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Risky Business:
New Payment Models and MACRA

MHA
Michigan Health &
Hospital Association

Traverse City, Michigan | February 23, 2017

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Agenda

1. Value-Based Contracts
   - Current Models
   - Risks and Rewards
   - Capability Requirements and Contract Evaluation
2. MACRA

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1 Value-Based Contracts

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Current Models

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The Truths

- **Definitions and the interpretations of the definitions are highly variable among all stakeholders**
  - What constitutes a **value** to one party, may not be a value to the other party
  - There are more stakeholders at the negotiating table than just, for example a payor and a hospital or health system
  - Value-based care is the intersection of cost and quality
  - What is **risk** to one party, may not be risk to another party
  - Population Health, likewise, has many interpretations. From a payor perspective, it is operationalized as a management system that includes aggregation of patient data across multiple health information technologies and analysis of the data to develop methods to improve clinical and financial outcomes

Everything is relative and depends on how closely visions align and whether there is a common understanding.

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What We Know About Contracting Trends

- Value-based approaches to payment and delivery are here now
- Value-based approaches vary by payer and by market

What We Know About Contracts Being Offered

- CMS is requiring hospitals to compete on value
- CMS has multiple initiatives in place or planned to evaluate different models
- Commercial payers are seeking significant reductions in provider reimbursement to either reduce or hold premium costs at current rates
- Commercial payers (based on employer demand) are placing a premium on quality and cost

What We Know About What We Should Be Doing

- Improving quality, access and efficiency is the right thing to do

Providers will need to answer a fundamental question:
At what level of risk are we able to participate now and at what level do we want to participate in the future?

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Factors Affecting Prevalence of Value-Based Payment Models

- Network adequacy regulations
- Hospital competition
- Spare capacity
- Payer requirements for specific market dynamics including:
  - Cultural and capability competency
  - High quality (comparative in the market)
  - A developed robust primary care network
  - A large care delivery footprint
- Demonstrated competencies **by both** providers and payers within current legacy systems

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Today's Models

Government

- **Medicare Innovation***
  - Accountable Care
    - ACO's
    - ESRD
    - Health Quality
    - Nursing Home VBP
    - PACE
    - Rural Community Hospitals
  - Bundled Payments
    - ACE Demo (closed)
    - BPCI – 4 Models
    - Oncology Care Program
- Primary Care Transformation
- New Payment Delivery Models
- Medicaid
  - State Innovation Models

Hybrid

- **Medicare Advantage Plans**
  - Partial Risk or PPO
  - Percent of Premium
  - Gainsharing Models

Commercial

- "ACO" or "CIN"
- Joint Ventures
- Pay for Performance Models
  - Bundling

* Innovation Center - future of Innovation Center programs under the new administration is unknown

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Payers Are Scaling Value-Based Reimbursement Agreements

- Locally controlled plans; no consistency among the various BCBS plans
- BCBS Association has contracting guidelines for all plans
- Most are primary care focused

- Collaborative Care Model; as of January 2, 2017, in 29 states with 161 contracts; Started model in 2008, with average per year contracts at 30 from 2013-2016
- Cigna has 4 Collaborative Model agreements in place in Texas
- "Together, we're building a sustainable health care system"
- Focus on health improvement and risk management, partnering and providing information and incentives to physicians to drive better, more cost effective health outcomes

- Expects to more than double industry leading accountable care contracts to $50 Billion by 2017
- Variety of models ranging from primary care bonus programs to accountable care incentives.
- ACO's showing promising results such as a 4 to 4.5% point reduction in medical cost trend through PCMH
- Has ACO relationships with more than 575 hospitals, 1,100 medical groups and 75,000 physicians across the country
- New product is Nexus ACO (benefit option) in 15 markets to self-funded employees

Cigna: https://www.cigna.com/newsroom/knowledge-center/aco/cigna-cac-partnerships, 1/3/2017; United Health Care: http://www.unitedhealthgroup.com/newsroom/articles 1/3/2017

