HealthScape Advisors

EXECUTIVE BRIEFING

MACRAnomics:

Patient-Level Economics and Strategic Implications for Providers

Introduction

By now you're probably familiar with the mechanics of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Thus far, there has been good discussion of the program's mechanics and regulatory impacts. In this paper, we go beyond these initial considerations and focus on the opportunity to use MACRA to think differently about business models, pursue sustainable growth, and expand margin levels. Even with implementation considerations, MACRA will likely shift physician reimbursement to alternative payment models, but only with careful strategic planning.

In this white paper, we help you look at MACRA through an alternative, strategic, long-term lens. By seeing MACRA as transformative, catalytic, and replete with opportunity to fully understand new patient economics, you can adopt new capabilities and transform your organization to succeed in this new business environment.

Setting the Stage

To date, much of the publication and analysis on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has been focused on summarizing the mechanics of the Quality Payment Program (QPP), inclusive of the merit-based incentive payment system (MIPS) and alternative payment model (APM) tracks.

The focus of this paper is not to summarize the regulation, but rather to acknowledge the compelling strategic opportunities for provider organizations that want to think differently about their business model and pursue sustainable growth and margin levels. Regardless of any potential delay in implementation, MACRA is the chosen model to shift physician reimbursement away from fee-for-service, and significant advanced preparation will be required to succeed under this new model.

As MACRA and related APMs drive the industry toward higher degrees of accountability, and solidify the linkages between integrated provider organizations and their enrolled or attributed patient populations, the concept of ***patient economics*** takes on new significance as a critical cornerstone of developing long-term strategies.

> ***Patient economics is not "cherry picking" the healthiest patient populations to manage risk.***

In contrast, once risk adjustment is considered, chronically ill, co-morbid populations can drive value when properly engaged. This value improves the longer patients are retained and their chronic care needs are effectively managed.

While current patient economics looks at value as a snapshot, the long-term strategy is to improve patient economics through investments in analytics, sophisticated consumer relationship management, sales and marketing strategies, network development, and wellness and care coordination initiatives. Organizations also should not overlook the organizational commitment to the change management needed to drive physician behavior to new care paradigms. Inherent in this strategy is effective stratification of patient populations based on current and future risk management capabilities of your organization, as well as patients' engagement propensities and preferences.

> ***In financial terms, patient lifetime value is the present value of net cash flows or margin that a patient brings to the provider over his or her lifetime.***
>
> *It is the balance sheet of patient-generated assets and liabilities that accrues over months and years, largely influenced by the management of their overall health status. The snapshot of these cash flows in any given 12-month period is analogous to the income statement.*

Managing patients throughout their stages of life and health status will optimize their lifetime value.

Health plans have traditionally owned the premium dollar and total financial risk over longitudinal periods of time and are familiar with this equation of patient lifetime value.

However, the historical, dominant, employer-centric model, combined with health plans' distance from actual patient care delivery, has limited health plans' ability to improve health members' health status. It has also prohibited health plans from optimizing their value proposition to the end consumers of healthcare in this country.

MACRA and the overall industry shift toward APMs creates the opportunity for provider organizations to succeed where these structural barriers have limited health plans' levels of success in long-term patient retention and management.

Moving forward, organizations should recognize that:

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

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

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

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

The QPP under MACRA is notable for a number of reasons:

Broad Range of Providers Impacted

Aggressive Timeline Implementation

Financial Alignment Development

Linkages to Other Non-Medicare Programs

MACRA will likely serve as the tipping point for some provider organizations to migrate a meaningful portion of their payment from fee-for-service to APMs, similar to how the HITECH Act of 2009 drove a significant shift in the adoption of Electronic Health Records (EHRs).[1]

> ***In 2014, 76% of acute care hospitals had adopted at least a basic EHR system, which represents a 27% increase from the previous year and a more than eightfold increase in EHR adoption since 2008.***

[1] *Charles D., Gabriel, M., Searcy, T., "Adoption of Electronic Health Record Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2014," The Office of the National Coordinator for Health Information Technology, April 2015.*

Today, the majority of hospital systems are dependent on fee-for-service revenue. While a limited number of healthcare systems have advanced along the adoption curve, the vast majority of systems are firmly rooted in fee-for-service. The industry payer mix is significantly lagging from CMS targets for APMs, and MACRA will likely drive the closure of this gap for value-based in both Medicare populations, as well as the under-65 commercial populations. In our experience, APMs are challenged by a consistent set of structural "gaps" that limit the carrier-provider partnership's ability to generate value for both parties.

