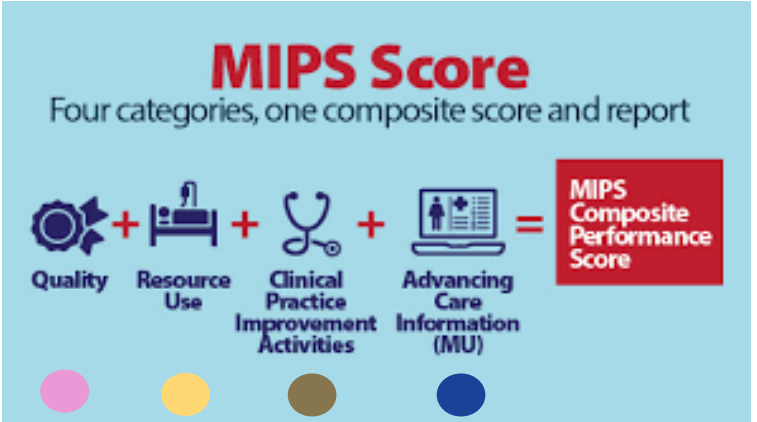
Source: Public Law 114-10 (April 16, 2015)

MACRA's Payment Tracks

MIPS Track

Merit-Based Incentive Payment System (MIPS)

- Rolls existing quality programs into one budget-neutral pay-for-performance program, in which providers will be scored on quality, resource use, clinical practice improvement, and EHR use, and assigned payment adjustment accordingly.
- Eligible clinicians can participate in MIPS as an individual or group (i.e., a group, as defined by taxpayer identification number (TIN), and such, would be assessed as a group practice across all four MIPS performance categories.)
- Payment adjustments will be done at the individual provider level, designated by a TIN/NPI combination. This allows a weighted average score to be created for each NPI that has reported under more than one TIN.
- Adjustments reach -9% / +27% by 2022.



CMS estimates that as much as 90% of eligible clinicians will fall into MIPS track this first performance year.

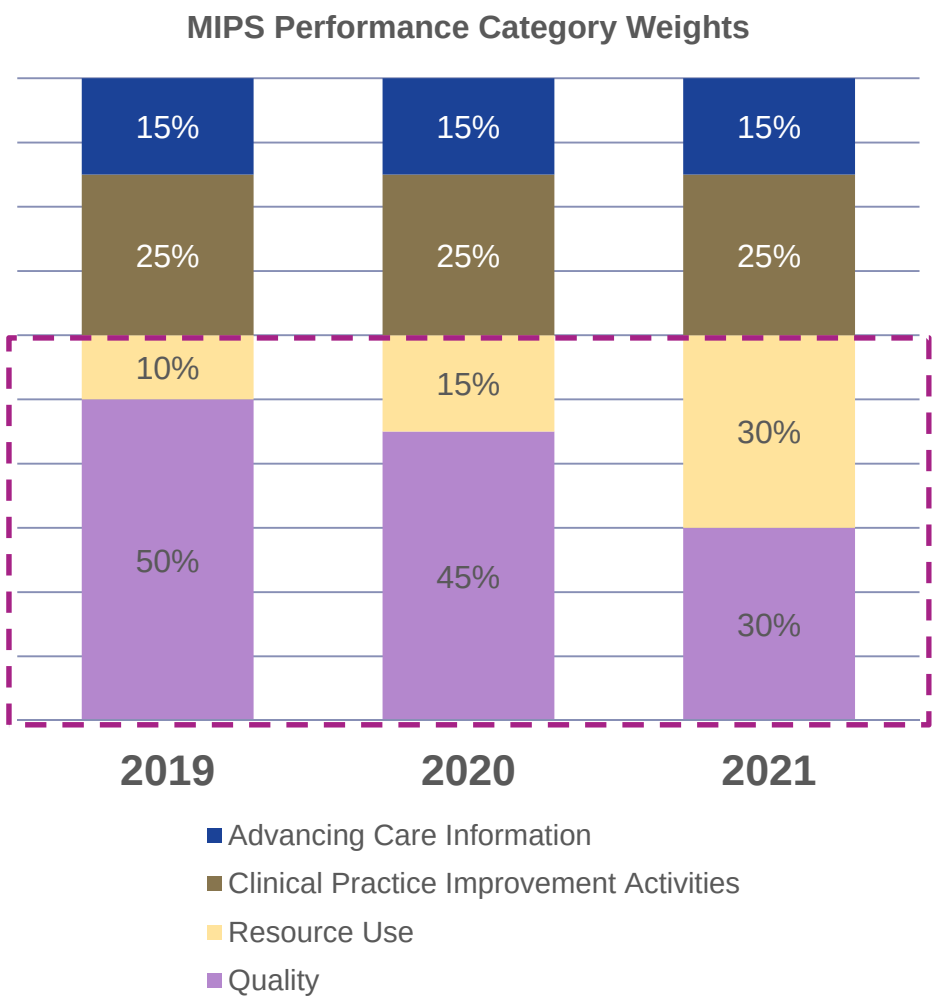
All eligible clinicians will report through MIPS for the first performance period (beginning 1/1/2017); those deemed (2018) to have been part of an A-APM entity for 2017 will be paid that way and their MIPS data not used.

