MACRA and Advanced Alternative Payment Models
Frequently Asked Questions (FAQs)

Is there a chance CMS will decide to not implement MACRA?
No. The Medicare Access and CHIP Reauthorization Act (MACRA) was passed by congress in April 2015 and CMS must, by law, implement it. CMS published its first draft of rules to implement in April 2016 and it is in the public comment period which allows feedback on those rules, but not the law itself.

MACRA doesn’t change reimbursement until 2019, why do I need to make decisions now?
Although reimbursement isn’t changing until 2019, reimbursement will be based on reporting from 2017. That means physicians and clinicians need to decide what reimbursement model they want to participate in and make preparations for reporting beginning Jan. 1, 2017.

Can a physician or clinician be enrolled in more than one Advanced Alternative Payment Model (AAPM) or multiple MSSP models (e.g. Participate in both MSSP Track 1 ACO and an MSSP Track 3 ACO OR MSSP Track 3 ACO and End Stage Renal Disease (ESRD) Model)?
No. CMS only allows physicians and clinicians to be associated with one AAPM including MSSP ACO models. If you currently participate in an MSSP Track 1 ACO and are considering participating in an AAPM to avoid defaulting into the Merit-based Incentive Payment System (MIPS), you will need to leave the MSSP ACO Track 1 and sign a new participation agreement with an AAPM.

When is the deadline to sign up for an AAPM if I decide to participate?
Notices of intent to file to form an AAPM were due by May 31, 2016. Trinity Health filed two notices of intent to apply for new MSSP ACOs. The final applications for the MSSPs are due to CMS on July 29, 2016. If you choose to participate in one of our AAPMs, you must sign a participation agreement prior to July 29, 2016.

Why should independent providers, clinicians or practice groups align with Trinity Health in an AAPM?
Trinity Health has experience with collaborative ACOs. In 2016, Trinity Health began participating in the Next Generation ACO model (Trinity Health ACO). This collaborative ACO brought together both employed physicians/owned practices and a large, independent, multispecialty physician practice. Our collaborative ACO has been successful using a shared governance model and by dividing work to take burdensome tasks off the local communities. Trinity Health's system office takes on analytics, IT support, care management tools, reporting and CMS relationships while each local chapter focuses on local work focusing on clinical needs.

AAPMs being proposed by CMS also include models such as Comprehensive End Stage Renal Disease Care, Comprehensive Primary Care Plus and the Oncology Care Model. Why choose an MSSP Track 3 ACO over these?
The disease-specific models are very prescriptive with a focused set of initiatives. To be successful, physicians and practices will need strong ties to specialty providers and facilities like imaging, infusion and dialysis. Because of the narrow scope, they are also not easily scaled and replicated making them less attractive for Trinity Health and our valued physician partners.

Who bears the financial risk of participation in the MSSP Track 3 model since there is downside risk?
Affiliated providers will not individually bear the risk of the ACO. (Risk will not come down to the independent TINs). Gain sharing and downside risk will be managed at the chapter/local level and will be allocated based on an agreed upon methodology. Ultimately, the ACO will bear losses.