



MACRA Quality Payment Program

Medicare Access and CHIP
Reauthorization Act of 2015

November, 2016

MACRA/Quality Payment Program (QPP) purpose

On October 14, 2016, CMS released the Final Rule that implements the Medicare Access and CHIP Reauthorization Act of 2015 (**MACRA**).



MACRA replaced the Sustainable Growth Rate methodology that pays Fee-for-Service (FFS) providers with a new payment system – the **Quality Payment Program**. The mandatory Quality Payment Program rewards providers for the delivery of high-quality care delivered to Medicare beneficiaries and is part of CMS’s commitment to transition the Medicare program from FFS to value-based payments.

CMS estimates that in 2017 **MACRA will impact over 50% of physicians**.

The Final Rule will be open for public comment for the next 60 days, with comments due to CMS on December 13, 2016. CMS indicated that the Agency plans to implement the law in an iterative process, and **new provisions will be introduced in the upcoming years**.

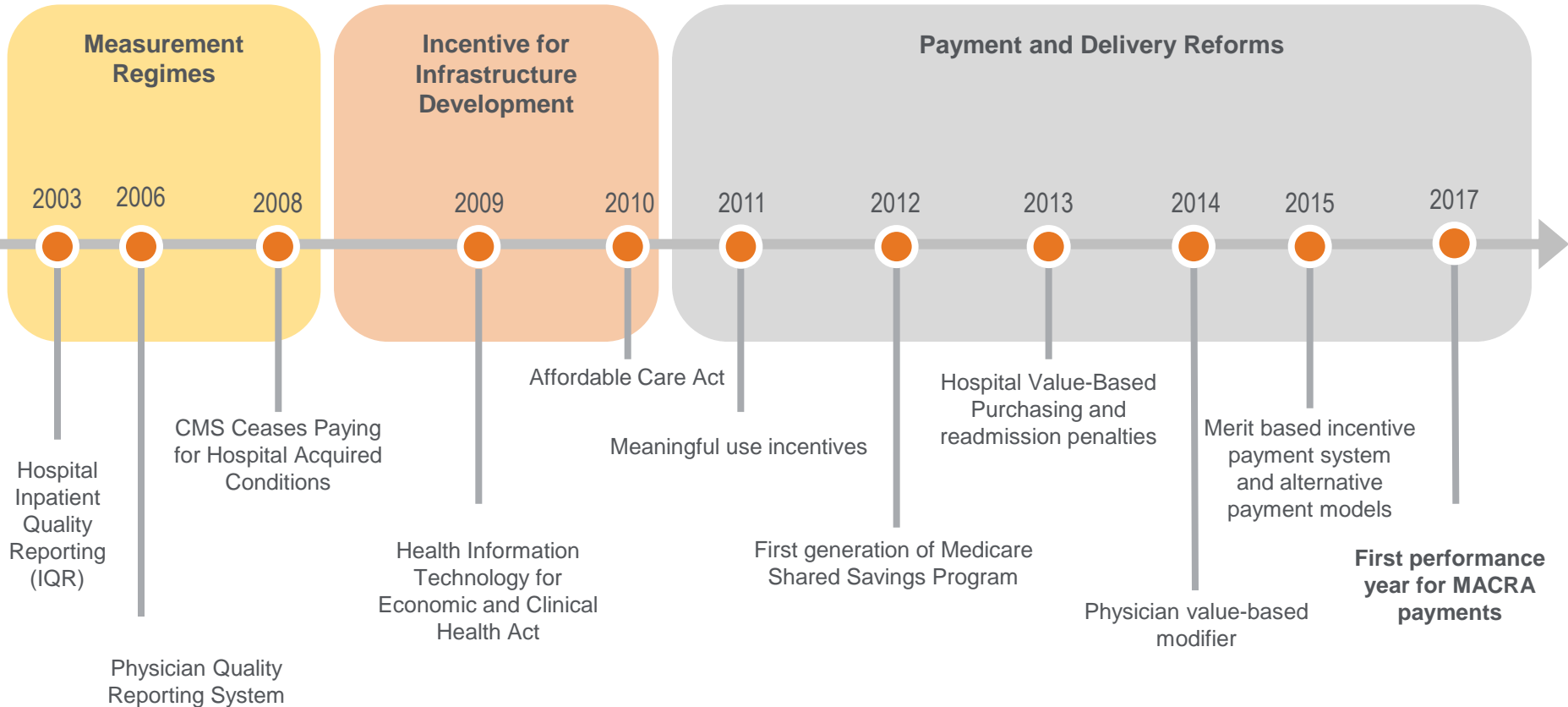
MACRA : AT A GLANCE

April 2015	Passed into law
Repeals	The Sustainable Growth Rate (SGR) Formula.
April 2016	Proposed rule released
Oct 2016	Final rule released
Applies to	Medicare FFS Physician Revenues only