Only 13 out of 80 hospital systems derive 10% or more of their net patient revenue from risk-based contracts.

surveyed by Modern Healthcare

MACRA will likely drive change in the following areas:

Provider Consolidation

As MACRA allows providers the option to report individually or as a group, expect to see providers form virtual (non-consolidated) reporting groups, which may include Clinically Integrated Networks (CIN) and Accountable Care Organization (ACO) entities. We will likely also see a consolidation of reporting groups by increased hiring of physicians by health systems, and more merger activity, as smaller, independent practices may have difficulty addressing the performance risks posed by the regulation.

Population Health Infrastructure

To address MACRA's performance standards, providers will try to close gaps in care coordination and wellness, risk adjustment/management, technology/ analytics, clinical workflow change management, value versus volume-based physician compensation, and enhanced network capabilities to address care continuum gaps (e.g., behavioral health, post-acute, etc.).

Financial Risk Transfer

Expect growing interest in advanced APM models that include downside financial risk and meet the nominal risk standard.

Long-Term Patient Population Measures

Expect metrics to shift from historical focus on process measures to expanded focus on population outcome measures in line with MACRA's requirements. There will be more longitudinal reporting of health outcomes as providers demonstrate their ability to make an impact over time. This shift will drive strategic and operational changes to effectively improve these measures year after year for the providers' population.

Providers must decide if and when they are ready to exceed the nominal financial risk threshold through qualifying APMs on their Medicare and non-Medicare payments, or if they will compete against their peers in the year-over-year footrace under MIPS.

Regardless of whether the MIPS or APM track is selected, all provider organizations will need to develop a road map to take on the risks posed by each path. ***Our experience in helping organizations assess their starting capabilities to succeed under APMs looks at the following dimensions:***

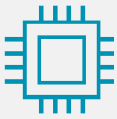
Alternate Payment Model Operations Road Map

People

- Linking physician compensation to performance
- Reducing network leakage
- Developing preferred relationships with efficient specialists
- Engaging patients in their care plans
- Peer-to-peer comparison/score carding
- Physician leadership

Process

- Reducing treatment variation through adoption of evidence-based practices
- Care process redesign
- Prescription drug management
- Reducing unnecessary hospital admissions/re-admissions
- Managing post-acute care



Technology

- Data acquisition and connectivity
- Data aggregation and management
- Predictive modeling
- Analytics to generate meaningful, action-oriented insights
- Improved user interface
- Delivery of insights at the point of care
- Electronic consultations & telemedicine

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

Success in this new risk environment will require that providers take a broad perspective to APMs and not craft their response to MACRA in isolation. It is an opportune moment for provider organizations to evaluate their risk contract portfolio and create a long-term road map of these relationships to minimize variance between contracts.

The optimal view of how to succeed under MACRA must be informed through an evaluation of a provider's patient portfolio across Medicare Fee-for-Service (FFS) and Medicare Advantage and commercial markets. This broad view is important as providers will be increasingly unable to rely on cross-subsidization across its payer mix. Strategically positioning your organization to minimize variation in risk contracts will allow you to build focus and discipline in your population health infrastructure investments.

Advantages to this portfolio view and to minimizing variance between risk contracts:

Clinician Engagement Challenges

By creating an aligned approach across numerous payers, provider organizations will be more likely to achieve the "tipping point" in any one clinician's panel to drive the behavior change needed for success in APMs.

Financial Challenge

APMs require significant investment but can be successful with careful planning and two willing partners. Historically, many providers have struggled to link investment decisions made for APMs to payment impact. However, an aligned approach can help create a greater financial impact across an aggregation of programs, creating a more specific linkage to investments made, and making it easier to quantify Return on Investment (ROI).

