The New Age of MACRA:

Accelerating to Advanced Alternative Payment Models (APMs)

AN ENCORE POINT OF VIEW

The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) represents the most significant change in Medicare reimbursement since the introduction of DRGs. While the concept of value-based reimbursement (VBR) is far from new, market penetration of this approach to care delivery and risk-based contracting has been spotty at best across the United States. MACRA creates the Quality Payment Program (QPP) which ends the Sustainable Growth Rate (SGR) formula (introduced in the 1997 Balanced Budget Act) for determining Medicare Part B payments, implements a reward for value of care instead of volume of services and combines existing physician quality reporting programs into a single program.
MACRA accelerates the move from fee-for-service to fee-for-value.

Payment adjustments under MIPS depend on how much data is submitted and how well you score relative to all other providers.

Seven Alternative Payment Models (APMs) will be included as Advanced APMs for 2017.

EXECUTIVE SUMMARY

Earlier this year, the Health Care Payment Learning & Action Network, CMS alliance, published the Alternative Payment Model (APM) Framework (figure 1) to create a common language to describe shared risk and population-based payment models which are the foundation for healthcare reform in this country. This framework aligns various payment models from both the public and private sector and creates a unified way to describe the delivery of “person-centered care”. The framework lays out the pathway to shared risk and population-based payment which is the basis for the MACRA QPP.

Many sources of information, including CMS itself, dissect and describe the various elements of the MACRA law. The final rules have now been published, and health systems should begin to assess their readiness and plan for the future. Most providers will start the MACRA journey with MIPS. Under MIPS, there will be winners and losers – all based on relative performance benchmarking – as this aspect of MACRA must be budget neutral (i.e., “the SGR fix”).

However, MIPS is not the end-game for MACRA. Health systems want to define a path to qualification for inclusion in an Advanced APM. Advanced alternative payment models (Advanced APMs) are health care payment and delivery models that include payment arrangements and other design elements as part of a particular approach to care improvement. In the final rules, CMS strengthens the movement toward Advanced APMs increasing the list of models that...
Alternative Payment Models (APMs) are payment approaches, developed in partnership with the clinician community, that provide an incentive to deliver high-quality and cost-efficient care.

Qualify, including the addition of Medicare ACO Track 1+. CMS lists a total of 33 alternative payment models; of those, 7 qualify as Advanced APMs.

If an eligible clinician participates in an Advanced APM, that clinician may become a qualified participant (QP). The clinician must be listed as a participant in an Advanced APM entity which must collectively meet the Medicare Part B patient visits or patient billing threshold values set by CMS for participation in an Advanced APM during the performance year. If the Advanced APM entity meets or exceeds the relevant payment amount or patient count thresholds, then all eligible clinicians become QPs and receive a 5% lump sum bonus.

Once a health system is in an Advanced APM, it is excluded from reporting for MIPS and, if qualified, would receive the 5% bonus described above. To succeed under MACRA, a health system must simultaneously focus on achieving the best performance possible under MIPS while defining and executing a roadmap to achieve Advanced APM qualification.

THE ROADMAP TO APMs

While health systems may adopt different paths along the continuum from MIPS to Advanced APMs, a set of common elements forms the basis for success. The diagram below illustrates a framework a health system can use to develop the roadmap required to progress along this continuum:

![Figure 2 – MIPS to Advanced APMs Framework Journey](image-url)
The five major elements to consider in the framework are:

- **Network** – Proficiency in developing, growing and managing their network of providers as well as in entering into risk-based contracts
- **Manage care** – Engaging patients and coordinating their care to produce improved outcomes
- **Measure performance** – Identifying opportunities for performance improvement through understanding provider performance against the metrics comprising the measurement mechanisms for MIPS and APMs
- **Improve** – Formal process improvement mechanisms to act upon the opportunities identified in measure performance
- **Health information infrastructure** – A robust portfolio of information technology capabilities that provide both the enablement of efficient and effective care delivery and care coordination and the analytics needed to understand performance

Within each of these elements are a set of competencies an organization must possess. Collectively these competencies represent the building blocks that pave the journey to successfully perform in Advanced APMs while simultaneously succeeding under MIPS.