Two new payment tracks:	1. Merit-Based Incentive Payment System (MIPS) 2. Advanced Alternative Payment Models (APMs)
Takes effect	Beginning 2017; impacts revenues in 2019 (i.e. two year lag)

CMS has been driving innovation for 13 years

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

Setting the foundation...



...Evolution continues

MACRA/QPP gives physicians a choice



Merit-based incentive payment system (MIPS)

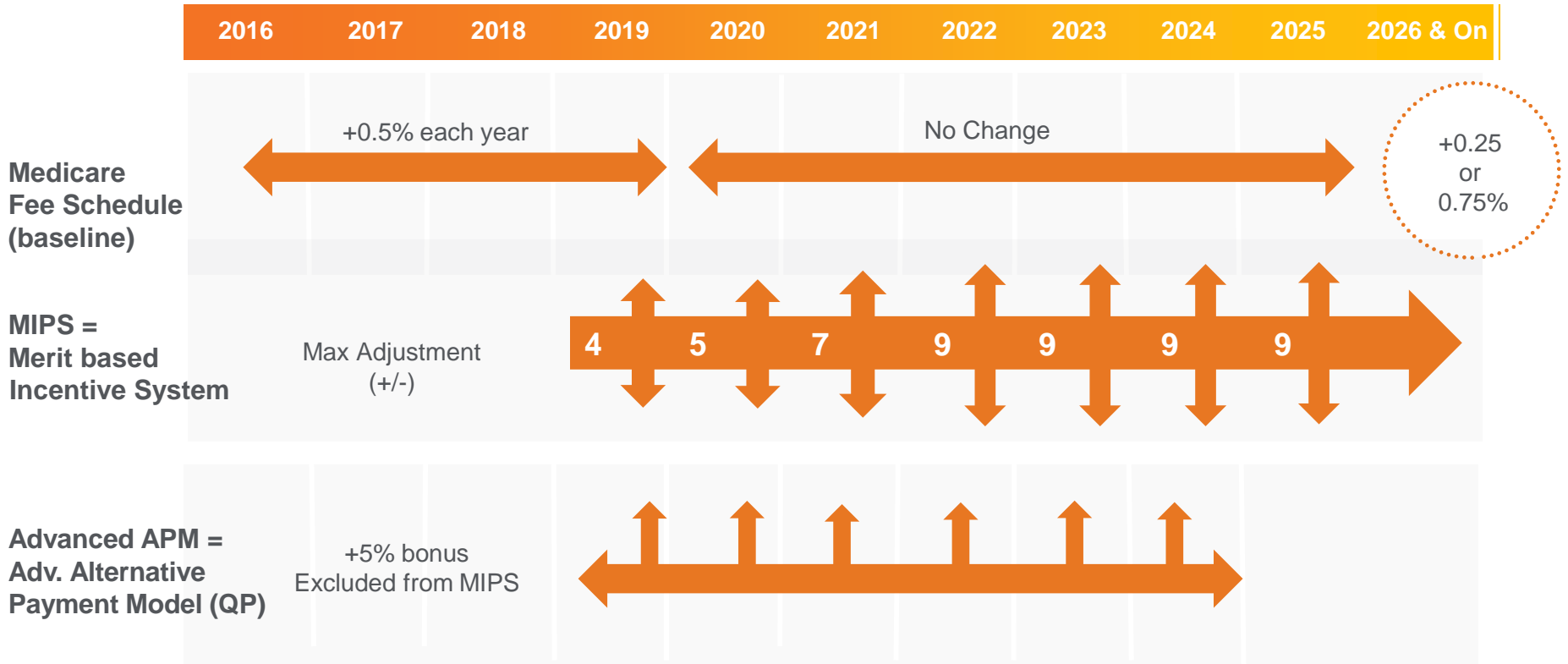
- **Measurement-based regime**, replacing PQRS, VBP modifier and MU and creating single reporting framework for physicians
 - **Four domains:** quality, improvement activities, advancement of care, resource utilization
 - **Physician discretion** in selecting metrics to report to CMS
 - **Increasing upside/downside risk**, depending on relative performance
 - **Exemptions:** Low volume; QP
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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), OCM (2 sided) and CPC+ programs
 - **New AAPM options 2018+**
 - **Upside bonus of 5%** & enhanced fee schedule increases if meet requirements
 - **All payer options** begin in 2019
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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.