MIPS Performance Categories

Category	Key Takeaways	Scoring
Quality *(Previously PQRS)* *YR1: 50% Weight*	• Fewer measures to report than PQRS, lots of measures to choose from • No longer pay for reporting, performance matters • Bonus points for electronic reporting	More complex measures. Competitive - score based on peer performance benchmarks.
Resource Use *(Previously VBPM)* *YR1: 10% Weight*	• No separate reporting requirement, based on claims. • Many new cost measures assess which conditions you treat, not just whom you treat. • Part D drug costs may be included in future years.	More complex measures. Competitive - score based on peer performance benchmarks.
Clinical Practice Improvement Activities *(New)* *YR1: 15% Weight*	• Over 90 activities to choose from, offers flexibility for many provider types. • Preferential scoring for PCMH, and MIPS APM participants.	More straight-forward measures. Score based on eligible clinician's own performance.
Advanced Care Information *(Previously Meaningful Use)* *YR1: 25% Weight*	• Applies to all clinicians, unlike previous Medicare Eligible Professional MU requirements (which only applied to physicians). • No longer requires "all-or-nothing" measure threshold reporting, clinicians scored on participation and performance.	Moderate complexity measures. Score based on eligible clinician's own performance.

Source: Advisory Board, 2016.

MIPS Performance Categories (Cont'd.)



The MIPS composite performance scoring (CPS) method accounts for:

- Weight of each performance category
- Exceptional performance factors
- Availability and applicability of measures for different categories of clinicians
- Group performance
- **The special circumstances of small practices, practices located in rural areas, and non-patient-facing MIPS eligible clinicians.**

Source: Advisory Board, 2016. CMS, 2016.

