MACRA: A 3-PART SERIES
We expect to see ongoing shifts with the Medicare Access and CHIP Reauthorization Act’s Quality Payment Program as feedback is received from stakeholders regarding implications. Regardless of these shifts, MACRA continues to drive changes in how care is delivered, improve patient health and increase care efficiency over time. QPP policy changes and newly proposed adjustments continue to restructure how eligible clinicians are paid under Medicare. These changes can pose both threats and opportunities to future payer and provider revenue.

With the first reporting year of the QPP already underway, crafting a MACRA strategy can’t be avoided. Although the QPP’s Merit-based Incentive Payment System allows eligible physicians to opt out of reporting, they will take a 4 percent hit on 2019 Medicare reimbursements if they do so, and perhaps more importantly, be at a disadvantage by not evaluating, planning and testing their MACRA strategy for future years. Hospitals and payers are not exempt from MACRA either — to be successful under the law, hospitals and payers need to stay ahead of changes and lay the groundwork as early as possible, according to experts from Optum.

“MACRA is a zero-sum game. There will be winners and there will be losers,” Jim Dolstad, Optum’s senior director of actuarial consulting, said in an interview with Becker’s Hospital Review.

This article is the first in a 3-part series looking at the short- and long-term impact of MACRA from the perspective of physicians, hospitals and payers. Part one discusses how MACRA can impact long-term financial success and how each of the major industry stakeholders — physicians, hospitals and payers — can position themselves to thrive with their patients in the future.

Financial implications of MACRA strategy

The best long-term financial strategy for providers looking to succeed, based on MACRA’s intent and policies, is to work toward qualifying for the Advanced Alternative Payment Model track, according to Erik Johnson, vice president of Optum’s value-based care practice. Advanced APMs, which offer physicians the potential to earn a 5 percent bonus on top of shared savings, provide a more stable path than MIPS and greater opportunity for financial rewards.

“MIPS is inherently unstable. It already has physician groups nervous,” he says. “Our recommendation is to move into the Advanced APM world, but that takes time. Quality is hard. Advanced APMs are hard. Otherwise everybody would already be doing it.”

The current reality is most physician practices...
do not qualify as advanced APMs and are subject to MIPS reporting requirements for the 2017 performance year. Even if MIPS is only a temporary challenge, it’s a significant one. Positive payments awarded to physicians with stronger performance are funded by payment reductions other physicians incur, meaning it’s all relative – the program is designed to be budget-neutral, ranking physicians on a curve. This poses both an opportunity and a threat to physician Medicare revenue, depending largely on three factors, according to Mr. Johnson – the measures physicians choose to report on, how well they perform on those measures and how well their peers perform in comparison.

Implementation of the QPP will not only impact physicians, but also the hospitals and health systems with whom they partner. Hospitals that employ physicians directly may bear the cost of ongoing compliance requirements and additional physician performance reporting, as well as be at risk for payment adjustments. Moreover, hospitals’ inpatient revenue may be in danger as MACRA encourages physicians to lower the costs of care. In fact, Jay Hazelrigs, vice president of Optum’s provider risk advisory consulting practice, urges hospitals to think about MIPS as a large, informal ACO.

To succeed in the program, physicians will be increasingly pushed to manage not only the quality of care, but also the cost of care through one of the track’s four performance categories – resource use. In the first performance year, resource use will not be a factor in MIPS composite scores, but its weight is expected to increase to 10 percent in the 2018 performance year and then up to 30 percent in the 2019 performance year. Increasingly, physicians will be looking to eliminate inefficiencies and excess costs throughout the care continuum in ways that could reduce the use of hospital care, such as avoiding hospital admissions and readmissions and moving patients to lower-cost settings, thereby putting hospital revenue at risk, according to Mr. Hazelrigs.

**Levers for success**

MACRA has financial implications for healthcare stakeholders across the board. Despite the many challenges of participating in MIPS or an AAPM, physicians, hospitals and even payers can come out on top in a MACRA world with careful planning and strategy. Here are four tactics healthcare stakeholders can use to position themselves for success.

1. **Evaluate past performance metrics.** Physicians should start by taking an honest look at past Quality and Resource Use Reports to gain a better understanding of where they excelled previously in the Physician Quality Reporting System and the Value Modifier Program, which should be fairly similar to MIPS quality and resource use measures, and to identify how much more administrative work they need to take on to comply with requirements. This historical look – plus a little game theory – can help guide physicians to select the best measures for their practice.