**NETWORK**

Health systems that successfully transition to Advanced APMs will master key capabilities around managing their network of providers. Since it is unlikely that a health system will be able to employ all the providers needed to address the complete spectrum of patient needs, the health system will need to create a Clinically Integrated Network (CIN) to collaborate and share patient information with the providers participating in the Advanced APM (and any commercial at-risk arrangements). The system must also be proficient in establishing and managing at-risk contracts in general. Further, health systems or physician groups will need to implement a formal program to recruit and retain employed physicians as well as align with other provider groups’. They must understand any “patient leakage” caused by physicians referring out of the network and have a process in place to reduce this leakage through stronger provider relationships.

Health systems also need to create programs to attract patients to their network – and, once in the network, keep those patients engaged. The system needs to put in place effective marketing campaigns to communicate with people within the geographic reach of the system but not yet engaged with the network. To attract and retain patients, the health system also needs to understand if there are gaps in its service offerings by evaluating market service offerings to determine if new services should be introduced.
MANAGE CARE

MACRA/MIPS places additional emphasis on care coordination as a means to ensure patients are receiving appropriate levels of intervention in the correct timeframes to achieve optimal outcomes. Managing care begins with an organization defining the models of care delivery it will use (e.g., Patient-Centered Medical Home (PCMH), telehealth) as well as the models of care it will use.

What is a “model of care”? Essentially, it defines the evidence-based practices that the organization is committed to follow in caring for patients – regardless of how patient care is reimbursed. All patients with the same condition must be treated the same way (i.e., insurance coverage cannot influence treatment decisions). Identifying the models of care is a critical element of an effective care management program as it defines the baseline against which actual care activities will be evaluated to determine the level of care management an individual patient requires. Models of care align with the three major groupings of patients managed under at-risk contracts:

- **High risk / high utilization** – these are patients with one or more chronic conditions who require active care management to ensure they remain stable and enjoy a good quality of life.
- **Gaps in care** – patients who are missing various screenings, immunizations and follow up wellness visits.
- **Wellness** – patients who do not have a chronic condition and are up-to-date on screenings, immunizations, etc.

To support the care coordination process, the system must be able to evaluate the populations of patients it is responsible for and stratify them based on the criteria above to identify which patients need which levels of care coordination. Identifying and implementing models of care is an incremental process, so when starting a care management journey, a health organization should determine the initial care management priorities.

For example, the care management model for reducing high risk/high utilization could include supporting categories such as the identification of patients with frequent emergency department (ED) visits and the need for inpatient discharge follow-up. If frequent ED utilization and inpatient discharge are categories being actively monitored, then specific care management campaigns can be created to support these categories. Care management metrics can then be established accordingly to enable the health organization to measure its performance over a specific period of time. An example of metrics for inpatient discharge follow-up could be a plan that verifies a follow-up call from a nurse within 24 hours from the time of discharge, aimed at assisting the patient in avoiding a return to the ED or inpatient readmission.
Care management campaigns are an important part of the activities needed to support meeting model of care thresholds. These campaigns consist of coordinated outreach activities that address the health organization’s priorities within their models of care. Examples of care management campaigns might be a focus on encouraging people to get their annual flu shot or to schedule a particular cancer screening. In general, campaigns are focused patient outreach efforts to improve and maintain health status.

Included in care management is ongoing patient education. The health system will need multiple channels through which it can provide a range of information targeted to the particular needs of a patient, such as through the patient portal, mail campaigns, or face-to-face classes.