MIPS vs. APM: Financial fee schedule implications

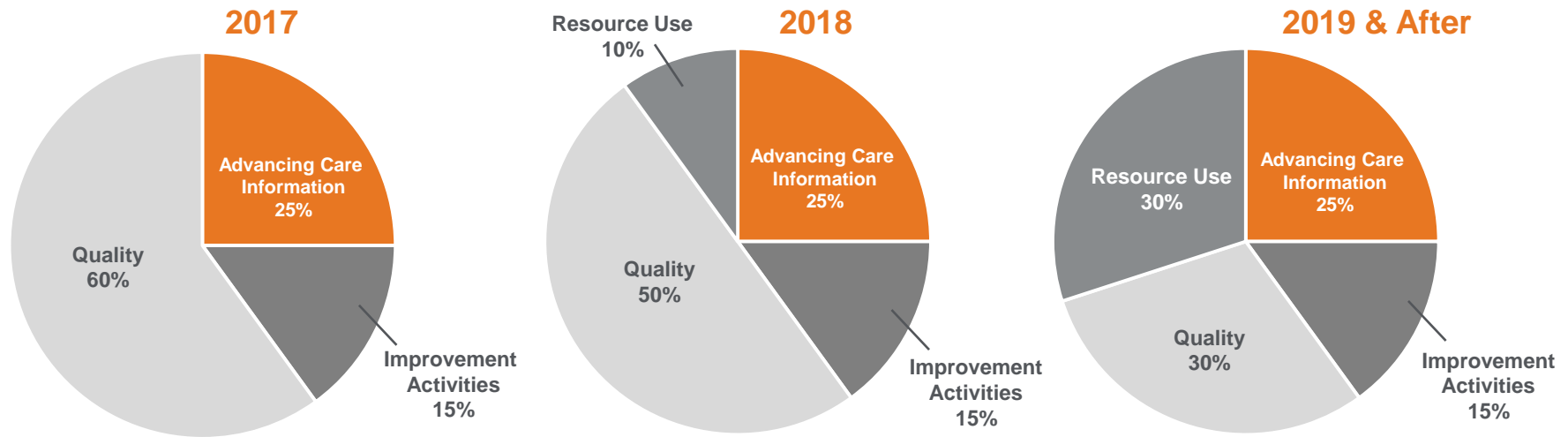


- MIPS positive adjustments have the potential for a 3X adjustment (i.e. +12% for 2019 up to +27% for 2022+). Intended to be budget neutral.
- For 2019-2024, exceptional performers (top 25th percentile) are eligible for additional payment from 0.5% grading up to 10% (**\$500M funding per year**).