   “Picking easier measures has an intuitive attraction. But if it’s easy to aggregate data and fairly easy [to perform well], a lot of folks will end up choosing them, and it will be hard to score well because the bar will be set so high,” says Mr. Johnson.

Health plans should assess STARs and other quality program market place trends to consider regional impacts and adjustments. Where volume is exceeding value, plans should be prepared to address potential decreases in Medicare Advantage county benchmark rates. These may also be regions where providers are more likely to consider shifting costs to commercial contracts or to
Medicare Advantage from Medicare fee-for-service.

2. Consider market peers. Mr. Dolstad also cautions both payers and providers to consider how geography can impact success in either track of the program because quality and cost vary regionally. The biggest blind spot in MIPS, especially in the early years of the program, is gauging how well other practices are doing. And in the Advanced APM track, regional variance in spending drives how CMS sets expenditure baselines for ACO models, Mr. Johnson adds. “You need to look at marketwide dynamics in addition to your own performance,” he says.

3. Increased hospital consolidation and employment. As physicians go through the MACRA impacts and planning process, they will be looking to hospitals and health systems for a leg up. Larger provider entities tend to have more data and more practice with that data, which is attractive to smaller physician groups with less reporting experience. “[Hospitals] are increasingly being put on the spot by employed and affiliated physicians asking, ‘What can you do to help me here? Can you get me out of MIPS to bundles or a risk-bearing ACO model?’”

While this puts the onus on hospitals to provide resources for physicians, it also puts them in the driver’s seat for consolidation. “Health systems can help quantify some of the opportunity and risk physicians might face, which is why there is going to be some implicit pressure for greater M&A activity in these markets,” Mr. Johnson says.

Hospitals also control a significant portion of the healthcare dollar through acute and post-acute care, which will play a large role in success under value-based care programs. “Hospitals have the ability to help aggregate physicians, provide that capital and that risk shelter area to help physicians move along and be able to manage populations and manage risk, which is required under both the MIPS and Advanced APM tracks,” Mr. Hazelrigs says.

4. Plan for MACRA’s affect on commercial business. Physicians trying to avoid MIPS reporting may also try to refocus their patient base in Medicare Advantage — a trend payers need to be aware of and prepared for, Mr. Dolstad says. However, beyond the initial shift to Medicare Advantage, payers should tune in and consider how MACRA will shape future commercial business. “As we think about Medicare and what it’s done historically – DRGs and risk adjustment – ultimately all of those concepts made their way into commercial plans and Medicaid,” Mr. Dolstad says. “As a result of that, we think it’s likely MACRA has the potential to have that same cascading impact into commercial business.”

In particular, Mr. Dolstad believes MACRA, “There is that natural friction right now. This could bring the wheels to a halt, or be the lubricant that streamlines everything,” he says.

Conclusion

MACRA and QPP will continue to shift and evolve as feedback is received, but regardless of the current policy or pace of change, MACRA’s objectives remain clear and consistent. And while there is no one surefire way to win or lose under MACRA, Optum’s experts advise payers and providers to simply understand the impacts and stay ahead of the changes. “Understand where you are today based on data driven analyses, not assumptions. Understand what your options are and the resulting implications of changes, including partnering with other physicians, health systems or gaining alignment between providers and payers to understand how you can be successful,” Mr. Hazelrigs says.
In June, CMS released the 2018 proposed rule for the Medicare Access and CHIP Reauthorization Act’s Quality Payment Program, which presents a handful of key modifications to the physician payment program. These modifications – which slow implementation and ease requirements, in some cases relieving physicians from participation entirely – could be interpreted as a change of course by CMS, or as inconsistent with the original intention to accelerate the shift to value-based care.

These inconsistencies may leave some physicians, particularly those required to report for the Merit-based Incentive Payment System, feeling hesitant to funnel more time and money into preparation efforts that could be rendered unnecessary. For example, if the proposed rule is finalized, more physician practices would be exempt from reporting – it raises the MIPS low-volume threshold of annual Medicare charges to $90,000 and beneficiaries treated per year to 200. And even those who are still required by volume to participate will not be held accountable for cost for another year – the proposed rule would delay weighting the resource use measure in the MIPS composite scores until 2019, when it would jump up from 0 to 30 percent. Under the proposed rule, the advanced Alternative Payment Model track would also pull more physicians out of MIPS by extending the nominal revenue-based standard of 8 percent to the 2020 performance year, effectively allowing more APMs, and thus providers, to qualify as advanced APMs.