Clinical Workflow Consistency

Consistency in APMs will drive more consistent clinical workflow design and execution across the entire patient population.

Administrative Complexity

Managing multiple risk arrangements is fraught with administrative challenges, including information technology/system issues, claims and payment adjudication issues, "measure confusion" due to multiple measures and metrics being used for different programs, and different attribution models. A portfolio approach can help to create standardization and minimize some of these administrative challenges.

As patients become more strongly aligned with provider organizations under MACRA and associated APMs, there will be an opportunity to harmonize their risk contract portfolio. Local competitive positioning, baseline payer mix, and sophistication of working with APMs will inform the correct strategy.

> ***It is important to note that there is no "one size fits all" approach to this portfolio balance.***

There are several sample strategy elements that an organization might pursue:

Strategy A

Shift revenue from Medicare FFS to Medicare Advantage

to avoid potential losses under MIPS and to shift to an enrolled patient base versus the inferior attribution model to more effectively improve quality, resource utilization, and financial performance.

Example

New West Physicians in Colorado stopped accepting traditional Medicare but continued to accept Medicare Advantage, which now accounts for 30% of patient visits and 55% of practice revenue. The shift to Medicare Advantage has resulted in lower administrative burden, higher reimbursement, and improved patient care and quality outcomes. One member of the medical group cited that his salary has increased by 15% since the practice converted to Medicare Advantage, while patient volumes dropped.[2]

Strategy B

Execute more advanced APMs with Medicare

to secure the 5% bonus and higher fee schedule updates, and avoid potential losses under MIPS' competitive footrace.

Example

Starting July 1st, nearly 200 medical groups and 17 insurers will begin participation in the initial round of the CMS Oncology Care Model (OCM), which requires participants to accept financial and performance accountability for six-month episodes of care. As one of the first CMS physician-led specialty care models, the program allows participating oncologists to count a large portion of their Medicare revenue under a qualifying APM program.[3]

[2] *Laff, M., "Colorado Primary Care Practice Succeeds With Medicare Advantage," American Academic of Family Physicians (AAFP) News, July 12, 2016.*
[3] *Center for Medicare & Medicaid Innovation; Oncology Care Model.*

The strategic options outlined here are not exhaustive, nor mutually exclusive.

Provider organizations' interest in these strategies will differ based on their attributes and will likely evolve over time. Providers need to critically assess the disease states, or centers of excellence, where they can compete in their market, and determine whether these strategies will advantage or disadvantage them with respect to APMs.

Successful portfolio balance will require a new way to look at existing capabilities, strategic options, and local market share opportunities.

Strategy C

Execute more advanced APMs with non-Medicare payers

to participate in savings opportunity, align commercial strategies, and secure the 5% bonus and higher fee schedule updates and avoid potential losses under MIPS.

Example

Texas Health Resources (THR) in the Dallas area recently launched a joint venture health plan with Aetna. Based on the high degree of vertical integration, the system is likely to roll out a number of commercial products that will eventually qualify as advanced APMs under the All-Payer Combination Option.

Strategy D

Pursue "MAP" (merger, acquisition, or partnership) strategies

which may include joining CINs or ACOs as virtual reporting groups for MACRA, or piggybacking on a partner's population health infrastructure, existing portfolio of advanced APM contracts, or superior patient population profile.

Example

Princeton HealthCare System announced a letter of intent to pursue a partnership with the University of Pennsylvania Health System. As part of the rationale for the partnership, information technology was cited as a key factor in the decision. Princeton HealthCare System wanted to install an integrated electronic medical record to support its population health agenda and Penn Medicine had the infrastructure to accelerate the process.[4]

[4] *Knapp, K., "Princeton HealthCare to Partner with University of Pennsylvania Health System," Planet Princeton, July 13, 2016.*

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

Pursuing this portfolio evaluation and the determination of the optimal approach and mix of APMs across commercial and government programs requires provider organizations to take new approaches to understanding their patient population.