Physician MIPS Scoring: Maximizing Performance

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

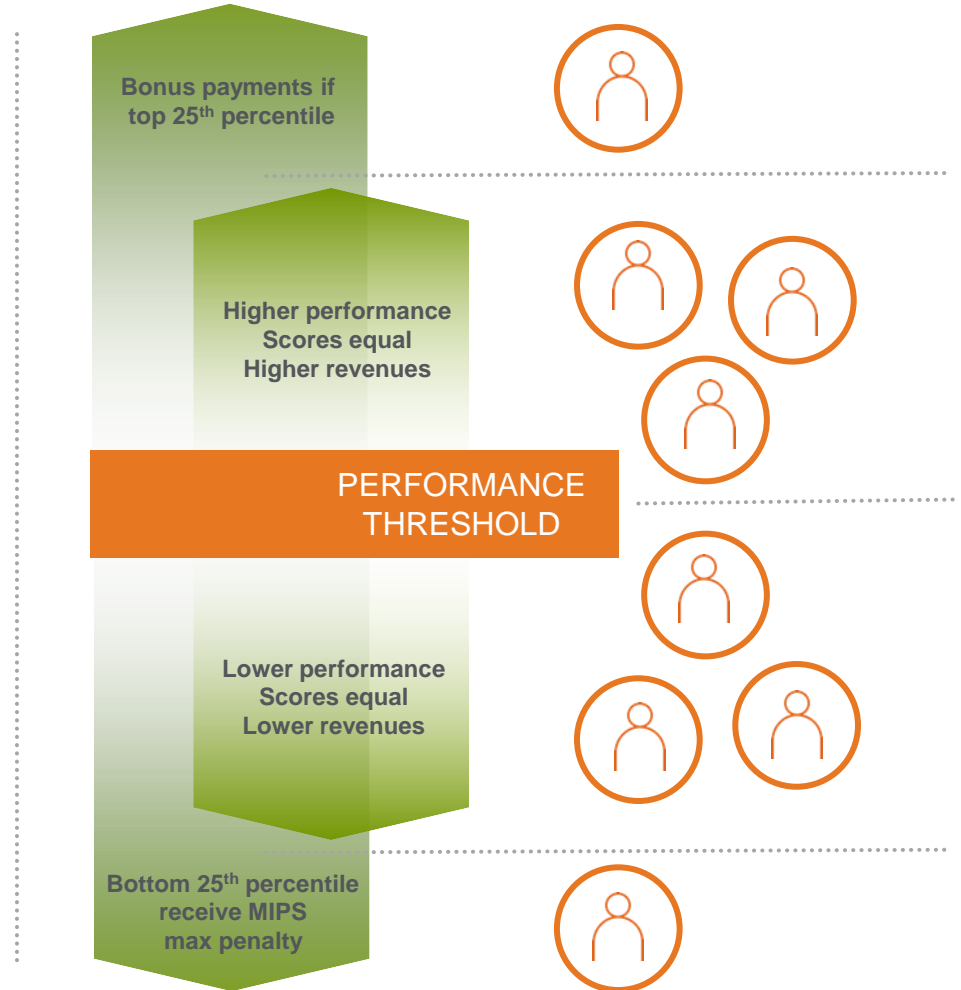
- **Quality:** Physicians must choose up to six measures or one specialty measure set, including one outcome measure
- **Improvement Activities:** Physicians must choose among 90 potential activities with focus on care coordination, beneficiary engagement, population management, and health equity.
- **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



