

MACRA for Successful Value-based care

A Review of the Short
and Long Term Impact

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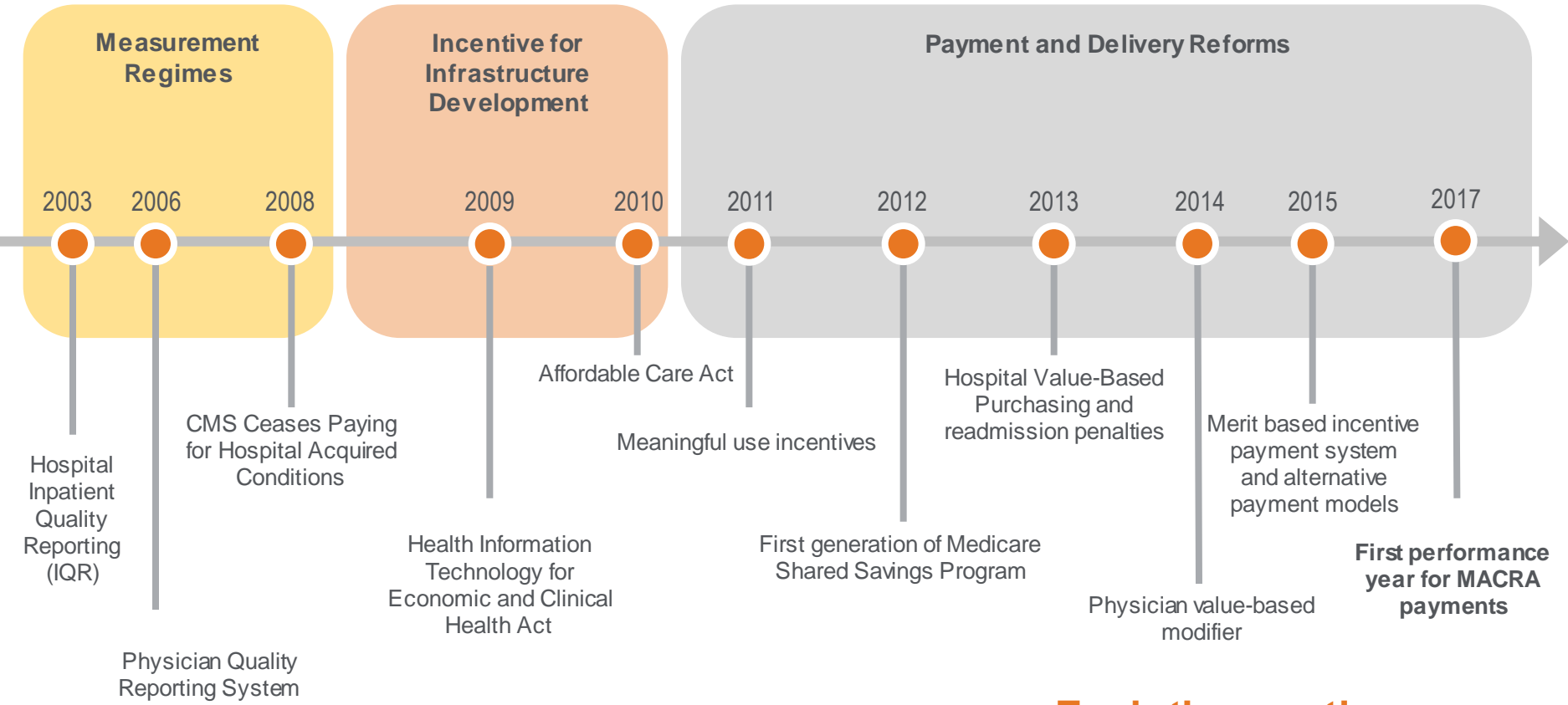
I think the MACRA realization is not going to manifest broadly until sometime next year, as people come to grips with, my God, it's real, and I'm going to have to do something about it.



CMS has been driving innovation for over a decade

MACRA is intended to help accelerate the transformation to value based care

Setting the foundation...