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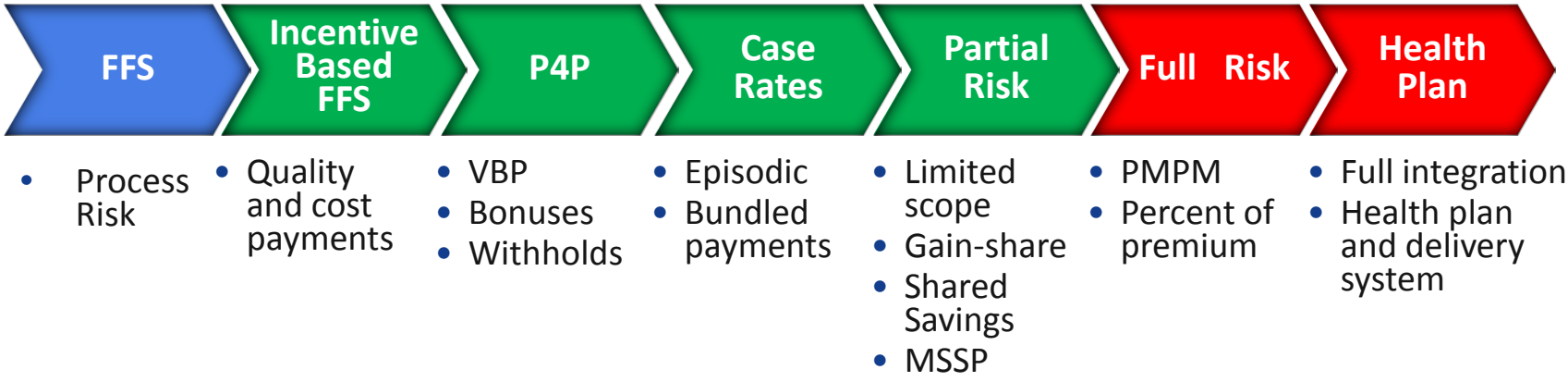
A Wide Range of Reimbursement Alternatives Exist

- Markets will offer a variety of choices based on payer, providers, costs, and capabilities sophistication
- Most contracts include one or more of the payor reimbursement mechanisms shown in the diagram below
  - Naming conventions of contracts don't necessarily mean the same thing from payor to payor
- The majority of "value-based" contracts today are incentive based FFS with shared savings
  - Some markets have full risk (% of premium) typically on Medicare Advantage products (e.g., Southern California, Colorado)



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Current Typical Value-Based Contract Structure

- Duration is two to five years
- A “shared savings” contract sits on top of the current legacy FFS contracts
- ACO/shared savings models include:
  - Attributed lives model (attribution method varies)
  - Upside or downside risk depending on entity’s risk tolerance and/or perceived capabilities
  - Requirement for reduction in total PMPM spend for attributed lives
  - Efficiency targets for select services (high spend, presumably over-utilized services)
  - Quality measure targets (HCAPHS, HEDIS, proprietary)
  - Quality and efficiency measures must be met to received shared savings payment
  - There may be different models by line of business within a single contract (fully insured vs. ASO)
- Early value-based contracts provided “infrastructure” funding typically for care coordination activities for a specific time period
  - These provisions are starting to be eliminated as payors perceive that providers have already invested in these operational capabilities
  - These funding amounts are often subtracted from the shared savings earned

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Today's Considerations as Payment Models Change

Current Limitations

- The end game isn't known, so legacy system infrastructures remain (for all participants)
- Current contract models are being "retrofitted" into legacy systems for claims processing, quality measurement, and financial reporting

What Is Changing

- Success is highly dependent on alignment with physicians and physician office staff
- Depending on the payer, providers will need technology capabilities to assist with managing contract provisions such as PHM components
- Coding accuracy is key to success under value-based models
- Data sharing is critical to success; reporting to the contracted entities is becoming more robust to provide program support

What Won't Change

- Current coding requirements and structures will not be eliminated; they will still be needed for statistics, identification of service acuity, and calculations

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Who Will Drive the Market Forward Towards Value?

