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Does MACRA Still Matter?

Out with the Sustainable Growth Rate, in with the MACRA – Preparation Is Still Important Under a New Administration

By now you are undoubtedly familiar with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The resulting Quality Payment Program (QPP) and its two participation pathways – Advanced Alternative Payment Models (APMs) and Merit-based Incentive Payment System (MIPS) – have been the subject of much attention. The final rule implementing the QPP was released in October 2016, signaling CMS commitment to the program in 2017 and beyond.

Given the outcome of the recent presidential election, many are wondering, does MACRA still matter? MACRA has bipartisan support, and consensus suggests that it will continue into the Trump Administration – it replaces arguably one of the most unpopular physician payment mechanisms (the sustainable growth rate or "SGR"), which required annual "Doc Fix" legislation by Congress in order to achieve equitable physician payments during much of the last ten years. In addition, it is widely recognized that the transition from fee-for-service payments to payment for quality and value is critical to the sustainability of the healthcare system.

It is, however, possible that the new administration will decide to make its mark on MACRA's regulatory roll-out by extending the timeline or modifying the options for participation. For example, it has expressed interest in eliminating or significantly shrinking the Center for Medicare and Medicaid Innovation (CMMI), which would impact many of the proposed APM models that are administered by CMMI (i.e., CPC+).. Changes to the proposed payment methodology to place a greater focus on incentives, and on meeting or exceeding those incentives, in order to reach historical fee-for-service reimbursement levels could also be forthcoming. Additionally, Part B spending impacted by MACRA could decline under the Trump Administration, as initial indications of the Administration's healthcare policy appear to favor privatization and further the existing trend of growth in Medicare Advantage (MA).

The election results have complicated the calculus for providers' planning and preparation. It is critically important for provider organizations to follow and gain an understanding of all changes impacting MACRA's implementation, starting with those found in the final rule. Organizations must also start thinking strategically to plan for success in the post-MACRA market governed by the Trump Administration, which will include performance-based payment (MIPS), alternative payment models, and MA plans.

What changed in the QPP Final Rule, effective January 1, 2017?

1. **2017 is a transition year, with four options for participation**
   CMS anticipates that 2018 will also be a transition year, with details yet to be determined during rulemaking in 2017. This phased approach represents another opportunity for the Trump Administration to influence the program's roll-out. Most of the proposed changes for this initial 2017 transition year are designed to ease the potential financial impact to providers in the first performance year. For example:
   - Provider organizations have three options to submit data to MIPS, as well as the ability to participate in Advanced APMs.
   - MIPS reporting options allow for flexibility in the reporting period (a full 90-day period is the minimum required) and flexibility in how many quality measures, improvement activities, and measures in the advancing care information performance category are reported in order to avoid a negative payment adjustment and potentially receive a positive adjustment.
   - CMS has lowered the MIPS performance threshold by 3 points for 2017, making organizations that receive a final score of 70 or greater eligible for an exceptional performance adjustment for payment in 2019.

> *CMS recognizes that most provider organizations will need to take action in order to participate. This approach encourages participation and allows for flexibility in organizational implementation, but* ***requires a focus on building the necessary capabilities to be successful in future program years.***

2. Advanced APM options available for participation have increased

Three required criteria for Advanced APMs were finalized: 1) Participants must use certified electronic health record technology (CEHRT); 2) Payment for covered professional services must be based on quality measures comparable to MIPS; 3) Participants must bear risk for more than nominal financial losses or be a Medical Home. CMS has announced that it expects to re-open applications for the Comprehensive Primary Care Plus (CPC+) model in 2017 and allow new participants in the Next Generation Accountable Care Organization (ACO Track 1+) model in 2018, which both qualify as Advanced APMs under these criteria. The following have been released for 2017 and 2018; however, CMS will continue to review qualifying models:

2017 Advanced APM Options

- Comprehensive End Stage Renal Disease (ESRD) Care Model (Large Dialysis Organization arrangement)
- Comprehensive ESRD Care Model (non-LDO arrangement)
- CPC+
- Medicare Shared Savings Program ACOs - Track 2
- Medicare Shared Savings Program ACOs - Track 3
- Next Generation ACO Model
- Oncology Care Model (two-sided risk arrangement)

2018 Additional Advanced APM Options

- ACO Track 1+
- New voluntary bundled payment model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT) track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)