MIPS Payment Adjustments

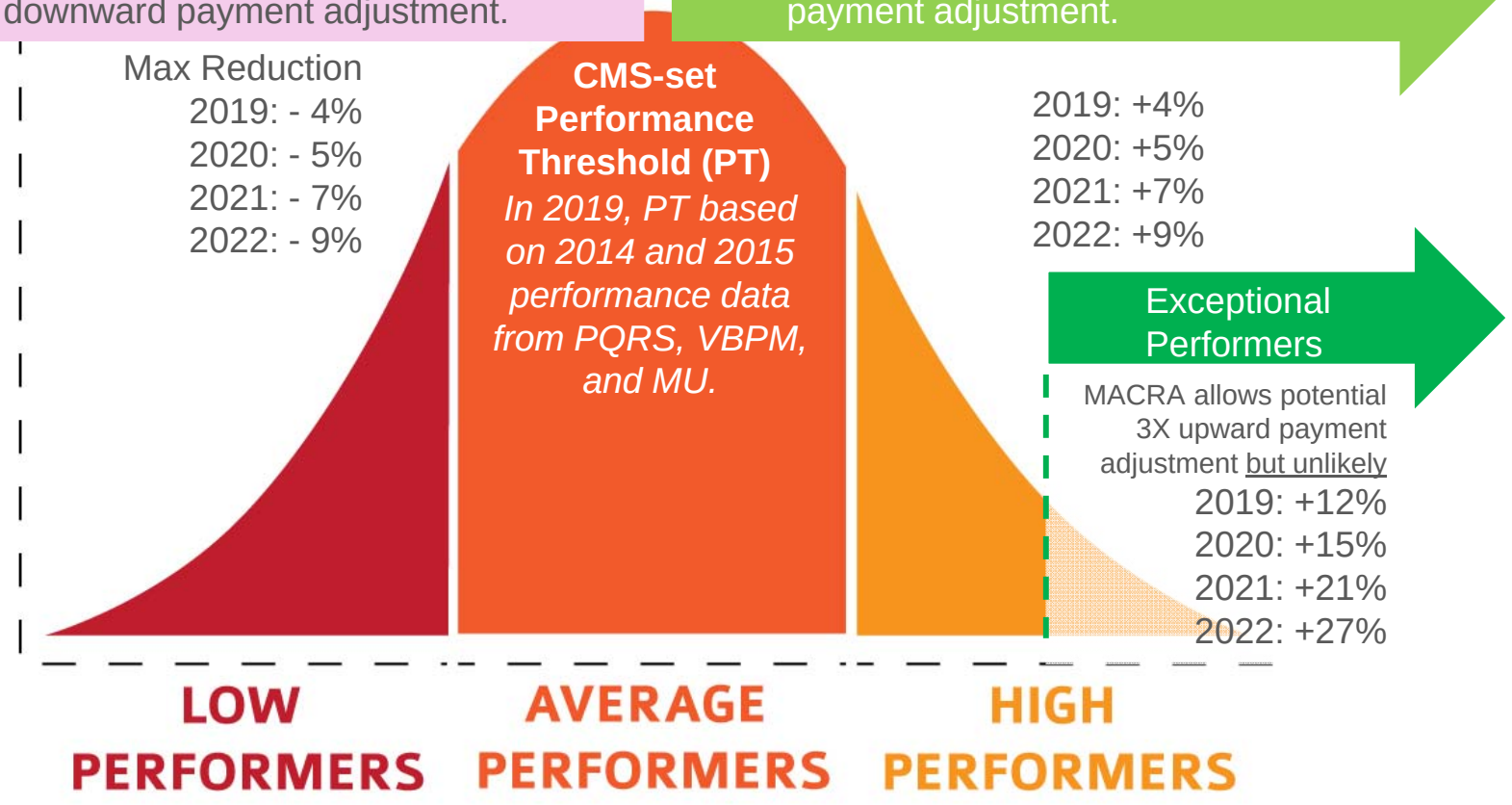
Illustrative

MIPS composite performance score
(0 – 100 based on performance across four MIPS categories)

Non-reporting groups given lowest score

A score below PT results in a downward payment adjustment.

A score above PT results in upward payment adjustment.



Special Group: **MIPS APMS**

Special kinds of APMs that qualify for preferential MIPS scoring, but not qualify for the A-APM track

- ✓ **Preferential Scoring**: Performance evaluated collectively at the APM Entity level; automatic 30 points for CPIA; Resource Use is not scored.
- ✓ **Simplified Reporting:** Quality measures submitted through CMS Web Interface by MSSP/Next Gen ACO on behalf of MIPS participants; Quality category is not report for other MIPS APMs; ACI, CPIA – submit data per MIPS requirements

Applies to two MIPS EC scenarios:

(1) Participates in Eligible Payment Models under MACRA's A-APM, but Below QP Volume Threshold
✓ Comprehensive ESRD Care Model (Large Dialysis Organization Arrangement)
✓ CPC+
✓ MSSP Track 2 and Track 3
✓ Next Generation ACO
✓ Oncology Care Model Two-Side Risk
✓ New! Mandatory Bundles (Cardiac & CJR)

(2) Participates in the Following Non-Eligible Payment Models under MACRA's A-APM for Any Volume
✓ Comprehensive ESRD Care Model (non-Large Dialysis Organization Arrangement)
✓ MSSP Track 1
✓ Oncology Care Model One-Side Risk

Source: Advisory Board, 2016. CMS, 2016.