Despite these changes, experts from Optum believe physicians should stay the course. MACRA is still coming down the pipeline, albeit at a more leisurely pace. “CMS is slowing down a bit, rather than actually reversing course,” says Erik Johnson, vice president of Optum’s value-based care practice. “We saw the same thing with meaningful use for EHRs. When that came out there was a lot of tinkering to make sure that CMS was not getting too far ahead of the market.”

The move is intended to meet physicians in the middle, many of whom are still unaware of the law, lack an understanding of it or are simply unprepared, according to Mr. Johnson. “CMS doesn’t want to put themselves in any more of an antagonistic relationship with the provider community.
than they might otherwise be in,” he said. “They are trying to be careful and make sure the calibration of the pace is correct.”

Despite any pacing adjustments, the general parameters of MACRA today most likely represent what the law will look like in the future, according to Mr. Johnson. This means reporting on cost and quality measures and the push to enlist in advanced APMs will continue for the foreseeable future.

“[Physicians] may prepare now and not have to put those preparations into practice for a few years,” Mr. Johnson said. “There’s certainly a time dimension to all of this, but I don’t think it behooves anybody to wait and see because I don’t think MACRA is going to fundamentally change what it’s going to ask physicians to do.”

The same advice holds for payers, according to Jim Dolstad, Optum’s senior director of actuarial consulting. MACRA is on track to change the game and that will trickle down into the commercial plans, regardless of the pace of implementation. “When you look at MACRA, it’s designed for providers in the Medicare fee-for-service arena, but the reality is it’s just like [Medicare Advantage] Stars, just like risk adjustment, just like DRGs and every other thing CMS has done over the years,” Mr. Dolstad said. “It will cascade into other lines of business.”

**Implications on payers and providers**

Regardless of changes that may occur between the final and proposed rules, payers and providers can count on the following four major changes as a result of MACRA within the next year.

1. **Physician MIPS scores will be public.**
   This is a first for providers – there is not an all-inclusive view of provider performance right now, according to Julie Witt, director of actuarial consulting at OptumInsight. For the first time, the public will be able to compare physician performance with a simple, standardized measure when MIPS composite scores are published next year. For physicians who perform poorly, this poses a threat to patient volume and revenue. “It will spur them into action,” Ms. Witt said.

2. **Score misalignment.** These scores also open the door for misalignment with commercial payer’s proprietary rankings, which will call the validity of narrow networks into question if providers do not earn similar scores from CMS. “When CMS comes out with a ranking, it will be hard for the public to differentiate that that’s a Medicare ranking and it doesn’t carry over into the commercial rankings,” said Mr. Dolstad. “You may have some misalignment as to what [plans] consider quality providers and not quality providers.”

3. **Providers will shift their payer strategy.** Payers should brace for changes to MA enrollment numbers and value-based care contracts, according to Mr. Dolstad. Physicians hoping to minimize their MACRA impact may shift portions of business to MA, he said. “We are aware of a few plans

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already where they are expecting higher than average growth,” he said. To lessen overall risk and administrative burden, physicians may also lean more heavily on commercial business to make up for potential lost revenue in Medicare, and they may pull out of commercial value-based contracts. “MACRA is going to take a lot of effort for providers to go through, and the effort may be better spent on CMS than on some initiatives payers have put out there through value-based contracting and population health,” Mr. Dolstad said.

4. An even greater premium will be placed on collaboration. MACRA requires long-term patient attribution, which requires payers and providers to work together, exchange data and track patients throughout the continuum of care. Physicians and hospitals will also need to work closely with each other and draw other organizations in, including post-acute providers, pharmacies and community-based clinics, according to Mr. Johnson. “That more than anything is the existential lesson MACRA is trying to teach to the healthcare provider community,” Mr. Johnson said. “You need to collaborate to truly manage care across 365 days, not just an episode and not just a visit, but across a year in a life.”

Steps for success

The best way to start preparing for the QPP is to analyze the available historical data. MIPS builds on legacy programs like the Physician Quality Reporting System, meaningful use and the Value-based Payment Modifier. Physicians should dig into past performance in those programs to select MIPS measures they feel they can excel in, and excel in compared to their peers, because the program is graded on a curve, Ms. Witt notes. Payers, on the other hand, should analyze the potential impacts MACRA will have beyond Medicare and what the magnitude of those impacts will be, according to Mr. Dolstad.