*More Advanced APM participation options will translate into more qualifying participants (QPs) – CMS anticipates an additional 30,000 – 40,000 participants in 2017. Organizations will **need to assess their capabilities** across multiple dimensions – people (e.g. care coordination, referral management), process (e.g. evidence-based practices that reduce treatment variation or care process design), and technology (e.g. data acquisition, aggregation, management, and analysis) – to ensure success under the APM model. Organizations should continue to monitor how these APM models may be influenced by the new administration. Additionally, providers should begin to evaluate non-Medicare APMs, including Medicare Advantage risk contracts, to meet the nominal risk standard for the All-Payer Combination Option available starting in Performance Year 2019.*

3. 2017 MIPS scoring will exclude the cost performance category

In 2017, CMS has finalized a zero weighting for the cost performance category. MIPS payments will be based on the quality, improvement activities, and measures in the advancing care information performance categories. In the interim, CMS will continue to calculate performance on certain cost measures (including per capita cost for attributed beneficiaries) and provide feedback.

*Expect the **cost performance category to contribute to MIPS scoring in 2018** (second performance year), as weighting must increase from 0-30% as mandated by MACRA by the third MIPS payment year (2021 for performance year 2019). Providers should **begin to develop capabilities to succeed in this metric category**, especially recognizing that the change management required to adopt new practice patterns and behaviors is long-tailed.*

4. More small practices will be excluded in 2017

The volume threshold for participation was revised to $30,000 in Medicare Part B allowed charges or less than 100 Medicare patients. This exclusion is expected to impact ~32% of Medicare clinicians, but only 5% of Medicare Part B spending. Providers that fall below this threshold are not eligible for MIPS; however, in future years, such providers may join "virtual groups" and combine their MIPS reporting. Virtual groups will not be implemented in 2017, and will be further defined through future rulemaking efforts. Small practices that still qualify for MIPS (less than 15 MIPS eligible providers) will have access to education and technical resources to help maximize participation.

*Even though smaller providers are shielded in the initial year, it is expected that provider consolidation will continue, as the demands of MACRA will be challenging for many practices. Provider organizations, both large and small, should **consider how this consolidation could impact their market**.*

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How can organizations position themselves for success in the post-MACRA market?

MACRA continues to represent a compelling strategic opportunity for provider organizations to think differently about their business model and pursue sustainable growth and margin levels. However, success in the post-MACRA model will require advanced preparation and a new understanding of the concept of *patient economics*. Current patient economics looks at value as a snapshot in time, while long-term strategy must be improvement of patient economics through investments in analytics and other targeted strategies.

Moving forward, organizations should recognize that:

MACRA is significant and transformative; risk is a matter of when, not if, and providers face a critical decision point

In an environment lagging behind CMS targets for alternative payment models, expect MACRA to drive increased provider consolidation, enhanced population health infrastructure, interest in financial risk transfer, and expanded focus on long-term patient population measures. Providers must determine which track (MIPS or APM) best suits their organization and develop a roadmap to address the risks posed by each path.

MACRA serves as a catalyst and establishes principles that will drive providers to establish a Senior Markets Strategy and harmonize this strategy across payers

Since providers will be less able to rely on subsidization across payers, organizations will need to evaluate their patient portfolio across Medicare FFS, Medicare Advantage and commercial markets and strategically position themselves to minimize variation in risk contracts. There is no "one size fits all" approach to achieve portfolio balance; organizations may pursue strategies such as shifting revenue from Medicare FFS to Medicare Advantage, executing more advanced APMs with Medicare and/or non-Medicare payers, or consider merger, acquisition or partnership singularly or in combination (among many other strategic options).

Execution on strategy requires an understanding of the new patient economics both currently and in the longer term

As data becomes increasingly available, organizations need to conduct analysis that cover the entirety of a patient's cost and engagement profile – the patient-level income statement, which captures intra- and extra-organizational cash flows and weighs those payments against expense categories to achieve a total P&L view. Segmentation analyses can then be completed to determine drivers of financial performance in both the short-term and throughout the patient's lifetime value. Organizational business models must evolve in order to deploy tactics that target patient segments qualifying as financially sustainable under this comprehensive view of patient economics.

Providers must begin to shift their focus from education and understanding of MACRA to strategic implications and strategy development

Read more, including recommendations and next steps, in our comprehensive Executive Briefing – *MACRAnomics: Patient-Level Economics and Strategic Implications for Providers.*

http://www.healthscape.com/sites/default/files/uploads/documents/HealthScape_MACRAnomics.pdf

Think strategically about MACRA – HealthScape can help

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