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MACRA's strategic implications:

What providers and health plans need to know

The Medicare Access and CHIP[1] Reauthorization Act of 2015 (MACRA) included sweeping changes to how physicians and other clinicians are paid through Medicare. Aside from simply addressing clinician payments, MACRA is intended to significantly improve patient outcomes and reduce the cost of health care by offering incentives to medical professionals for the overall quality of care they provide, rather than the number of services and procedures performed. While the final rule was released in October 2015, the Centers for Medicare and Medicaid Services (CMS) continues to refine the regulations on an annual basis.

Included in MACRA is the Quality Payment Program (QPP), which introduced two incentive paths for clinicians: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs). The primary goal of this legislation was related to transforming traditional fee-for-service (FFS) payments to value-based payment models built around improving quality of care.

As the focus for clinicians moves from volume to quality, hospitals and health plans must also consider the potential implications. Some impacts include:

- Indirect impact to Medicare FFS revenues because of utilization reduction pressures
- Potential reduction in Medicare Advantage (MA) county benchmark rates
- Potential misalignment of CMS MIPS scores relative to health plan high-performance networks
- Streamlining and harmonizing the metrics for provider performance
- New product offerings
- Additional policy changes
- Potential cost shifting

There is no one-size-fits-all solution for stakeholders to address these concerns, since quality, competition, provider group composition and demographics vary by location.

Overview and objectives of MACRA

Passed by large majorities in both houses of Congress, MACRA replaced the Medicare physician sustainable growth rate formula, which was largely unpopular among clinicians due to the unpredictability of payment reimbursements on a year-to-year basis. Instead, MACRA explicitly codifies the principles of "value-based care" articulated in the Affordable Care Act (ACA) of 2010 and endorsed by CMS for more than a decade. In simplest terms, it moves the majority of fee-for-service payments to a system based on value and quality of care, which is in alignment with health care transformation in the United States. Figure 1 illustrates the evolution of CMS policies.

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

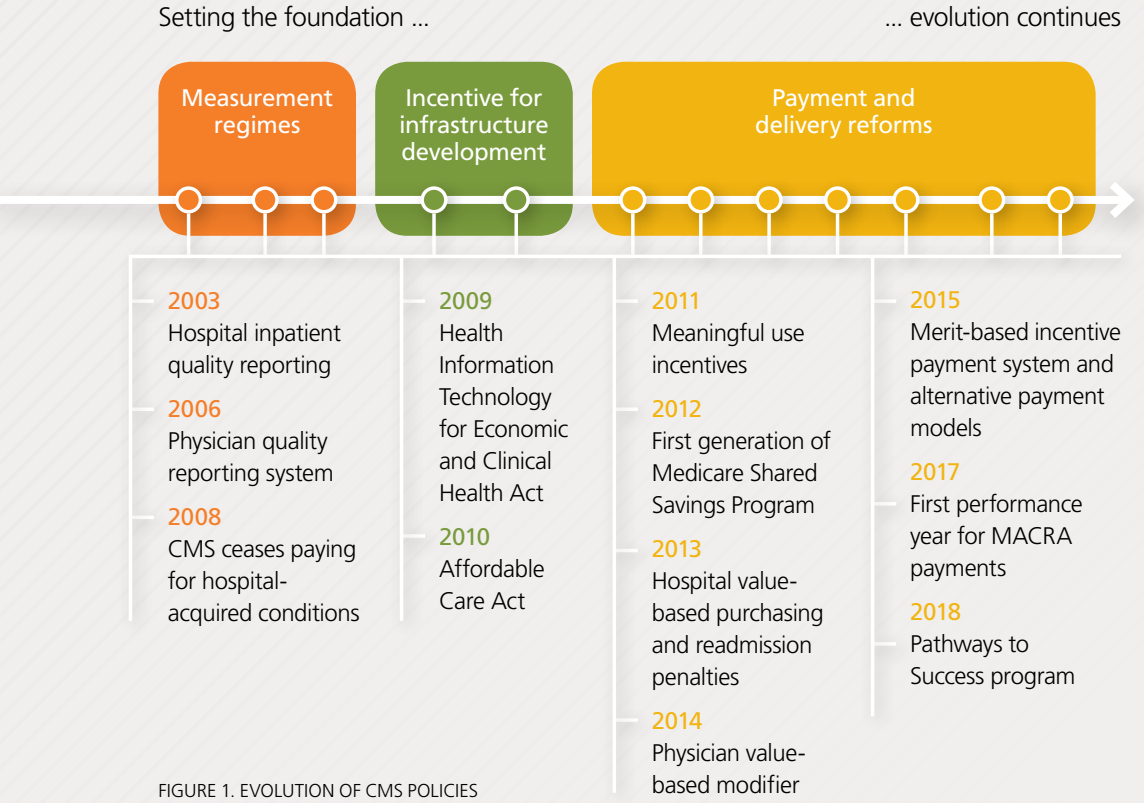

FIGURE 1. EVOLUTION OF CMS POLICIES
Source: Optum

The new payment approach, QPP, bases compensation to providers on:

- Patient health outcomes
- Activities that improve their clinical practices
- Efficient use of medical resources
- Meaningful use of certified electronic health records

Providers will be paid either under MIPS or based on their participation in and adoption of AAPMs. This could have additional revenue implications for individual clinicians. CMS will offer payment incentives for clinicians participating in AAPMs and for those who exceed

goals tied to patient outcomes and population health metrics. MACRA provisions offer the potential for improved patient health and more stable updates to Medicare physician fee schedule payment rates. However, a larger percentage of clinician revenue will be at upside/downside risk.

MACRA offers strategic and financial incentives for most health care organizations. Finding the best path to comply with MACRA will afford organizations the stability and freedom to gain market share in the ever-changing health care economy.

Choosing a MACRA path

To understand MACRA's reach, it is critical to understand what it is designed to do currently and in the future. The law authorizes the QPP for providers, which offers two pathways: MIPS and AAPMs.

MIPS

MIPS is a measurement-based regime that consolidates the three CMS existing programs — Physician Quality Reporting System (PQRS), Value Modifier (VM) and Meaningful Use (MU) — into a single, metric-driven track. Eligible professionals will be measured on quality, resource use, clinical practice improvement, and the ability to capture and share health information. This is shown in Figure 2. Clinicians will be scored in varying degrees over the next several years on these categories. However, MIPS won't necessarily drive down the overall cost of care. It is simply a measurement-based regime lacking the financial incentives of a value-based care program.

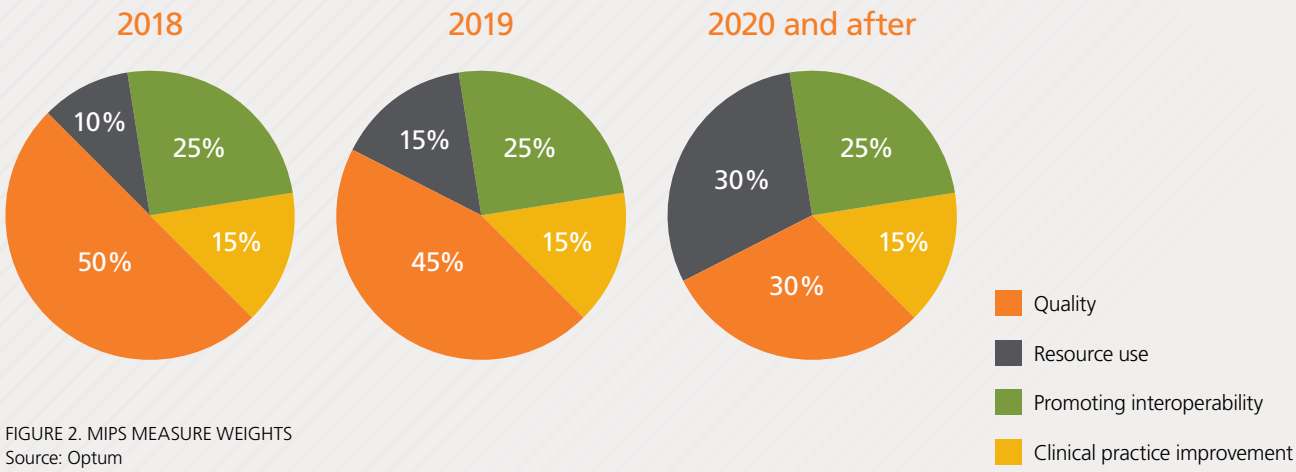

FIGURE 2. MIPS MEASURE WEIGHTS
Source: Optum

Medicare intended the MIPS payment program to be a zero-sum game, meaning that positive payment adjustments will require taking revenue from other participants via reduced fee schedules. Providers who choose MIPS can't predict with certainty whether they will gain or lose revenue because fee schedule adjustments will be determined by the relative performance of all clinicians in the MIPS program. As the program is currently structured, past performance will be no guarantee of future success.