> ***An intricate understanding of patient economics is needed to identify targeted consumer segments and determine which patients will derive the most benefit across the portfolio of available APMs.***
>
> *It will also support superior patient segmentation based on risk and engagement propensity.*

As MACRA spurs more APM activity, it is anticipated that provider organizations will receive greater access to government and commercial claims data to help analyze the organizational experience and conduct these patient economics analyses for the whole of a patient's cost and engagement profile.

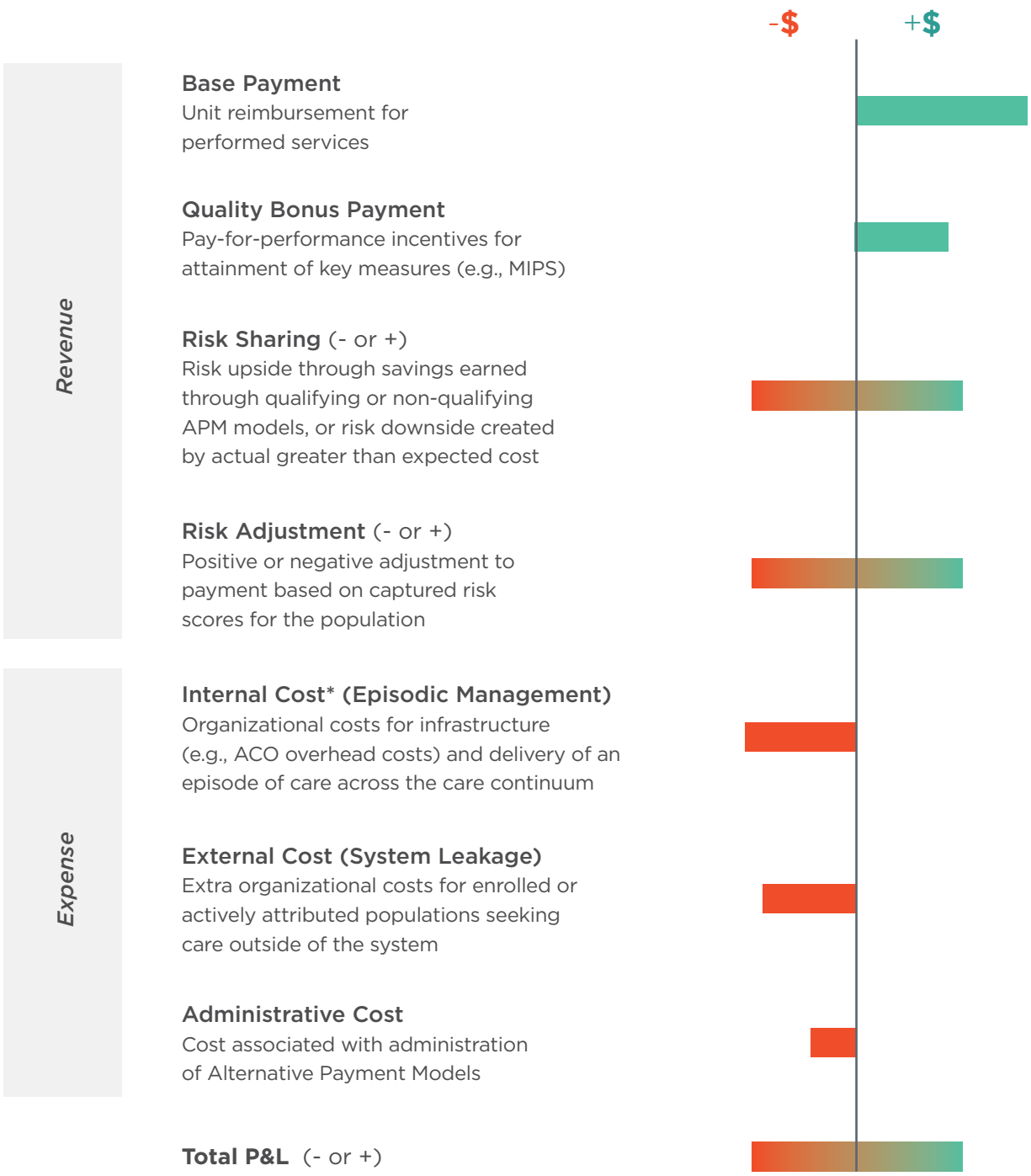
The first step is to put together a patient-level income statement to understand the net cash flows over the course of an annual period.