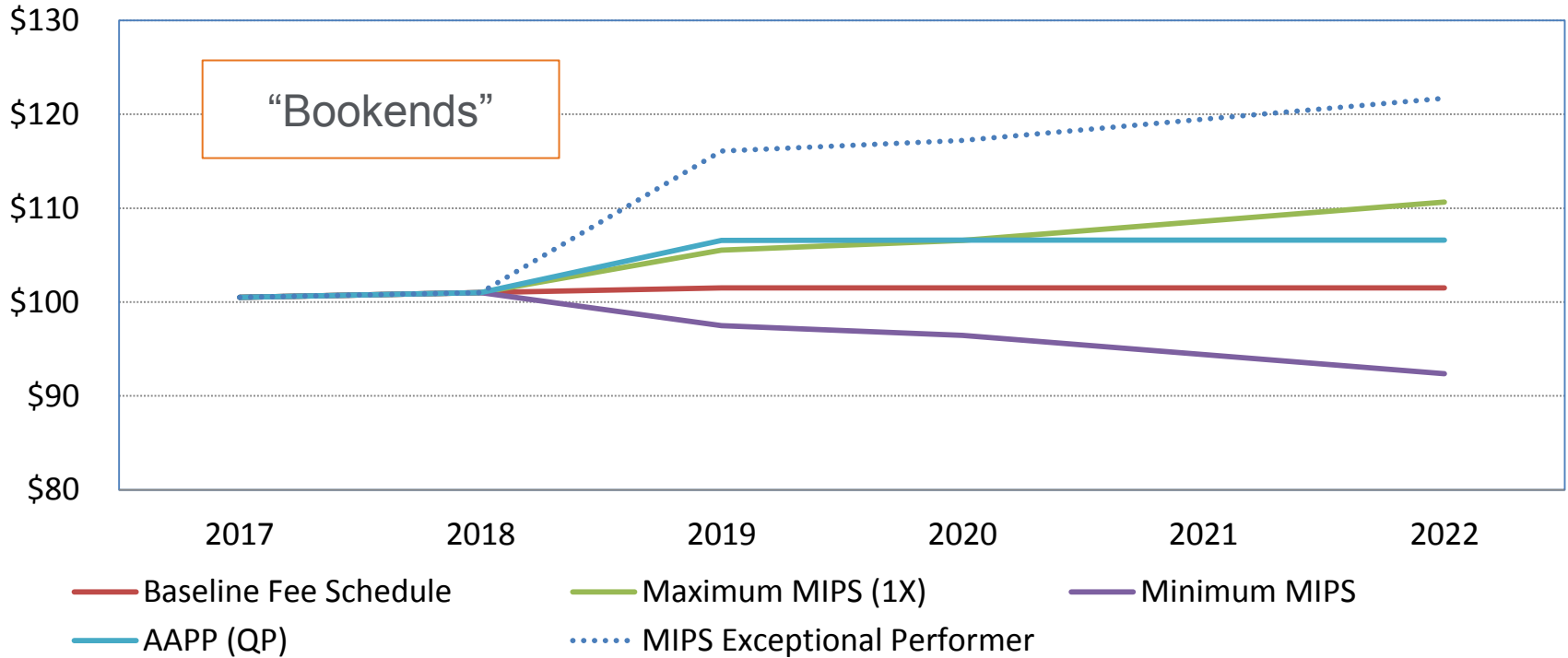
2017 Weights for MIPS APMS (MSSP & NGACO): 50% Quality, 30% ACI, 20% Improvement Activities.

MIPS relative impact to physicians revenues

- Performance Threshold is set based on the performance year's mean or median of composite performance scores
- Physicians are ranked against each other to determine MIPS payment
- Payment adjustments are scaled for budget-neutrality
- **There will be winners and losers**



Medicare FFS revenue adjustments under MACRA/QPP (fully implemented)



- Baseline Fee Schedule is frozen from 2020 to 2025.
- MIPS payment will vary based on composite performance score as compared to performance threshold and will fall between the Maximum and Minimum; Maximum could be up to 3X.
- MIPS Exceptional Performers (top 25th percentile) can receive up to an additional 10% payment.
- AAPP QP receives 5% bonus payment through 2024.