Payers	Employers
• Mix • Scale • Initiative	• Size • Progressiveness • Benefit Design
Hospitals	**Physicians**
• Degree of consolidation • Value-based competencies	• Degree of Integration • Value-based competencies

When payers and employers lead, rates see more pressure and providers become reactionary

When providers lead, focus is placed on care delivery model and network development

- A recent Aon survey of more than 800 employers conducted approximately a week after the election, revealed that 48% say the employer mandate is their primary concern. Other leading areas of concern are: prescription drug costs (17%), excise tax (15%), tax exclusion limitations on employer sponsored health care (10%), paid leave laws (8%) and employee wellness programs (2%)

Source: http://aon.Mediaroom.com/2016-11-18-Nearly -Half-of Employers-View-Employer-Mandate-as-Top-Health-Care-Concern-Going-into-2017; 11-18-2016

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Will Value-Based Programs Be Viable Long Term?

- Despite the proliferation of new care delivery models (e.g., ACOs, CINs, PCMHs), **provider communication, collaboration, and behavior change** have yet to materialize on a broad basis across the care continuum
- **Benefit design** has not been dramatically changed, causing misalignment of incentives between providers and patients (e.g., open access networks, non-gatekeeper design, retroactive medical management)
- Effective patient **attribution models** have yet to be developed that provide for clear understanding of what members providers are responsible for
- **Technology, data collection, and reporting**, while improving, are not yet robust or timely enough for the effective management of patient populations
- Current value-based programs represent a **minority** share of providers' overall reimbursement
- It is expected that there will continue to be mixed models – including a shift to bundled services constructs – given diversity of arrangements across the country
- ***Focus has been on the low hanging fruit – controlling costs of the chronic condition population. A model for reimbursement for preventing illness has not been developed. Likely to be a phased in approach depending on success of programs such as the CMS CPC+ model***

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Moving Up the Risk Continuum Won't Be Easy

- Many providers have **not** been successful in past pursuit of risk
- Provider networks and distribution of care are often fragmented and inefficient across the continuum
- Clinical outcomes are unmanaged, clinical outcomes measurements are poorly defined, and poorly performing providers are not held accountable in meaningful ways
- Meaningful data exchanges and formats are nascent with inconsistent interoperability
- Broad alignment of compensation with quality of care has not occurred
- Regulatory environment is not yet conducive to integrated delivery models
- Legacy costs and infrastructure do not align with the "new era" of healthcare change