MACRA's Payment Tracks

APM Track

Alternative Payment Models (APMs)

Eligible clinicians who collectively qualify based on their participation in one or several eligible Advanced APM models:

Proposed Medicare Advanced APM	2017 Enrollment Status
Comprehensive ESRD LDO Arrangement	CLOSED
MSSP Track 2 and 3	CLOSED
Next Generation ACO	CLOSED
Oncology Care Model Two-Sided Risk	CLOSED
CPC+	N/A – Alabama was not selected
New! Mandatory Bundles (Cardiac & CJR)	TBD

and receive at least 25% of their Medicare reimbursement and/or at least 20% of their Medicare patients through these eligible APM models beginning 2018.

Qualifying participants will be:

- ***Exempt from MIPS payment adjustments and reporting requirements***
- ***Receive a lump sum incentive payment equal to 5 percent of their prior year's payments for Medicare Part B covered professional services***

A-APMs in Medicare Advantage may be integrated in future years.
(Beginning performance period 2019+)

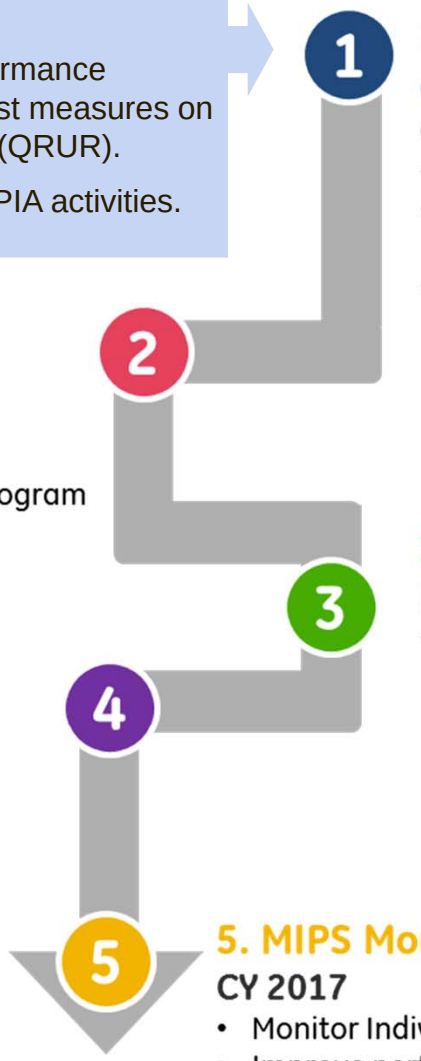
Key MACRA Questions for Medical Groups / Clinicians

- What does the current Quality and Resource Use Report (“QRUR”) tell you?
- What is the implementation plan for 2016 and 2017?
- What are the right measures that should be tracked and reported? Are workflow changes required?
- What clinical practice improvement activities will be added?
- How will the current infrastructure (resources, workflows, education, etc.) support the initiatives?
- How will the composite score be optimized?
- How do we update our clinician recruitment and onboarding processed?
- How we continue align incentives towards MACRA optimal performance?
- How do we facilitate greater end-to-end clinical integration and collaboration (e.g., post-acute, behavioral, pharmacy) to ensure collective optimal performance?
- How do we make informed, strategic choices around moving in a swift and responsible manner towards qualifying new APMs, as they all require up- and down-side reimbursement risk?

Develop a tactical MACRA roadmap focusing on strategic and operational objectives

Others

- Review proposed Resource Use performance category under MIPS and evaluate cost measures on VBPM Quality and Resource Reports (QRUR).
- Assess CMS inventory of proposed CPIA activities.