Once payers and providers have a solid understanding of the program, its potential impacts and what their strategy will be, they should look to partner up. “You need really good partners. That’s going to be critical,” Mr. Johnson said. Providers may even find their best partners are commercial payers. Beyond technology and data, payers have valuable experience to share. “Payers have gone through this on the reporting side with [Healthcare Effectiveness Data and Information Set] before, and now Stars,” Mr. Dolstad said. “They understand how to go through the reporting process with CMS and with HEDIS to improve scores as rapidly as they can, and they understand what changes are needed to score well.”

Payers and providers can work together to best understand their local markets, coordinate care within that market and integrate risk and quality programs to streamline reporting requirements and processes. Teaming up will position both entities for success under MACRA.
Two years after the passage of the Medicare Access and CHIP Reauthorization Act and six months into the first performance year of the law’s Quality Payment Program, health plans, health systems and physician groups are still trying to get up to speed on program requirements, close gaps in readiness and identify strategies for success, according to Optum.

Optum conducted a survey in June of about 150 payer and provider decision-makers who influence MACRA strategy within their organizations to find the majority of respondents have major concerns about MACRA readiness.

"While more clinicians are now aware of MACRA, we’re still very much in a world where there’s a lot of education that still needs to be delivered and received on the part of the stakeholders," says Erik Johnson, vice president of Optum’s value-based care practice. "We’re not quite to the point where we’ve hit critical mass with regard to how many people are actually taking proactive steps to address and prepare for the issue."

Preparing for MACRA’s QPP, which overhauls the Medicare physician payment system, is no easy feat. Payers and providers must use data and analytics expertise to project future financial performance under MACRA and craft a reliable strategy based on those projections. "This is all very difficult and tough stuff," Mr. Johnson says. "Many [stakeholders] have tried to take on risks under Advanced Alternative Payment Models in the past and gotten burned."

Albeit difficult, no one can debate the importance of MACRA preparation. CMS has indicated it is serious about embracing value-based payments and does not intend to delay the QPP ad nauseum like its predecessor, the sustainable growth rate, according to Jay Hazelrigs, vice president of Optum’s provider risk advisory consulting practice.

“What we heard loud and clear from CMS is [MACRA] absolutely is here. It’s not going away, and although we have two years of transition, it is going forward as a program,” Mr. Hazelrigs said after attending a collaboration session with CMS leaders, payers and providers at the Optum Forum in August. “And quite frankly, when you look at the [Medicare] trust fund and the challenges MACRA is trying to address, it has to move forward.”

Based on survey findings and observations from the forum, Optum’s experts spoke with Becker’s Hospital Review about payer and provider progress in preparing for MACRA, identified critical gaps in readiness and recommended several strategic shifts to close those gaps.

Industry consciousness of MACRA has improved

Most payers (88 percent) and providers (83 percent) reported being aware of the data, metrics, reporting and performance management required to succeed under QPP, according to the Optum survey. Yet awareness
of the requirements doesn’t mean payers and providers are confident about fulfilling them – 88 percent of health plans and 86 percent of providers indicated they had concerns about implementation.

For providers, these concerns may stem from the range of choices presented by the QPP beyond choosing between its two tracks, the Merit-based Incentive Payment System and the AAPMs, according to Mr. Johnson.

“There is a real need to get conversant, articulate and ultimately fluent on the decisions you need to make in terms of the metrics you select, especially in the quality and practice improvement domains,” he says.

Choices providers make within the QPP will affect other business areas, particularly those related to Medicare Advantage and other commercial payer contracts – a likely source of payer concern. Optum expects MA plans to experience membership growth over the next few years and providers seeking to lessen their risk in MIPS may add momentum. This growth in membership will add unknown risk to MA plans, with potentially changing risk pools and CMS Star ratings, according to Jim Dolstad, Optum’s senior director of actuarial consulting.

**Gaps in payer readiness: Finding clarity**

In the survey, health plan decision-makers say they anticipate operational impacts (85 percent) and financial impacts (78 percent) from MACRA, but half of respondents are still unclear about the financial implications. Because payers are not directly involved with MACRA, this lack of clarity around potential implications represents a significant challenge. Health plan success in the era of MACRA hinges on anticipating how the law will affect commercial business and adjusting long-term strategy to account for those changes.

MACRA presents several potential risks to commercial payers in addition to cost shifting, which is likely in most markets. There is a potential reputational risk for payers who operate narrow networks if CMS’ provider scores and commercial provider scores do not align. MACRA provides newfound negotiating leverage to providers with high MIPS scores in their network contract negotiations with payers. Finally, many payers are struggling with how they will actually pay claims. For commercial plans using a percentage of Medicare rates for reimbursement, the formula will have to be expanded to incorporate unique MIPS multipliers for each provider. This may sound simple, but the reality is this modification will be difficult and expensive for many payers.