...Evolution continues

MACRA gives physicians a choice



Merit-based incentive payment system (MIPS)

- **Measurement-based regime**, replacing PQRS, VBP modifier and MU and creating single reporting framework for physicians
- **Four domains:** quality, clinical practice improvement, advancement of care, resource utilization
- **Physician discretion** in selecting metrics to report to CMS
- **Increasing upside/downside risk**, depending on relative performance

Advanced alternate payment models (APMs)

- **Demonstration** of preponderance of patients/revenue in value-based care models, most of which must include 2-sided risk
- **Includes** MSSP Tracks 2 & 3, Next Generation ACO, Comp ESRD (2 sided), and CPC+ programs
- **Upside bonus of 5%** and enhanced fee schedule increases if meet risk requirements

CMS has also created an option for APMs that do not qualify for advanced status (MIPS APM). Benefits include significantly reduced reporting burden and preferential scoring against MIPS only peers.

2017 Provider engagement

Clinician Category	Count	% Count	Part B Allowed Charges (\$M)	% Charges
Total Medicare FFS Clinicians	1,380,209	100%	\$104,674	100%
<i>Ineligible Specialties</i>	<i>199,308</i>	<i>14%</i>	<i>\$10,614</i>	<i>10%</i>
<i>Low Volume</i>	<i>383,514</i>	<i>28%</i>	<i>\$4,751</i>	<i>5%</i>
<i>Newly Enrolled in Medicare</i>	<i>85,268</i>	<i>6%</i>	<i>\$1,283</i>	<i>1%</i>
<i>Total Exclusions</i>	<i>668,090</i>	<i>48%</i>	<i>\$16,648</i>	<i>16%</i>
MACRA Eligible	712,119	52%	\$88,026	84%
QP AAPM *	95,000	7%	\$9,047	9%
MIPS	617,119	45%	\$78,979	75%



* Count range is 70,000 to 120,000. Charge range is \$6,666 to \$11,428.

Five MACRA paths in 2017

1. MIPS: Don't participate.

- If a physician does not send any 2017 data to Medicare, then they receive a negative 4 percent payment adjustment.

2. MIPS: Test the Quality Payment Program.

- If the physician submits a minimum amount of 2017 data to Medicare (for example, one quality measure and one improvement activity), the physician will avoid a negative payment adjustment.

3. MIPS: Participate for part of the calendar year.

- Physician may choose to submit Quality Payment Program information for 90 days of 2017 data to Medicare. The physician may earn a neutral or small positive adjustment.

4. MIPS: Participate for the full calendar year.

- For physicians that are ready to go on January 1, 2017, physician may choose to submit Quality Payment Program information for a full calendar year. The physician may earn a moderate positive payment adjustment.

5. AAPM: Participate in an Advanced Alternative Payment Model in 2017.

- Instead of reporting quality data and other information, the law allows physician to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model. If physician has a large enough percentage of Medicare payments, then physician will qualify for a 5 percent incentive payment in 2019.

Key client concerns and needs

- Which MACRA path is best for today and in the future?
- Which quality metrics and risk/reward variables will lead to highest impacts?
- Where and how should we invest for success and differentiate ourselves?
- Where are gaps in our data reporting and capabilities?