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Risks and Rewards

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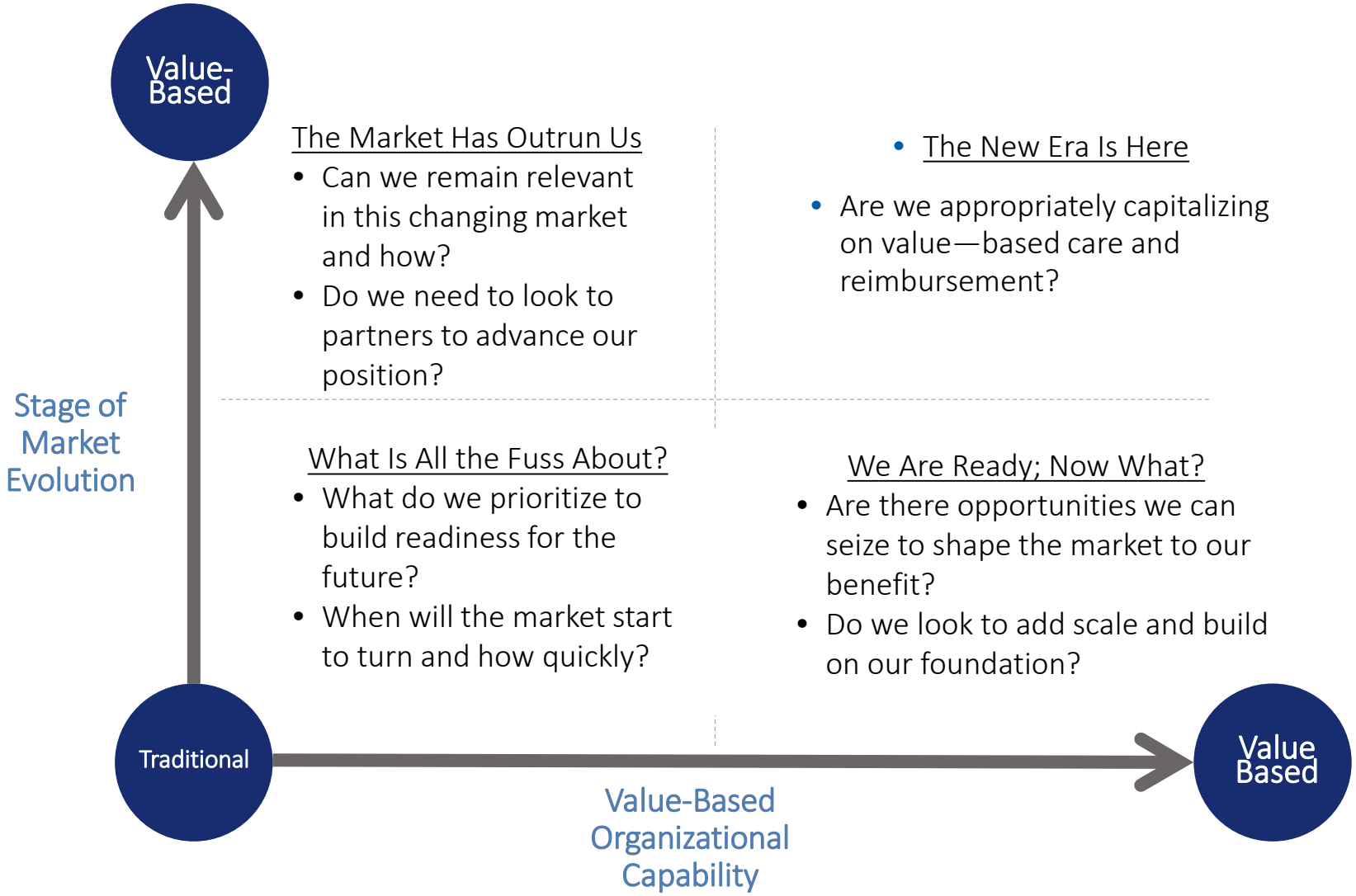
Biggest Organizational Risk Is Falling Behind the Market, but There Is Financial Risk to Getting Too Far Ahead



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Risks and Rewards – Is Non-Participation an Option?

- Risks
  - Increased costs for infrastructure build (e.g., IT, staff, downstream relationships)
  - Redistribution of revenue models requiring understanding the impact of contractual "efficiency measures" and reduction in "total PMPM spend" on facility and physician revenues with shift of revenues to "shared savings" payments
    - Who are the participants in the shared savings arrangement and how are shared savings distributed?
  - For percent of premium or partial/full risk, are the correct management models in place to monitor and control in an open access model?
  - Ability to monitor costs with "incomplete" data due to legal constraints
- Rewards
  - Provision of a care model consistent with Triple Aim goals; if structured correctly, could allow for payor agnostic care protocols reducing administrative burden and providing a robust value proposition to patients and physicians
  - Sharing in "savings" realized through efficiency's in providing care
  - Creation of an entity structure capable of participating in outcome payments, when those models are created

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Always Know Where You Are and Where You Are Going

- What's your desired future position with regard to risk and reimbursement?
- What is your desired service area and what delivery system infrastructure, resources, and contracting scope are appropriate?
- What types of arrangements can/should you participate in?
- What is your definition of risk?
- How much risk can you carry?
- What types of risk can you carry?
- What's your strategy and plan for risk contracting?
- Are you legally and operationally structured flexibly to accommodate new and emerging models?

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Assess and Prepare: What Is Our Strategy and Contracting Plan?