AAPMs

AAPMs are value-based payment programs authorized by the ACA to pay for care given to Medicare beneficiaries. These include accountable care organizations (ACOs) that involve two-sided risk models. These offer the potential for increased payment for improving quality and containing costs, but also potential downside penalties for failing to achieve financial and quality targets. AAPM structures encourage providers to collaborate across the continuum of care, bear financial risk for episodes and populations, and more proactively engage patients. Examples of AAPM models include:

- Medicare Shared Savings Program (MSSP) Track 2
- MSSP Track 3
- Medicare ACO Track 1+
- Next Generation ACO
- Bundled Payments for [as seen on web] Care Improvement (BPCI) Advanced
- MSSP Basic E and Enhanced

An AAPM model must meet several criteria, including use of certified electronic health record technology (CEHRT); require payment based on quality measures; and involve two-sided financial risk. In addition, the model must meet the revenue or patient threshold requirement for qualified participant (QP) status under these models each year. If all criteria are met, the AAPM will earn a 5% bonus payment based on its Part B revenue. AAPMs are exempt from MIPS. Figure 3 shows how the fee adjustments work.

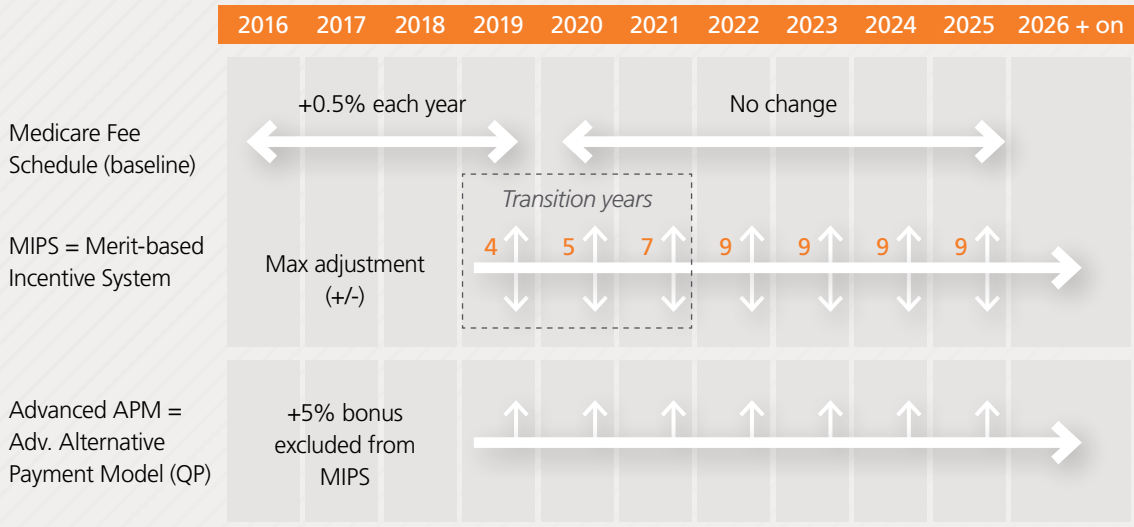

FIGURE 3. PART B FEE SCHEDULE ADJUSTMENTS
Source: Centers for Medicare & Medicaid Services

Provider reactions and implications

Clinicians are at the center of MACRA and its ramifications, yet many providers find themselves in a difficult position adapting to the law. Since the ACA was passed, value-based care has been positioned as a beneficial idea rather than a requirement. However, CMS put the weight of law behind value-based care for most clinicians, increasing the urgency of care delivery transformation due to increasing incentives and penalties. Like most transformations, however, moving from a volume to a value payment policy will come with significant challenges.

To understand the QPP's impact and develop the best short- and long-term strategies, provider organizations need to consider their ability to manage risk and prioritize investments over the next few years. To understand the business risks and choose the best QPP path for 2019 and beyond, clinician groups need to develop and deploy financial models.

Of course, MACRA has implications beyond just revenue, including the models providers and payers use to conduct business and provide care for patients.

MACRA will change the way clinicians practice and the way they refer patients, which will have a direct impact on hospital admissions and revenues. Because clinician referrals are critical to a facility's bottom line, health systems should use the opportunity MACRA provides them to become more valuable partners with clinicians and connect providers across the continuum of care (e.g., ambulatory, acute, post-acute and rehabilitation).

Many clinicians may rely on health systems for assistance in complying with whichever payment pathway they choose. A larger organization could scale its administrative infrastructure, relieving the clinicians of some administrative duties, thus allowing providers to focus on clinical improvement. Providing such an option will give clinicians valuable assistance to promote greater loyalty and establish or strengthen referral relationships.