1. 2016 PQRS and MU work plan optimization

Current 2016

- Align 2016 PQRS and MU work plan with MACRA
- Identify activities to optimize and improve performance
- Implement performance management tools by provider and TIN

2. 2017 MACRA Roadmap

August - October 2016

- Create Steering Committee
- Develop 2017 MACRA work plan
- Implement change management program

3. MIPS Implementation

November – December 2016

- Revise and implement work plan based on final rule, focusing on:
  - Workflows
  - Measures
  - Performance
  - Compliance
  - Change management

4. Reporting and Tracking

Q1 2017

- Report 2016 PQRS measures
- Compete 2016 MU attestations
- Track MIPS performance monthly

5. MIPS Monitoring

CY 2017

- Monitor Individual provider and TIN performance
- Improve performance

Source: GE Healthcare, 2016.

QUESTIONS?

FAQ #1: What if an experienced clinician joins my group in the middle of the year? How will her MIPS performance score be calculated? How will her payment adjustment work?

- Payment adjustments are assigned at the level of the individual provider, defined as the National Provider Identifier (or NPI)/Tax Identification Number (TIN) combination. So, even though the provider is working in a new practice, her payment adjustment when she joins the practice will be based on prior-year performance at her previous practice location(s). That's because CMS will tie payment adjustments to the MIPS performance from two years prior (i.e., the performance year).

- For example, if the provider joins the new practice in 2020, then their payment adjustment that year will be based on their historical performance from the practice(s) they worked at in 2018. In other words, this means that the incoming provider would bring with them the repercussions of their performance at previous practice(s) to the payment adjustment they will incur at the new practice.

Source: Advisory Board, 2016. CMS, 2016.

FAQ #2: If I am in the MIPS track, what are the components of my Medicare Physician Fee Schedule Payment that are impacted by MACRA?

- The annual adjustment you can expect to receive based on the Medicare Physician Fee Schedule can be broken down into three parts: the RVU, the Conversion Factor, and the payment adjustment under MIPS. This can be expressed as:

1) Relative Value Unit.
2) Medicare Physician Fee Schedule.
3) Merit-Based Incentive Payment System.

Source: Advisory Board, 2016. CMS, 2016.

FAQ #3: How does CMS define nominal financial risk under A-APM?

- In the Weeds: To be considered an Advanced APM, an APM must meet three criteria noted in slide 15, including bearing "greater than nominal financial risk". CMS defines "greater than nominal risk" using the three following APM criteria:

	Nominal Risk Criteria	What Does This Mean?
1	**Minimum Loss Rate:** A threshold to trigger losses no greater than 4%	The APM contract must require the APM entity to assume responsibility for losses once spending reaches 4% or less above expected expenditures
2	**Marginal Risk:** Loss sharing of at least 30%	APM Entities must share with the payer in at least 30% of the losses in excess of the expected expenditures
3	**Stop Loss:** Maximum possible loss of at least 4%	APM entity's maximum potential losses can't be capped lower than 4% of the total expected expenditures

Source: Advisory Board, 2016. CMS, 2016.

FAQ #4: Our group takes Medicare Advantage patients; do I qualify for the Advanced APM track?