Physician participation choices (2017 - transitional year)

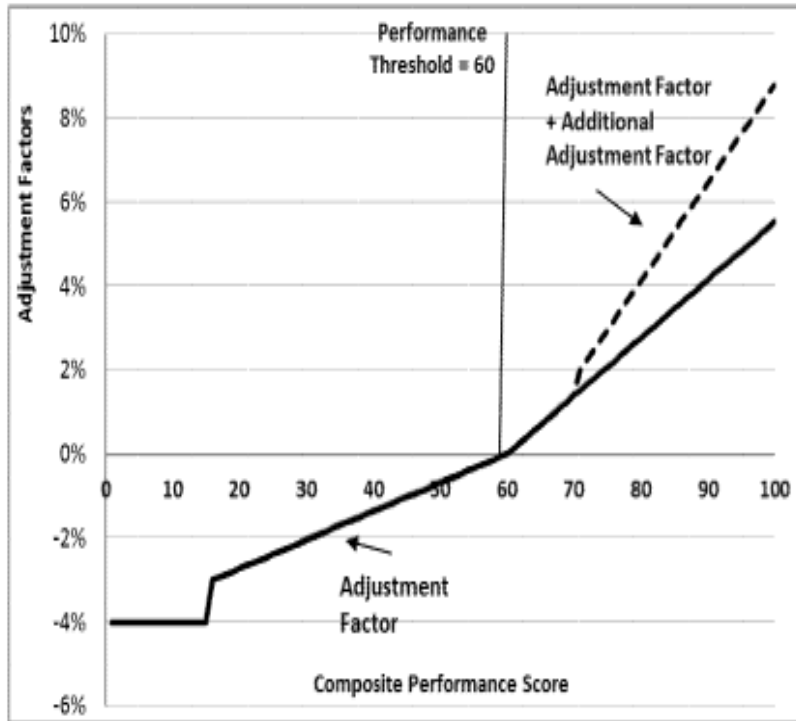
Program	Option	Description	Impact
MIPS	1. Don't participate	Does not send any 2017 data to Medicare	Receives a negative 4% payment adjustment
	2. Test the quality program	Submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity)	Avoid a negative payment adjustment
	3. Participate for part of the calendar year	Submit 90 days of 2017 data to Medicare	Earn a neutral or small positive adjustment
	4. Participate for the full calendar year	Submit data for full calendar year 2017	Earn a moderate positive payment adjustment
Advanced APM	5. Participate in an Advanced Alternative Payment Model in 2017	Participate in the Quality Payment Program by joining an Advanced Alternative Payment Model	If physician has a large enough percentage of Medicare payments/ patients, then physician will qualify for a 5 percent incentive payment

.....will 2018 be a transitional year also?

MIPS Assumptions – Transition Year(s)

Proposed Rule - 2017

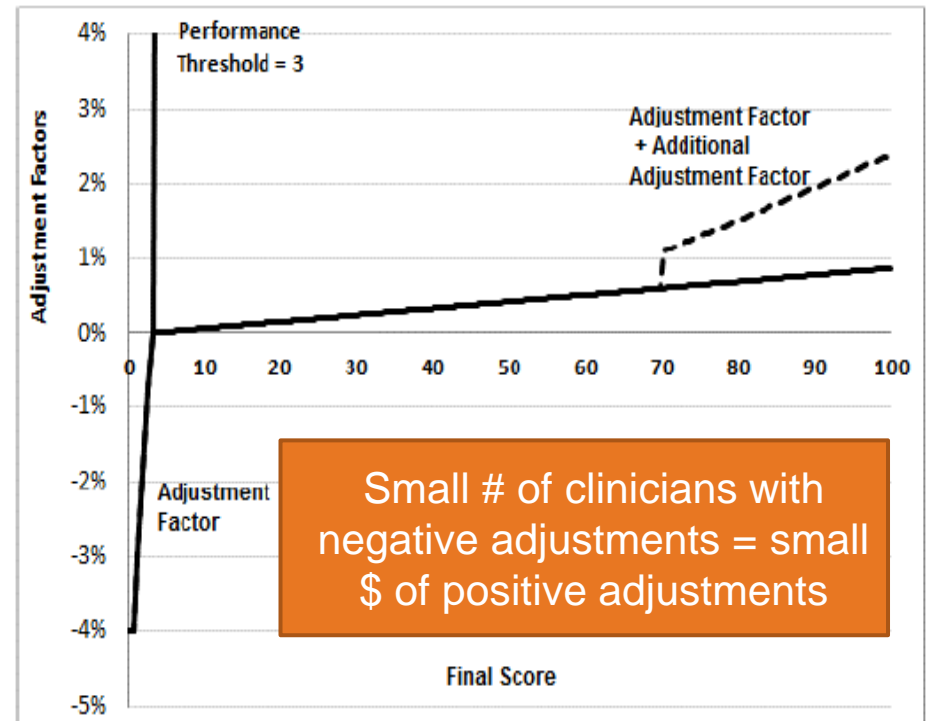
FIGURE A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)