Setting up an AAPM takes capital and capabilities that many individual clinician organizations often don't possess. Larger health care facilities, on the other hand, may possess some of the functions necessary for AAPM success, including the following:

- Population health management (PHM) applications
- High-risk care management programs
- Tools that enable clinical integration and collaboration across care settings
- Community outreach programs

Despite the many challenges of participating in MIPS or an AAPM, clinicians, hospitals and even payers can have positive outcomes due to MACRA with careful planning and strategy. While there is no single sure-fire strategy that will guarantee a win or loss, health care stakeholders must understand the potential financial implications of each pathway.

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MACRA's impact on payers

While MACRA is largely directed at providers serving Medicare FFS members, its indirect impact will cross all lines of a payer's business: Medicare, Medicaid and commercial. However, whether MACRA will ultimately have the same impact of some of its predecessor CMS programs, such as diagnosis-related groups (DRGs), risk adjustment and Star Ratings remains unknown. Meanwhile, MACRA continues CMS' objective of stressing value over volume within the economics of the health care system.

MACRA is in its early stages, but its downstream impact is quickly becoming a reality for payers. Currently, the primary payer concerns include the following issues:

- How will we process, in theory, over 1 million unique provider fee schedules?
- Will our brand reputation take a hit if our narrow network providers have below-average MIPS scores?
- How are our payments to providers, and cost to customers, impacted, since they are expressed as a percentage of Medicare reimbursement?
- Will our concerns over MACRA reporting erode our gains in value-based care?
- When, in what counties, and by how much are the MA benchmark rates likely to decrease?
- How will the distribution of members across our Medicare plans be impacted, and what will be the change in the underlying mix of risk?

Variation of MACRA's impact by payer and geography

MACRA's financial impact on payers is dependent upon numerous variables, including market competitiveness by line of business, coding and documentation accuracy capabilities, clinical quality, value-based care sophistication and MA plan penetration, to name just a few. These factors vary significantly by both geography and payer, and will result in the magnitude of MACRA's impact to vary by geography and payer as well.

For example, counties that have strong MA penetration rates, above-average Star Ratings and above-average coding and documentation have traits and performance that reflect mature value-based care markets. Many payers in these markets are less likely to be impacted by MACRA than payers operating in less mature markets, as less transformation is required. MACRA, from a provider-reimbursement perspective, is a zero-sum game, with variables such as risk adjustment designed to be budget neutral to CMS.

Adaptations from across the health care ecosystem

MACRA has now been in place long enough for many providers to develop and begin execution of their initial game plans for success going forward. Meanwhile, most payers have also had the opportunity to study providers' initial reactions and develop their own formulas for success.

While some providers are looking for ways to collaborate with payers on MIPS, other providers have decided MIPS is not a viable option for their practice and have developed FFS exit strategies. MACRA was created with minimum membership, paid-claim and claim-count thresholds. As a result, many providers have encouraged their FFS patients to move to MA plans. Payers that did not anticipate this movement when developing their 2018 and 2019 MA bids may find their underlying risk pool to be different than they assume. This could lead to potential deviations between actual and expected claims experience.

Providers may also be considering, or already participating in, the AAPM track. CMS is encouraging provider/payer collaboration in this track through the All-Payer APM option. Participation in non-Medicare APMs in 2019 and later can help providers meet the QP threshold to qualify for the AAPM 5% bonus payment and receive an exemption from MIPS.

As trusted advisers to the health care industry, actuaries need to provide guidance to payers and providers around the potential impacts of MACRA and the QPP. A white paper funded by the Society of Actuaries (SOA)[2] provides insight and considerations for the profession so actuaries can assess the potential risk and opportunities for their organization across numerous areas, including:

- Financial implications and risk to providers, both MIPS and AAPM pathways
- Collaboration opportunities across providers and payers
- Implications on provider/payer contracting and relationships, including financial and reputational impacts
- Implications to MA, Medigap and commercial lines of business

As MACRA continues to evolve, organizations — both provider and payer — need to respond and adapt with strategies that meet their business objectives and provide opportunities for growth and profitability. There is no one-size-fits-all strategy, but the goal is clear: Improve patient outcomes and reduce health costs by rewarding value over volume.

Sources:

1. Children's Health Insurance Program.

2. Dolstad J, Witt J. 2019. Health Plan Strategic Implications of MACRA. Forthcoming report.

This article first appeared in *Health Watch* as "MACRA's strategic implications: What providers and health plans need to know," prior to the "2020 Quality Payment Program Proposed Rule" which CMS released in July, 2019.

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