“From the operational perspective, people should rightfully be concerned,” Mr. Dolstad says. “Some of the providers who score really well in MIPS may become coveted by payers because of that high mark. They may not have scored as well historically with the payer because they are looking at a different set of criteria, but as you try to come up with the public perception that you’ve got a really good network, you’ve got to look at how CMS is scoring clinicians.”

MACRA also calls for payers to anticipate changes to their financial strategy. In addition to changes in MA membership, Optum expects commercial value-based contracts to decline as providers are distracted by CMS requirements. “If that’s the case, then momentum could be partially offset or lost in the commercial marketplace, which would put upward pressure on the claims rate,” Mr. Dolstad says.

**Gaps in provider readiness: Education and action**

Perhaps the greatest red flag in the survey was the lack of MACRA preparedness on the part of providers.

Health system decision-makers reported low levels of general knowledge about the program (36 percent felt very or extremely knowledgeable) or its financial implications (29 percent were very or extremely knowledgeable). Additionally, only 14 percent of health system leaders indicated their clinicians are prepared for MACRA – even though the first measurement
year is well underway.

“Everybody has to step up to the plate and make this a front-and-center issue and not a side-of-the-desk problem that people deal with in their non-existent spare time,” Mr. Johnson says.

Providers’ understanding was visibly amiss regarding MIPS measures and reimbursement structure. The survey showed nearly 31 percent health system decision-makers were unsure about how MIPS reimbursement bonuses work and 27 percent incorrectly believed all providers can receive positive payment adjustments under MIPS, when in fact only half of providers can receive positive adjustments.

“If 50 percent of clinicians experience reimbursement increases, then 50 percent of clinicians will experience reimbursement decreases,” says Julie Witt, director of actuarial consulting at OptumInsight. “MIPS is a zero-sum game.” Clinicians in MIPS will be evaluated against their peers and scored on curve so the financial penalties collected by CMS pay for the rewards. This will be slightly different in the transition years of the program, when very few clinicians will receive a negative adjustment, Ms. Witt noted. “However, that also means … there’s not a lot of money in the transition years to create positive adjustments,” she says.

Nonetheless, Optum’s experts remain optimistic. “This is different in degree, but not in kind with what CMS has done in the past with regard to payer reimbursement,” Mr. Johnson says. Past provider behavior during the introduction of DRG payments, the Physician Quality Reporting System and the Inpatient Quality Reporting program indicate providers can react quickly to incentives they understand. “Once [providers] get this, they can react pretty quickly and with a degree of alacrity and efficiency that is a little surprising,” he says.

After education, the final gap in preparedness is collaboration. Most respondents (86 percent of health systems and 87 percent of payers) indicated their organization is working in silos to address MACRA.

“There is a certain irony to that, given that MACRA is designed exactly as we read it. Specifically, to foster collaboration across the delivery chain,” Mr. Johnson says. The program aims to get physicians, health systems and post-acute care providers to work together to improve quality, cost and efficiency. This type of collaboration is beginning to take hold in other CMS-led payment reforms like ACOs, according to Mr. Johnson, but he added, “We’re not seeing that level of collaborative planning and implementation happening with regard to MACRA, and it is at least as big of deal as those other programs.”

**How to the close the gaps**

Payers and providers can position themselves for success under MACRA by better leveraging analytics to forecast potential performance scenarios and assess their standing in the market. For providers, this will help with the selection of MIPS quality measures and the monitoring of resource utilization. In the long-term, analytics can also help providers assess their readiness for the advanced APM track.

“Our view has long been … that advanced APMs are really the more stable, long-term option for folks, albeit the harder one to undertake upfront and certainly the one that has a lot more associated risk,” Mr. Johnson says.

From a payer perspective, data is crucial to forecast market-level implications. “The magnitude of the impact is going to vary by geography, and within each geography, it’s going to vary by market,” Mr. Dolstad says. “You have to look at the solution that works for you as a payer, not what might work for peers, because it will be different in each payer’s case.”

Most importantly, industry stakeholders – both providers and payers – need to identify partners who can help support affordable long-term success. “Those are table stakes at this point,” Mr. Johnson says. “You’ve got to be able to do that in order to succeed in a value-based care world.”