MACRA – Recommendations from a Health System Committed to Transformation

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Our 22-State Diversified Network

92 Hospitals* in 20 Regional Health Ministries**
47 Home Care & Hospice Locations Serving 116 Counties
59 Continuing Care Facilities
14 PACE Center Locations
23.9K Affiliated Physicians
3.9K Employed Physicians

*Owned, managed or in JOAs or JVs.
**Operations are organized into Regional Health Ministries ("RHMs"), each an operating division while maintaining a governing body with managerial oversight subject to authorities.
Transforming care requires a transformed business model

Strategic Aim: 75% of all care will be reimbursed via Alternative Payment Models (APM)

Expanding ACO programs are the primary driver of APM growth

- **14** Medicare Shared Savings Program ACOs
- **5** markets partnering as a Next Generation ACO
- Participating in **98** non-CMS APM contracts
- **13.8K** physicians participating in our Clinically Integrated Networks accountable for **1.2** million lives
Delay MACRA & adjust ACO program deadlines

- Delay first MIPS and Advanced APM payment year to 2020 and delay start date of performance year to January 1, 2018
- Reduce barriers physicians to participate in Advanced APMs by adjusting start dates and participation deadlines

Modify definition of Advanced APM

- Implement a definition of “more than nominal risk” that recognizes investments as business risk, and allows MSSP Track 1 to qualify as Advanced APM
- Modify rules so that ACOs may voluntarily move into a two-sided risk model at the start of any performance year
- Develop and implement a new MSSP Track 1.5, moderating provider risk yet while including downside accountability
Adjust BPCI & CJR to qualify as Advanced APMs

- Allow BPCI participants to amend their contracts to CEHRT and quality requirements to qualify as Advanced APM
- Allow CJR programs to voluntarily assume CEHRT obligations to qualify as Advanced APM
- Consider alternative approaches to current overlap policy so both ACO and BPCI models can thrive