Planning is essential

Strategic Plan	• Clearly defined strategy • Short-term and long-term goals • Defensive/offensive • System and provider buy-in
Tactical Plan	• Service delivery – employed/contracted • Geographic coverage and gaps • Carved-in versus carved-out services • Support services – current and future
Financial Plan	• Payer risk level (upstream) • Provider risk tolerance (downstream) • Reserves, stop loss, risk limits, corridors • Impact on current and future revenue

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Implementation Success Factors

- Clear delineation of risk and responsibly across all stakeholders, supported with timely and accurate data flow are necessary

Physician Engagement

- Aligned incentives
- Investment in primary care
- Physician leadership in redesigning the delivery system to meet value objectives

Transparency and Accountability

- Well-defined process for clearly delineating and communicating responsibilities
- Transparency of quality and pricing data

Performance Measurement and Reporting

- Data collection, ownership, flow, timing, analysis, communication and response
- Clear policies and procedures for risk and performance measurement and management

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Capability Requirements & Contract Evaluation

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Know Thyself – Assess, Assess, Assess

Understand current position and create your unique story

- **What do we have to offer?**
  - Service Inventory – care across continuum; geographic coverage, physician network
  - IT infrastructure
  - Reporting capability
  - Quality and volume
- **What are the healthcare needs of the market? (now and future!)**
  - Do we offer the services available to address these needs?
  - Are we able to address both short and long-term improvements in health status?
- **Where are we on the journey to value-based capability (and payment)?**
  - Do we track and manage risk?
  - Do we have a way to track value metrics and patients?
  - Do we have robust coordination of services (physicians and departments)?
  - Are all stakeholders on board?

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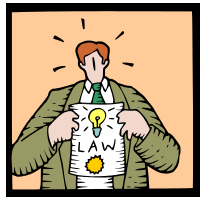
Know Thyself – Assess, Assess, Assess

- **Costs**
  - Do we know the full cost of care?
  - Do we know how this compares to the market and to health plan trends?

- **Risk Management**
  - Do we know which elements we can control?
  - Do we know which elements we CANNOT control?

- **Market**
  - Do we know our target population demographics?
  - Do we know historical trends?
  - Do we know the benefit designs (coverage)?
  - Do we know the fee structures for all providers in the network? **(MUST BE FINANCIALLY OR CLINICALLY INTEGRATED TO KNOW THIS)**
  - Do we know the size and geography of the required primary care network?

- **Regulation**
  - Do we know the state and federal regulations and requirements associated with bearing risk?



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Value-Based Contract Evaluation

- Before looking at the rates being offered, review the operational requirements to determine the "costs" of the contract requirements that will offset the potential shared savings earnings; for example:
  - IT applications such as patient-centric registry
  - Additional staffing/expertise in care coordination or care navigation
  - PCMH constructs
  - Additional staffing for communications and education efforts to support the contract
  - Certification costs – direct and indirect
  - New financial/administrative expertise requirements to track the contract
- If there are gaps in your capabilities, develop the time line required to build or purchase these services and perform an impact analysis on the potential shared savings earnings and timing of potential earnings

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Value-Based Organizational Competencies

- Necessary competencies vary by payer
  - The challenge is to assess requirements for various payers and find your participation path
- Key competencies:
  - Access to the appropriate services in the right setting
  - A truly organized cross-continuum care coordination process, including:
    - Outreach
    - Referral, case, and disease management programs, including care navigators
    - Care continuum planning
  - IT systems and point-of-service tools to allow for:
    - Evidence-based medicine protocols
    - Identification of gaps in care
    - Evaluation and measurement of interventions to identify best practices
    - Enabling tools to assist all stakeholders in understanding payment and savings provided under alternative methods

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Value-Based Organizational Competencies (continued)

- Focus on quality measurement
  - Understanding of how each payer calculates “quality” down to the CPT, ICD10, HCPCS coding level
  - Communication of coding requirements to measure success to **all** stakeholders
  - Reporting
  - Timely, succinct reporting to stakeholders on performance and identification of action items
- Accurate service coding by all stakeholders
- Financial expertise to model shared savings models and shifting reimbursements

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Value-Based Contract Financial Considerations

In reviewing value-based contract financial terms, understand, in detail, all the calculations being performed under the contract terms. Specifically:

- What are the time frames for calculations? What is the claims run-out time? Are there ever "true up" calculations?
- Is the payer comparing your performance to market, state, or your past performance?
- Is the payer adjusting baseline? What factors are being used?
- Does the contract have risk corridors? Are they reasonable?
- Is the payer applying risk adjustments? What is the mechanism and frequency?
- What data will the payer share with you relative to cost information? Is the data auditable? If all data is not auditable (e.g., if sharing other providers' payment rates is a legal concern) what is your trust level with the payer?
- Determine what is within the entities control or influence (directly or indirectly) and attempt to remove these services from cost calculations
- What is the source of the cost information?
- Are any portions of allow amounts excluded—for example, patient cost sharing amounts?