The patient-level income statement approach is very different from traditional methods used by provider organizations to understand profitability.

In fact, traditional accrual-based hospital and physician accounting will no longer be a reliable indicator of future financial performance. Rather, the emphasis will shift to risk-based accrual with deeper and wider tracking of key performance indicators.

Most provider organizations are accustomed to viewing their financials by transactional profitability (contribution margin, net income) and rolling up the results of transactions into an organizational income statement. The patient-level income statement captures intra- (within the health system) and extra-organizational (outside the health system) cash flows and weighs those payments against expense categories to get to a total Profit & Loss (P&L) view for the patient. Sub-segmenting this P&L view by characteristics that relate to carrier, patient, condition, and provider will allow for further targeting of patient groups.

Patient-Level Income Statement

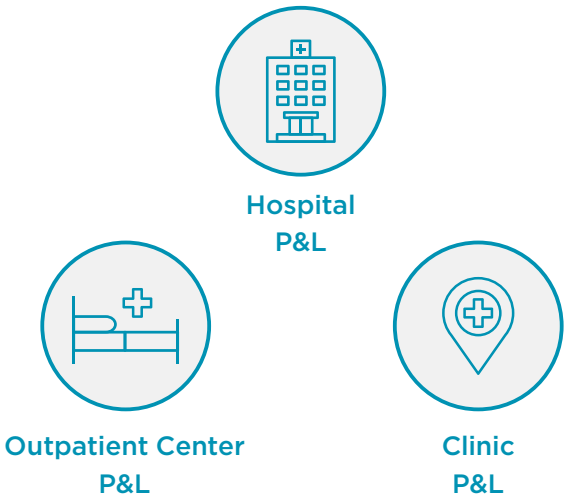


**Internal cost accounting should take into account fixed and variable episodic costs; however, many organizations have insufficient processes to properly account for these categories at the patient level. Further efforts to improve cost accounting systems in provider organizations will lead to greater accuracy of patient P&L.*

Once provider organizations have developed their P&L view of the patient, additional segmentation criteria can be applied to determine drivers of financial performance.

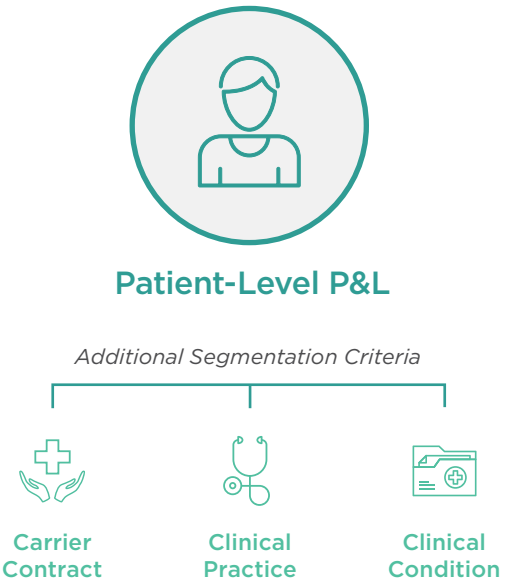
Traditional

Site-of-Care Transactional View



New

New Patient Economics



Total Cost Missing
Cost of care outside of the system

Total Revenue Missing
Risk Adjustment, Risk Sharing

View across all providers
Inside and outside the health system

Accounts for all forms of Revenue and Cost

The issues impacting performance in any given segment can be multi-factorial and involve specific attributes of carrier, patient, condition, or provider. For instance, the P&L segmentation analysis might show that a segment is over- or under-performing related to issues around contract pricing, medical cost management, risk adjustment coding, or quality results. These insights can drive strategic decisions around APM participation or new tactics to increase levels of patient engagement.