**MEASURE PERFORMANCE**

Health systems will need the ability to measure provider performance in two different ways. For MIPS, the organization must understand the four different performance categories (Figure 4) that will be weighted and used to calculate a final score. The final score is then compared nationally to all peers to determine whether the provider (or group of providers, depending on how the organization is reporting) is above or below the relative midpoint to determine the fee schedule adjustment.  

<table>
<thead>
<tr>
<th>Quality (previously PQRS &amp; MU eCQMs)</th>
<th>Improvement Activities (new category)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.</td>
<td>• Most participants: Attest up to 4 improvement activities for a minimum of 90 days.</td>
</tr>
<tr>
<td>• Groups using the web interface: Report all web interface quality measures for a full year</td>
<td>• Groups with fewer than 15 participants or in a rural or health professional shortage area: Attest up to 2 activities for a minimum of 90 days</td>
</tr>
<tr>
<td>• If no outcome measure, report one other high priority measure</td>
<td>• Activities improve clinical practice or care delivery and are likely to result in improved outcomes</td>
</tr>
<tr>
<td>• Measures can be selected individually or from specialty-specific measure set</td>
<td>• 93 options to choose from</td>
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<tr>
<th>Cost (previously VBPM)</th>
<th>Advancing Care Information (previously MU)</th>
</tr>
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<tbody>
<tr>
<td>• No data submission required</td>
<td>• Continued support of foundational objectives of the HITECH Act</td>
</tr>
<tr>
<td>• Calculated from adjudicated claims</td>
<td>• Encourage continued progress on health information exchange and patient engagement</td>
</tr>
<tr>
<td>• Not included in composite performance score for 2017</td>
<td>• A total of 5 required measures for a minimum of 90 days; 4 required for transition measures (Mod S2)</td>
</tr>
</tbody>
</table>

| 60% | 15% |
| 0% | 25% |

*Figure 4 – MIPS Performance Categories*
Participation in an Advanced APM requires use of certified EHR technology (CEHRT) and bases payment incentives on performance in cost/utilization and quality measures comparable to those in the MIPS quality performance category. The APM will either bear more than nominal financial risk for monetary losses or will be an approved Medical Home Model. MACRA does not change how any particular APM functions or rewards value but instead creates extra incentives for APM participation.

The specific metrics required for Advanced APMs will be defined by the particular program. In general, health systems will need the ability to calculate those metrics, determine where improvement is needed and identify the specific changes that will drive that improvement. When identifying focus areas for improvement, health systems should be able to model the impact (i.e., quality and/or cost improvements) a change might have to determine which changes will yield the greatest benefit.

**IMPROVE**

Success in MACRA will rely on the ability of an organization to put into practice the changes needed to drive improvement. While process improvement methods have been employed by hospitals for many years, this concept may be new to physician practices, so health systems will need a strong emphasis on change management principles including training, communication, standards, and workflow management. The typical areas that organizations focus on to drive improvement are briefly described below:

**Care**

The primary focus in any performance improvement effort is care delivery – delivering the right care at the right time and achieving the desired results, based on the specific patient condition. Increasingly, whether or not the desired outcomes were actually achieved (e.g., did the patient return to activities of daily living within 7 days) will be scrutinized. Advanced APMs are required to report on at least one evidence-based outcomes measure.

**Cost**

There will always be pressure to do more with less, requiring an understanding of cost drivers at an increasingly granular level. Are all practitioners practicing at the “top of their license”? Are supplies standardized? Are supplies being obtained at the best cost under the health system’s GPO contract? Are the right clinical activities occurring in the right quantity? This analysis, coupled with a focus on the care process, will be required to provide optimal care.

**Transitions of Care**

As patients move through the care delivery process, the handoff from one provider setting to another can be fraught with risk – whether from acute
Of increasing importance as a health system progresses from MIPS to Advanced APMs is a high level of patient engagement.

episode discharge to physician office or between physicians. Studies have shown that major risk factors for readmission are related to activities outside the acute care setting, including socio-economic factors. Are the appropriate follow up visits scheduled? Does the patient have transportation to get to the visit? Was medication reconciliation completed to ensure patients are not “double dosing” with discharge medications on top of medications they have at home? Ensuring that these and other issues are addressed is one focal area for care management which can often benefit from improved processes and information support.