Fully Implemented Bookends

2017 Transition Year

FIGURE A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold for the 2019 MIPS Payment Year

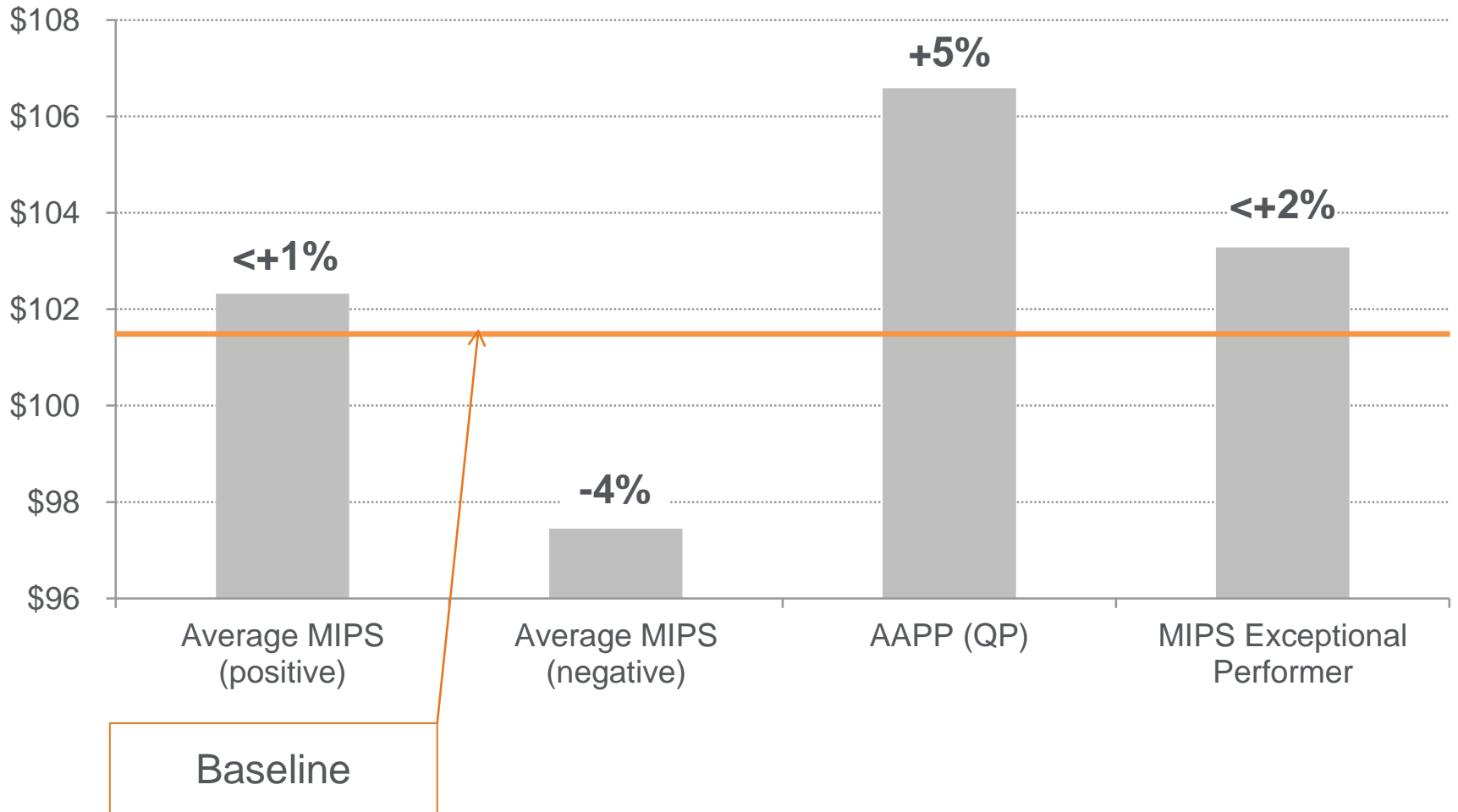


Small # of clinicians with negative adjustments = small \$ of positive adjustments

Transition Year Bookends

Graphic courtesy of the Centers for Medicare & Medicaid Services

2019 MIPS expected revenues based on 2017 transition performance yr



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 an APM and/or 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?
- Do our contract terms need to be modified to not be based on Medicare?

Physicians seeking assistance from partners

Develop ACO Model with Medicare FFS Population

- 2018 1 or 2-sided risk ACO model with Medicare population
- Develop a network model that supports a broad enough population that most physicians can participate



Create Reporting Analytic MSO

- Scale a reporting solution for physicians defaulting into MIPS
- Develop report cards and communications plans for physicians

Seek Advance APMs MSO Support

- Provide analytical and clinical infrastructure for targeted AAPMs for specific elements of physician network
- Assist in development of PCMH model with HIT and other assets

Develop/Modify Medicare Advantage Strategy

- Aggressively pursue Medicare Advantage (MA) contracts/partnerships while encouraging physicians to move patients into MA products

Assist in Metric Selection