Strategic Questions

This view of patient economics can help providers determine the optimal portfolio strategy by addressing the following questions:

What are the characteristics of patients (e.g., demographic, diagnostic, etc.) that will drive profitability?

How do I change the patient engagement and health management model to improve margins?

Based on these characteristics, how can we engage these patient cohorts meaningfully in a productive APM?

What are competitors offering in the market? Would these offerings be attractive to the patients we are trying to engage? How can we create differentiation for our clinical offerings?

What is the current efficacy of our existing condition management capabilities?

A critical component of the approach outlined previously is the calculation of not only short-term patient economics but also the adoption of a long-term lens when conducting segmentation analyses in order to consider a patient's lifetime value (i.e., the balance sheet perspective).

> *In turn, provider organizations need to move away from transactional, episode-based models to longitudinal, consumer relationship management models of care delivery.*

Provider and patient relationships are becoming less transient; enrollment and active attribution models, accountable care metrics, and plan design are coming together to solidify the opportunity to forge long-term relationships.

Patient lifetime value approaches require tactics that bend the cost and quality curve over months and years, not individual episodes. It requires patient retention over a long period of time, even as they move from commercial to Medicare benefit designs. Those tactics are best deployed against patient segments that have been qualified as financially sustainable under a comprehensive view of patient economics.

Emerging organizational business models that blend payer-provider capabilities will be best positioned to deliver on patient lifetime value strategies. The focus of the current and future state organizational models will be different, as illustrated by:

Current vs. Future State Business Models

Patient Satisfaction	*Consumer Engagement*
Care Delivery	*Care Coordination & Delivery Efficiency*
Access & Discharge	*Acquisition & Retention*
Facility Infrastructure	*Analytics Infrastructure*
Independent Operating Model	*Integrated Operating Model*

These domains contain specific competencies and organizational skills that can be assessed and evaluated along a spectrum of performance required to meet organizational goals.

After an assessment has been completed, provider organizations will need to determine their strategy around build, buy, or partner to develop competency. Provider organizations have made very expensive decisions to try and build a capability that they were better off buying from a third party. It is critical to apply rigor to questions of business process outsourcing and internal capabilities development to avoid costly errors in moving toward converged business models.

Patient lifetime value strategies will fail if populations "leak" from provider networks. MACRA will result in greater amounts of delegated risk, which in turn will prompt providers to proactively work with their patients to keep them in tighter, more closely managed care networks. This goal can be accomplished through care coordination and navigation as part of a patient-centered medical home, or it can be achieved through greater penetration of Medicare Advantage, which has the advantages of patient enrollment, PCP assignment, and more managed networks/systems of care.

Recommendations & Next Steps

MACRA signals that providers are going to be increasingly linked with enrolled patient populations and measured on their production of value over annual and multi-year periods. With performance years quickly approaching, providers must now shift their focus from education and understanding of the MACRA regulation to strategic implications and strategy development.

1

RECOMMENDATION

Patient lifetime value is an important strategic frame of reference, and it is very different than the traditional frame of episodic management. It is highly impactful to put together a patient-level P&L and balance sheet.

Next Steps

Build Capabilities
to analyze claims and clinical data to create a full view of revenue and expenses that includes intra- and extra-system experience.

Ensure Revenue Integrity
by accounting for actively pursuing risk coding opportunities that relate to suspected or previously documented conditions.

Identify the Main Drivers
behind revenue and expense categories, and size the potential for improvement or degradation over time.

Ensure Accuracy
of the expense portion of the P&L by accounting for fixed cost allocations resulting from accountable care infrastructure investments, variable cost allocations due to clinical episode-of-care costs across the care continuum, and the capture of extra-system costs stemming from system leakage.

Forecast the Trend
in the P&L to provide a cumulative balance sheet view of the patient in order to understand the stakes for longitudinally delivered patient lifetime value.

2

RECOMMENDATION

Adopt a portfolio view to risk relationships and craft a road map to risk that recognizes the needed capabilities to deliver on patient lifetime value.

Next Steps

Inventory Current Payer Contracts
to determine the baseline levels of financial risk.