Compliance
The move to fee-for-value reimbursement requires clear and accurate calculation of “value” for provider payment with a focus on outcomes measurement, including patient-reported outcomes. Compliance with evidence-based care is necessary on both the part of the provider and the patient to promote positive clinical outcomes, and the CMS Quality Strategy for 2016 expands the use of evidence-based care into the community to prevent and treat chronic disease.

Compliance with evidence-based guidelines is vital for accurate measurement of patient care to inform improvement activities, and measure success. For example, providers should follow guidelines for appropriate colon cancer screening activities, and patients need to follow through on the prescribed activity (e.g., colonoscopy, fecal occult blood test, etc.) to ensure adequate performance scores on quality metrics.

Patient Engagement
There are three pillars of value-based care: quality, cost and patient engagement. Of increasing importance as a health system progresses from MIPS to Advanced APMs is a high level of patient engagement. Patients’ active involvement in their care in collaboration with providers is the cornerstone for improved care coordination and better outcomes.

There are many means through which an organization can engage patients in addition to direct care delivery – from targeted campaigns and outreach programs using mail, email, text messages and phone calls to a content-rich patient portal and/or patient reported outcomes. The means of patient engagement and the information that is shared with patients must be tailored to the wishes, capabilities and health status of each individual patient and supported by the right tools and technology.

HEALTH INFORMATION INFRASTRUCTURE

Underlying these building blocks that define the path to Advanced APMs is the need for a health information infrastructure that combines data, technology and processes to:
EHR-Agnostic Capabilities

Data and analytics • Care Management • Patient Portal • HIE

• Inform decision making with analytics
• Provide the needed measurement to understand performance and outcomes
• Enable more efficient care management and care delivery processes.

Critical to this infrastructure is data liquidity to support analytics, measurement and care coordination. Figure 5 below provides a high-level framework of the information technology (IT) infrastructure required.

Many health systems have implemented a single electronic health record (EHR) in their acute care and ambulatory settings. However, due to the dynamic nature of health system composition (i.e., acquiring new hospitals, physician practices), the ideal of a homogeneous EHR environment, even among owned facilities and providers, will be an elusive target. Further, there will always be affiliated providers with which the health system will need to collaborate to provide longitudinal care for patients. In addition, data from other participants, such as retail pharmacies, payers, reference labs and even remote monitoring devices, need to be included to represent the full picture of a patient. The bottom line is that health systems will need to operate in a heterogeneous environment of data sources.

To leverage the data effectively from these heterogeneous sources requires EHR-agnostic capabilities in four areas:

• Data and analytics – the ability to aggregate reliable data from across the health system to support measurement and analysis of at-risk populations.

• Care management – IT-enablement of care coordination work queues and
A system-wide steering committee should be tasked with setting priorities, making decisions, and ensuring buy-in to make the transition to an Advanced APM.

• **Patient portal** – a single point of contact for patients to engage with all their providers to perform activities such as asking questions, receiving educational material, scheduling appointments, requesting prescription refills, accessing test results, and paying bills. Technically, this is by far the most challenging. Absent this capability, patients will need to access multiple patient portals due to the heterogeneous EHR environment.

• **Health information exchange (HIE)** – the technical capability to move data securely and efficiently from the source systems to the three capabilities listed above.

Encore has defined a framework that organizations can use to help evaluate their current capabilities and identify gaps and redundancies (see figure 6 below).

The Foundational building blocks of this framework are the EHR and Infrastructure environments. A number of capabilities need to be well-supported within these two foundational building blocks for any organization seeking to manage populations. The Enabling building blocks of care management and analytics allow a health system to fully realize the IT-enablement for care coordination, performance and outcomes measurement and drive performance improvement.