50%

of physicians surveyed in 2016 said they had never heard of the law

74%

plan to implement MIPS, and many are not aware of MIPS implications



70%

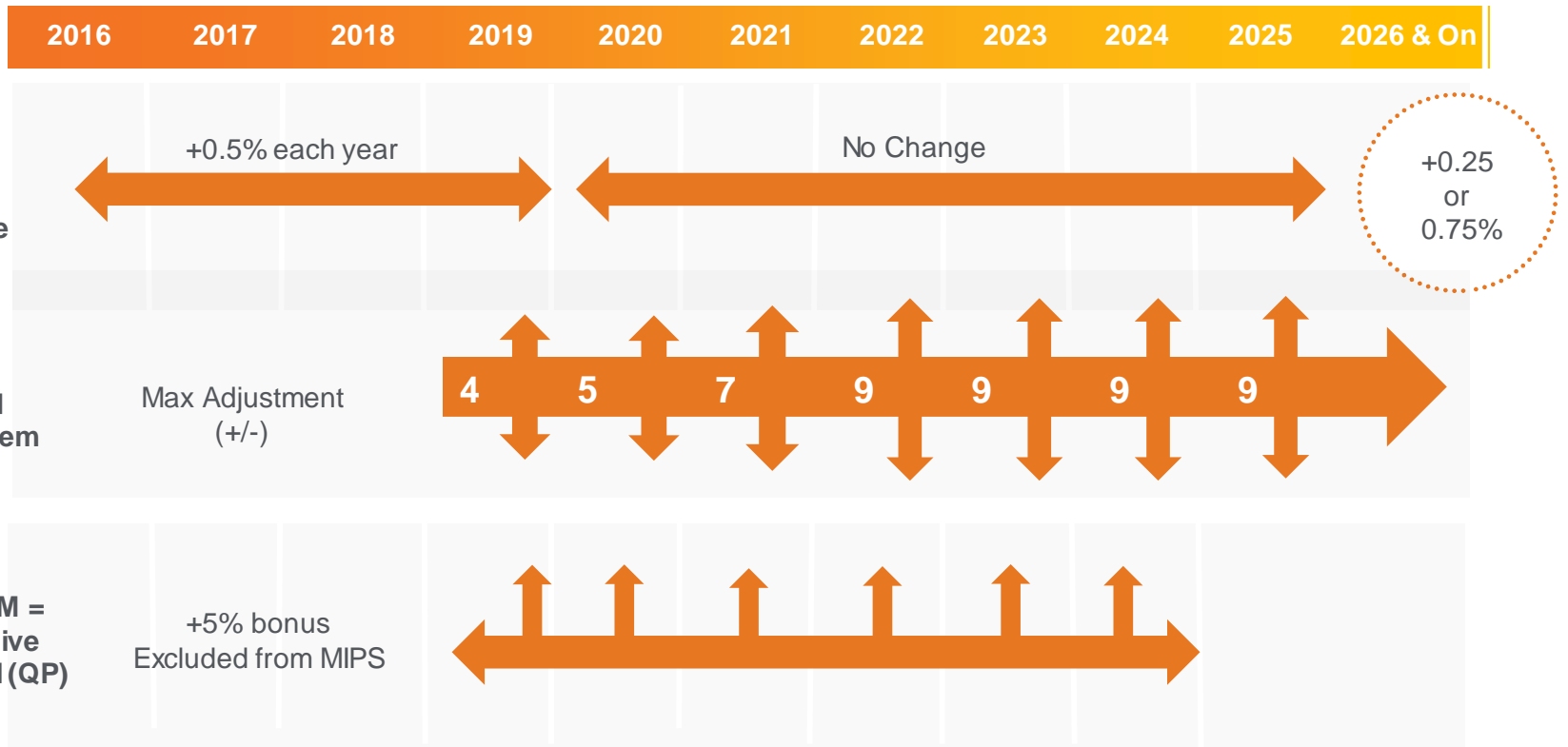
of health system leaders are concerned about addressing MACRA requirements