Characterize Variation
in payer contracts and assess consistency with the principles and standards contained within MACRA.

Model Potential Growth
in financial risk and enrolled populations under several scenarios and arrive at a consensus expectation for the future rate of payment evolution.

Pursue Opportunities
to renegotiate risk contracts, execute new risk contracts, and participate in APM models that are best aligned with growth targets.

Recommendations & Next Steps *(continued)*

3

RECOMMENDATION

Invest in building or outsourcing the capabilities to bend the cost and utilization curve over longitudinal periods.

Next Steps

Assess existing people, process, and technology competencies and address gaps in current performance.

Identify opportunities to link physician compensation to performance.

Leverage analytics to generate meaningful, action-oriented insights.

Engage in care process redesign and develop preferred relationships with efficient network partners among other tactics.

Construct the Business Case

to invest in capabilities to deliver on value-based care that reflects a holistic financial accounting of patient lifetime value, sophisticated and targeted consumer engagement strategies, and a comprehensively defined organizational road map to risk.

Evaluate Consumer Retention Activities

for populations that are enrolled in your network, such as enhanced investment in sales and marketing tactics (e.g., targeted advertising, private exchanges, financial navigators, branded managed care products) and affiliation strategies (e.g., optimized broker networks, wellness partnerships, joint ventured or wholly owned managed care companies).

Cultivate Consumer Loyalty and Engagement

by analyzing product pricing and placement in the market and differentiated clinical service offerings to determine the relative attractiveness to various population segments.

CEO'S PERSPECTIVE

A Note From Senior Advisor Jack Friedman

With the advent of MACRA, there is no better time to lean toward a true population health business model. Provider systems have been complaining for years about the trailing reimbursement in traditional Medicare, and CMS has made it clear they have no intention of improving that schedule. It is clear that margins in publicly financed healthcare will come from accepting a global population health budget and managing total cost of care below those budgets with added focus on population health and service delivery. This is the best time ever for integrated systems to embrace Triple Aim methods, measures, and tactics.

To do this well, hospital systems will need to find their best and brightest in primary care and educate them fully in population health economics, actuarial science, and care management. Primary care has the chance to reinvent itself much like it did in the late 1980s with the emergence of capitation and prepaid healthcare. The difference now is that there is much better information with which to make better care decisions, and information can flow more quickly with integrated medical records. Case-mix is also better understood and health systems should be looking for long-term partnerships with medical groups and health plans that provide much of the infrastructure to succeed in these new payment models.

The most effective systems will embrace these opportunities and will seek to capture the value they create in better managing attributed populations. For years, traditional health insurers have tried to accomplish this with limited success. MACRA makes it clear that CMS seeks to lodge this competency with the provider community, and providers will have more influence in refining these models over time. That will require leadership that understands this is a journey, one that has the potential to rightsize national health expenditures by capturing the rewards when waste is eliminated. **Understanding the mechanics in this document is a critical first step in the journey.**

Jack is a HealthScape Senior Advisor and most recently served as Chief Executive Officer of Providence Health Plan and Senior Vice President of accountable care services and payer relations for Providence Health & Services, the third largest not-for-profit health system in the United States. In his role, Jack was responsible for the strategic direction of accountable care delivery and financing models to improve quality, cost, and access throughout Providence Health & Services' five-state region. Jack led strategy and operations of Providence Health Plan, serving 500,000 people.

ABOUT HEALTHSCAPE ADVISORS

Where insight meets execution

We bring healthcare executives market-leading insights and actionable strategies that create sustainable value.

Why HealthScape

We are experts in healthcare.

We are committed to one industry, demonstrated by our award-winning data analytics platform and network of industry relationships.

We are innovating for tomorrow.

While we help our clients navigate today's dynamic climate, it's our focus on the future that sets us apart.

We are invested in people.

We are smart, resourceful, data-driven professionals, not just a brand. We create an environment of excellence and relationships based on follow-through and trust.

We execute solutions.

While we provide market-driven strategies and superior problem solving, it's our ability to help our clients execute solutions that moves business forward.

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