- Provide data analytics support in determining the 'best' metrics for MIPS reporting
- Provide ongoing reporting and benchmarking support to network physicians

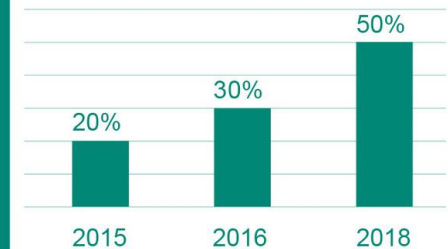
MACRA/QPP's impact

- **CMS has explicitly articulated** a value-based agenda to move the majority of fee-for-service payments to a value and quality basis -- continuing a policy direction that began in 2003 with the IQR
- **In addition** to holding physicians accountable for performance, MACRA/QPP will accelerate the development of advanced APM that will require:
 - Providers to collaborate across the continuum of care
 - Providers to bear financial risk for episodes and populations
 - Engage more proactively with patients

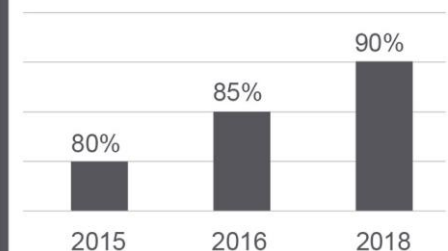
IMPLICATIONS FOR PROVIDER INDUSTRY TRANSFORMATION

- **More Medicare-specific** and other payer ACOs and APMs will emerge with two-sided risk
- **Greater collaboration and alignment** between health systems and physicians will happen
- **Health system-physician consolidation** activity will increase
- **MA plans have an opportunity** to drive greater physician engagement as physicians seek alternative arrangements

Percentage of Medicare Payments Tied to Alternative Payment Models



Percentage of Medicare Payments Tied to Quality or Value



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



Thank you

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