85%

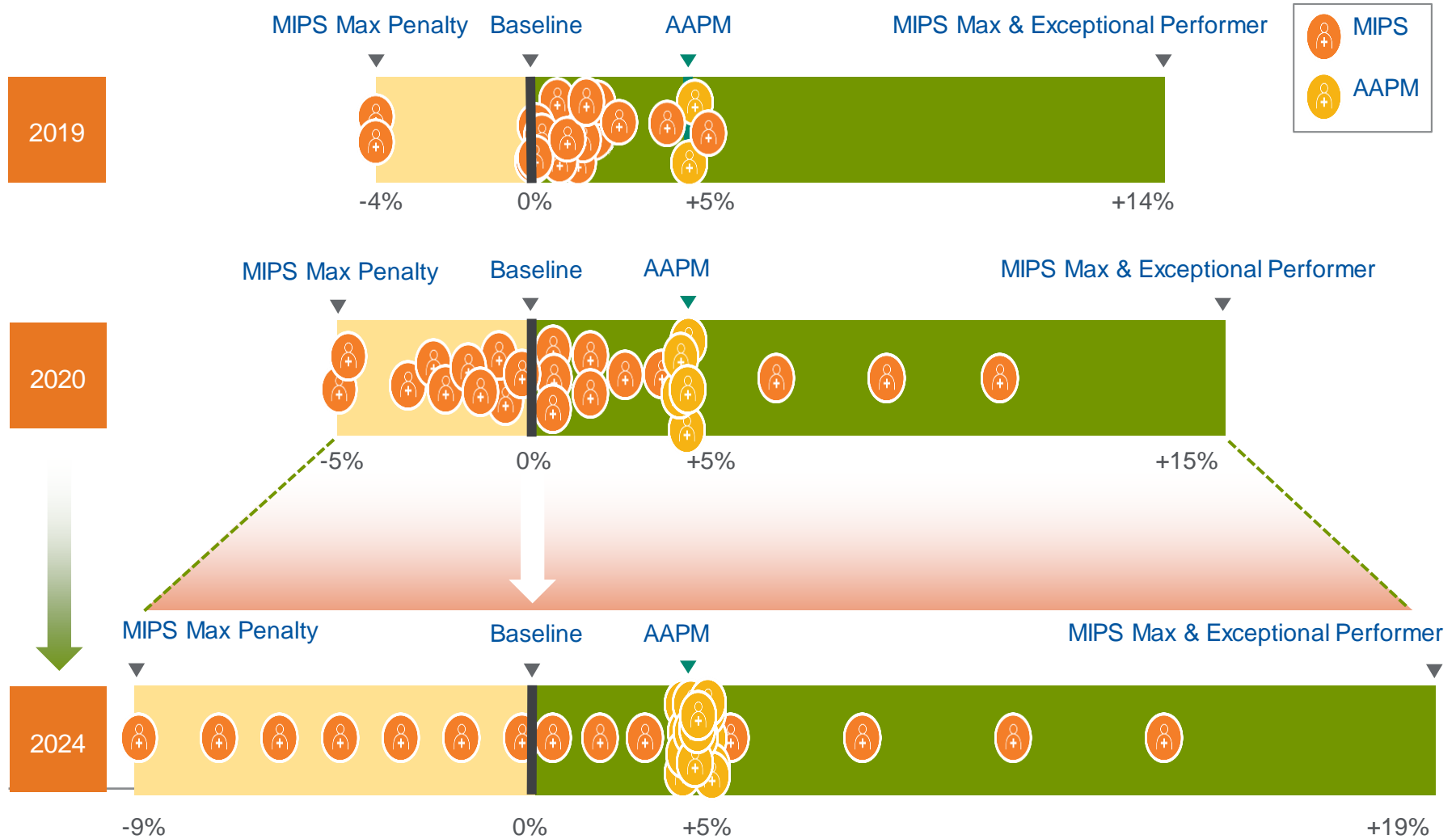
of affected physicians will experience revenue decreases

MIPS vs. APM: Financial fee schedule implications

- MIPS positive adjustments have the potential for a 3X adjustment (i.e. +12% for 2019 up to +27% for 2022+).
- For 2019-2024, exceptional performers (top 25th percentile) are eligible for additional payment up to 10% (**\$500M funding per year**).