<table>
<thead>
<tr>
<th>CARE MANAGEMENT</th>
<th>ANALYTICS</th>
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<tbody>
<tr>
<td>• Ambulatory care manager work queues</td>
<td>• Data aggregation from disparate sources</td>
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<tr>
<td>• Disparate EHR integration</td>
<td>• Population stratification by risk profile</td>
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<tr>
<td>• Content to support models of care</td>
<td>• Benchmarking</td>
</tr>
<tr>
<td>• Intervention alerts and tracking</td>
<td>• Metrics calculation</td>
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<tr>
<td>• Real-time data integration</td>
<td>• Registries</td>
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<table>
<thead>
<tr>
<th>EHR</th>
<th>INFRASTRUCTURE</th>
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<tbody>
<tr>
<td>• Certified technology</td>
<td>• Data sharing and exchange internally and externally</td>
</tr>
<tr>
<td>• Content to support models of care</td>
<td>• Telehealth</td>
</tr>
<tr>
<td>• Data capture for reporting as part of clinical workflow</td>
<td>• Single point of contact patient portal</td>
</tr>
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</table>

Figure 6 – Advanced APM IT Framework

**GOVERNANCE**

Wrapping around all the building blocks described above is the need for a robust, integrated governance structure and process for operational, clinical and IT decisions. A system-wide steering committee should be tasked with setting priorities, making decisions, and ensuring buy-in across the organization. The
structure will need to be extended into provider practices to ensure all voices are heard.

Data governance will be critical to ensure that the foundational health information infrastructure provides complete, accurate and reliable information on which to base measurement, analytics, population stratification and care coordination.

In essence, governance structures and processes will be needed to address each component of the framework, and they must all be coordinated through overarching, network-level governance.

**CONCLUSION**

The final rule was released on October 14, 2016, and there is now a “pick your pace” option that may cause many clinicians to breathe a sigh of relief, but health systems should not relax. As noted in the executive summary of the final rule, the Quality Payment Program aims to:

1. Support care improvement by focusing on better outcomes for patients, decreased provider burden, and preservation of independent clinical practice
2. Promote adoption of alternative payment models that align incentives across healthcare stakeholders
3. Advance existing efforts of delivery system reform, including ensuring a smooth transition to a new system that promotes high-quality, efficient care through unification of CMS legacy programs.  

In addition, it should be noted that since MACRA was made law by a Republican majority Congress it is unlikely to be effected by the 2017 change in the Oval Office. While it is unclear what a repeal of the Affordable Care Act might mean to value-based performance models, MACRA is here to stay.

Health systems must begin to look now at the demands and needs of each of the five elements of the framework described above in addition to the likely increased level of support providers will need as they transition into the new world of MACRA.

Through MACRA, CMS has created an accelerated pathway to value-based reimbursement: MIPS to MIPS-APMs and, finally, Advanced APMs. Due to the budget neutrality of MIPS, there will be winners and losers with maximum adjustments of up to plus or minus 9% by 2022 based on comparative performance to other providers. Though Advanced APMs by their nature require financial risk, systems are measured only against themselves and thus have more control over their performance and related risk, and, as a bonus, are able to earn extra incentives from CMS for their participation. As MACRA goes into effect in 2017, it is in a health system’s best interest to set a path to Advanced APMs.
REFERENCES

5. See link to CMS in foot note 3
6. For the purpose of this document “health system” refers both to Integrated Delivery Networks and large multi-specialty physician groups
7. Some states do not allow health systems to own physician practices; other collaboration arrangements can address these physician/health system arrangements as well.
10. Ibid
11. CMS (2016). CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Baltimore, MD. (link)
13. http://www.bmj.com/content/354/bmj.i2976 (October 6, 2016)
17. Being “EHR-agnostic” means that the four capabilities described can operate in a heterogeneous EHR environment. These capabilities might be available from an EHR vendor or obtained from other sources.