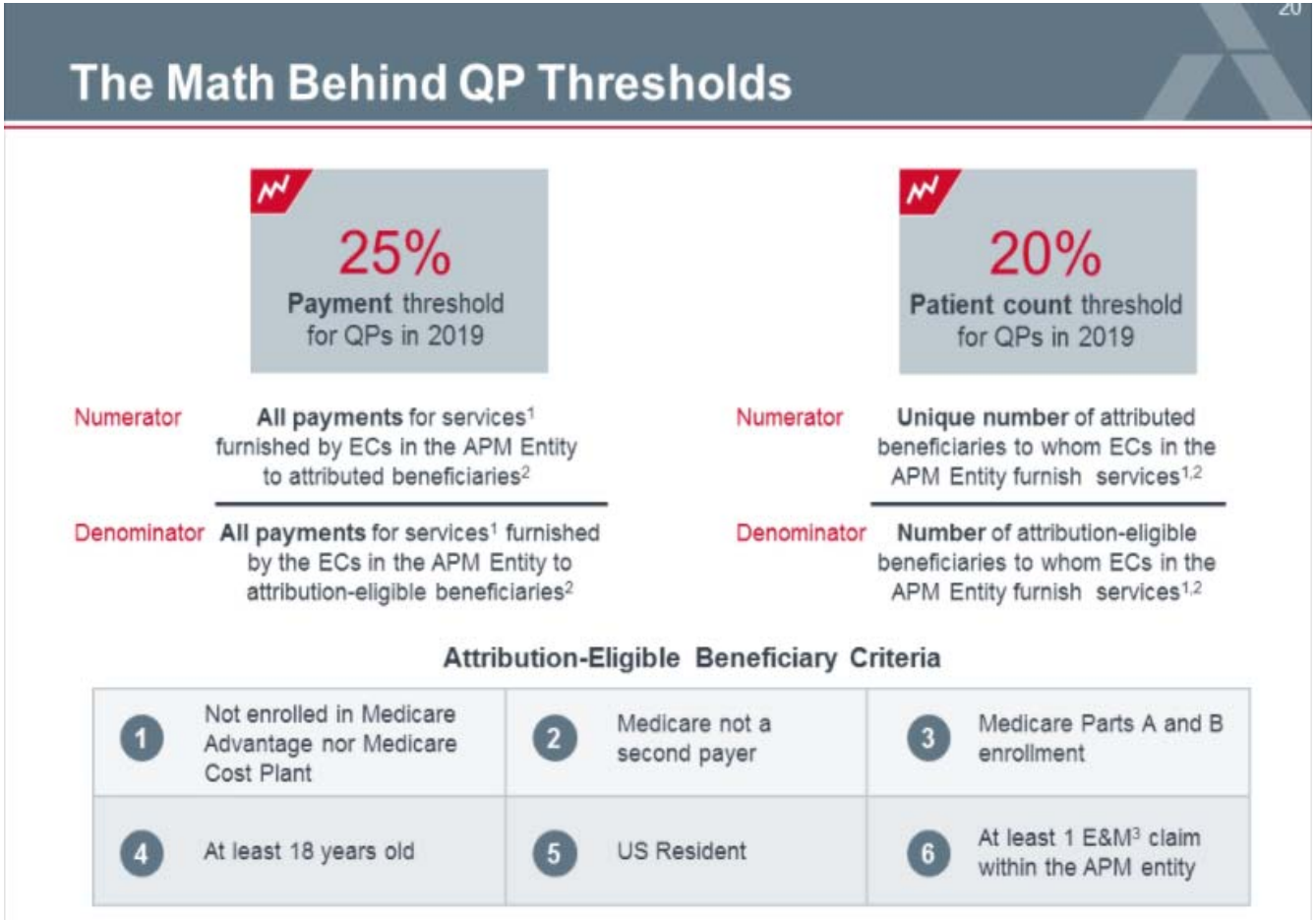
- Not in the first few performance years of the program. Starting in 2021 (based on the 2019 performance year), CMS will allow clinicians to use their “other payer” book of business including Medicare Advantage contracts to help meet the revenue or patient count thresholds for qualifying for the Advanced APM model.

- But not all downside risk Medicare Advantage plans will qualify clinicians for the APM track in 2021. The commercial alternative payment model must meet the same criteria that CMS uses to assess CMS-run APMs (see slides 15, 21).

- CMS also proposes that full capitation risk arrangements would meet this Other Payer Advanced APM financial risk criterion. CMS defines a full capitation contract as a payment arrangement in which a per capita payment is made to an APM Entity for services furnished to a population of beneficiaries.

Source: Advisory Board, 2016. CMS, 2016.

FAQ #5: For bedtime reading, can you give me additional details to how the APM qualifying participant calculations work?



MACRA Life Hack:

Submit under MIPS in 2017 and find out if you're A-APM eligible in 2018.

Source: Advisory Board, 2016. CMS, 2016.