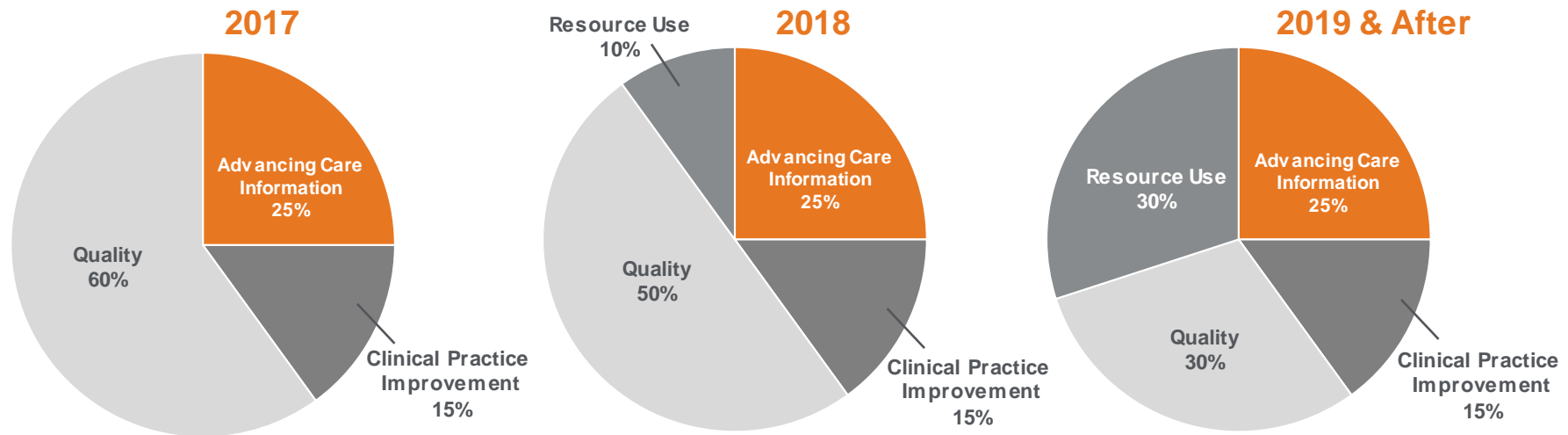
How MACRA impacts Medicare physician reimbursement



Physician MIPS scoring: Maximizing performance

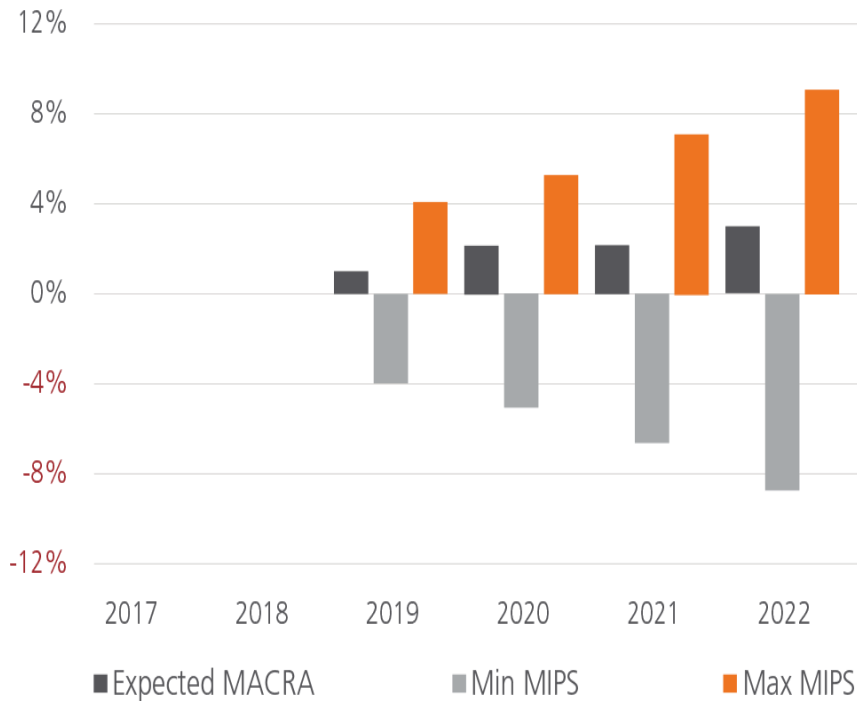
Physicians will receive a Composite Performance Score (CPS) based on four categories

- **Quality:** Physicians must choose up to six measures for their practice/specialty, including one outcome measure
- **Clinical Practice Improvement Activities:** Physicians must choose among 90 potential activities with focus on care coordination, beneficiary engagement, population management, and health equity. Physicians choose a smaller subset to meet threshold (as little as two activities)
- **Resource Use (Cost):** No reporting requirements, but data and actuarial expertise needed to proactively measure and monitor performance risk across multitude of episode-specific measures. The cost category will be calculated in 2017, but will not be used to determine your payment adjustment. In 2018, this category will start being used to determine the payment adjustment.
- **Advancing Care Information:** Scored based on combination of EHR/security standards and choice of measures based on HIE use and patient access

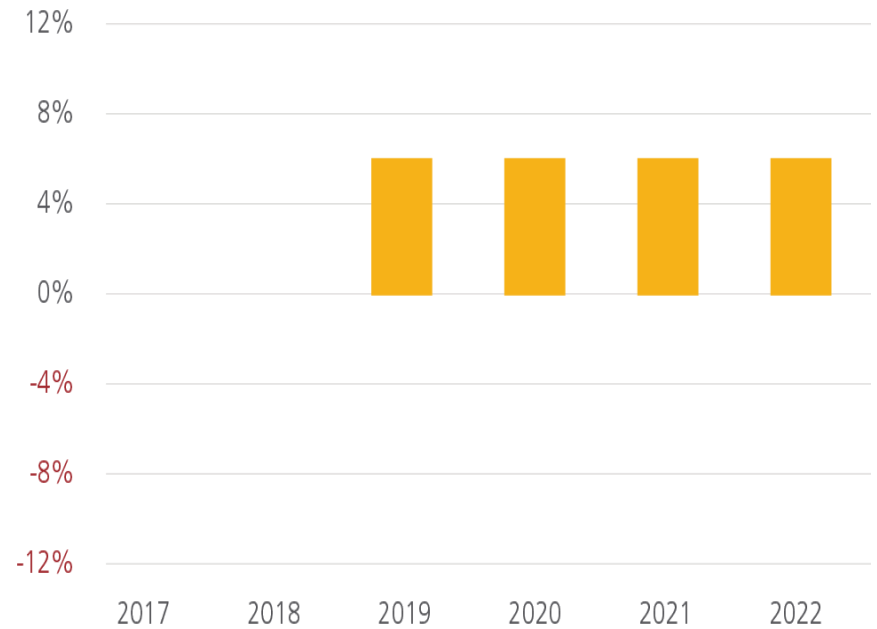


AAPM offers more predictable upside incentives

MIPS financial impacts



AAPM financial impacts



MIPS is a stand-alone, temporary approach to VBC

MIPS as Stand-Alone Model



Physician Groups

Advanced APMs Meet Market Needs



Medical Center



Physician Groups

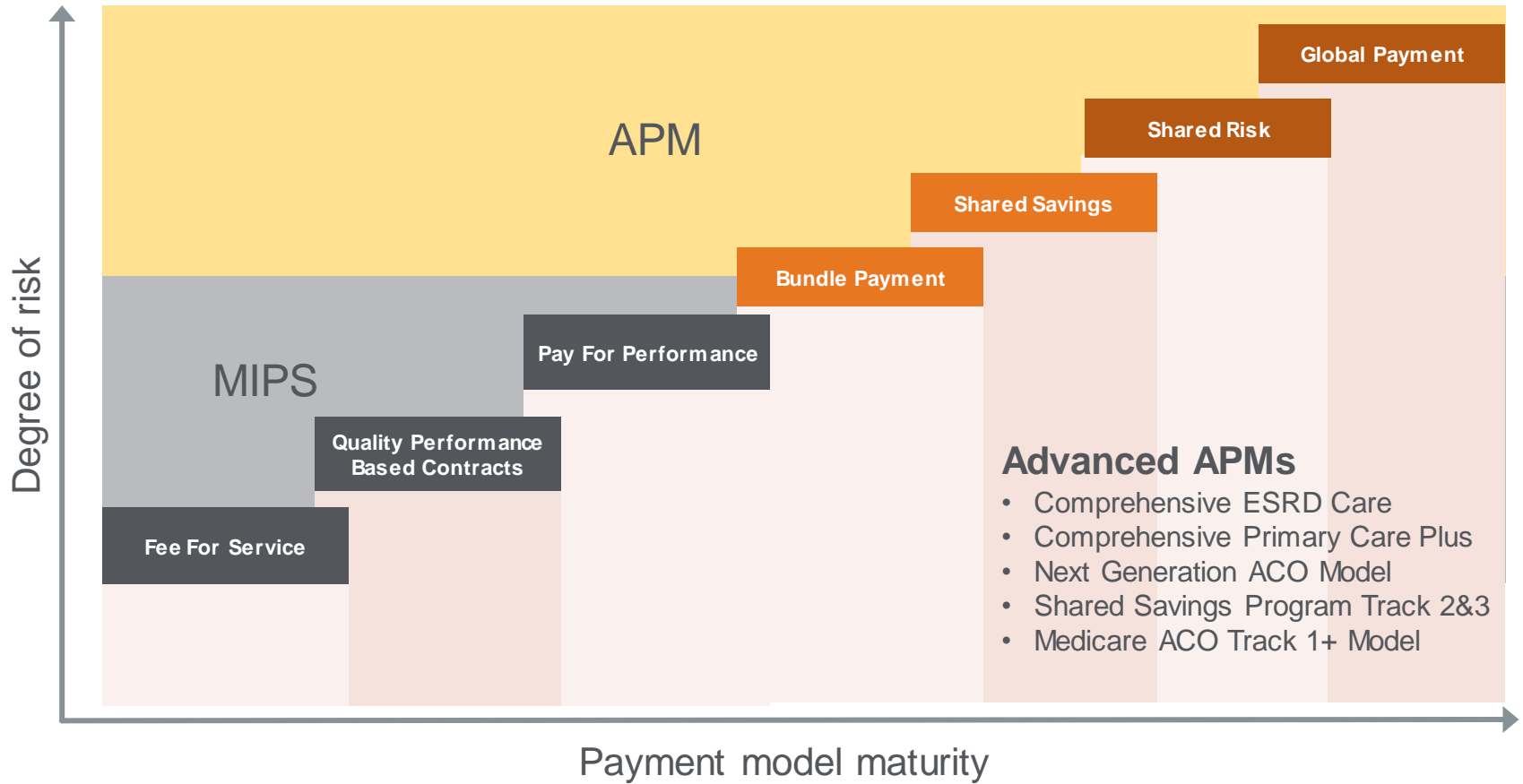


SNF Partner(s)

- MIPS stands apart from market trends
- Re-sets annually with no guarantee that past performance will drive future success

- Provider collaboration to meet demands of:
- Medicare VBC models (ACOs, bundles)
 - Medicaid reform (Medicaid ACOs and managed care)
 - Commercial ACOs (employer-based, MA)

Incentive payments are tied to provider risk



AAPMs – providing greater long term value

Value-Based Care models premised on two objectives:

1. Create broader financial risk for episodes and populations
2. Facilitate, foster, or require collaboration across multiple providers

Medicare Fee-for-Service Model



- Readmission penalties
- Resource utilization measures
- Mandatory bundles

Required Collaboration



- Physician-hospital
- Hospital-post-acute care
- Physician-pharmacy
- Provider - community

Consistency and Discipline



- Parameters around best clinical delivery
- Consistent measurement over time to measure improvement
- Models reward year-over-year improvement

AAPMs:

- Reward these expected behaviors
- Reward the scale required to achieve these results
- Reward year-over-year improvement
- Dovetail more closely with emergent commercial models than reporting models

Stakeholder considerations

Physicians



- How will this impact practice revenues and margins over the next 3-5 years?
- Should I limit my Medicare patients to remain exempt?
- Should I consider joining a larger practice and/or assess employment opportunities?
- What is the added reporting burden to comply with QPP and achieve incentives?
- How can our practice become part of a qualified APM and Advanced APM?

Health Systems



- What can we do to help physicians maximize their QPP revenue?
- What levers do we pursue to make physicians effective and align to QPP performance metrics?
- What actions do we need to take to sponsor or join a Medicare and multi-payer APM and Advanced APM?
- Should we offer more physicians an employment option?
- Should we consider merging with a larger system?

Payers



- How will physician revenues from CMS impact our MA plans? What payment and quality should we pursue?
- Should we partner with physicians and hospitals and implement Advanced APMs that will qualify for the Medicare bonus?
- Should we partner with high performing health systems and share accountability, responsibility and risk for managing the total cost of care?
- Can we leverage our strengths in benefit and product design, regulatory compliance, claims processing, data management and analytics to support risk bearing provider systems and support their care and utilization management programs across the continuum?
- Should we promote multi-payer AAPM programs that use the same quality measures and reporting requirements?

Key attributes for success

Lead value transformation by accelerating transition to financial risk



Innovate and collaborate on care delivery



Widely adopt and integrate technology and operational assets



Aggressively pursue population health, and quality initiatives to engage patients



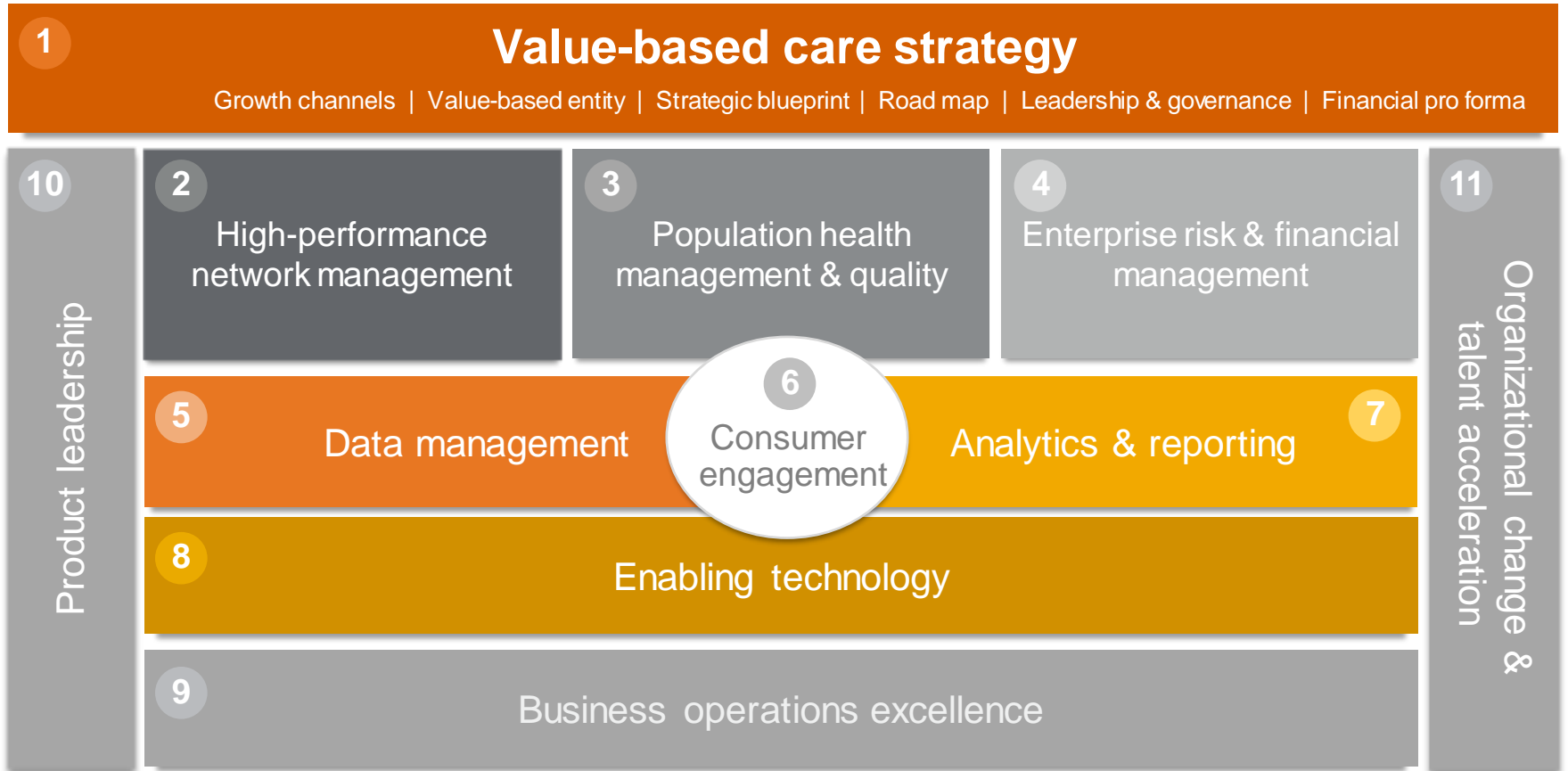
Deliver superior cost performance compared to the market



Enable the transformation with comprehensive data and analytics platform



Assembling the necessary capabilities for MACRA success





Thank you

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