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Value-Based Contract Financial Considerations (continued)

- Are any claims removed from inclusion? What is the basis for removal?
- Are any costs added? What is the basis for addition?
- If some services are capitated to some providers, do they use the capitation rate or equivalent costs for services performed and encountered?
- Has the payer provided trend reports (1-3 years)? Has the payer asked you to review to determine whether you believe they are accurate?
- Is the model sustainable over time?
- Does the contract include a provision to convert the contract to any newer structures that may be offered by the payer without financial penalty?
- If a percent of premium contract, ensure that there are detailed descriptions of what is included and excluded in revenue and expenditure calculations
- Understand your current position and model proposed contract terms taking into account utilization and reimbursement amount

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The “Other” Contracting – Building Provider Networks and Legal Considerations

Provider Network contracting (employed or affiliated) must align with overall strategic goals

- Many of the “payor” strategy components are applicable in your downstream provider contracting strategy and requirements
- Contract as partners or subcontractors depending on where the provider wants to fit in the continuum
- Be consistent across all providers; don’t pit specialty against specialty or employed against independent
- Need to address legal issues early in the process
  - Need to ensure downstream contractual provisions are incorporated and clearly explained
- Execution against contract provisions is critical to success
  - Communication, measurement, and contract administration

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Ground Rules for Strategy Development and Contracting

- The Golden Rule – Do unto others as you would have others do unto you
  - Don't burn bridges and work on forming a collaborative trusting relationship with the payers. Ask them what their challenges are and what steps you could take to assist them with overcoming those challenges. This will set the stage for proposing alternative solutions
- Remember that a contract exists if two parties agree to all the provisions (and the provisions are not illegal)
  - Both parties should have clearly delineated obligations listed and both parties are responsible for ensuring that the other party is meeting those obligations
- Make sure you are speaking the same language and agree on definitions. Never assume that you know the other parties definition or intent
- The process is iterative – contracts models may require rethinking of strategy and re-assessment of capabilities
- Remember that if you build it, they won't necessarily come! There needs to be a compelling reason and early discussions with payors as to their likelihood of contracting with specific entity types (CINs, ACOs, PHOs)

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Decision-Making Framework

- **What are the net consequences of my options?**
  - Short term and long term?
  - How will my decision be viewed/communicated internally and externally?
- **What are my core obligations?**
  - Fiduciary obligations
  - Affects of decisions (walk a mile in each stakeholder's shoes)
  - Set aside biases/Assume nothing
- **What will work in the world as it is?**
  - Value sustainable over safe
  - Focus on meeting stakeholder needs today and in the future
- **Who are we?**
  - Select options that best reflect the organization's belief systems
- **What can I live with**?
  - Imagine explaining the decision to someone you respect; how would they react and how would you feel about their reaction?
  - How would your decision read in a blog or as a news headline? Does it fill your heart with pride or your stomach with dread?
- ***Remember opting for what has always been done is an abdication of choice that leaves an organization vulnerable to unanticipated consequences***

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2 | MACRA

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Post-Election MACRA: The Push to Value-Based Care Will Continue

Even with the November election outcome, **MACRA is likely here to stay**

- MACRA was introduced by Republicans and received wide bipartisan support:

92 - 8

Senate votes for MACRA

392 - 37

House votes for MACRA

The same **macroeconomic forces underpinning MACRA** remain, and the **overall transformation to value-based care** will likely continue across commercial, Medicare, and Medicaid populations

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MACRA Has Arrived – How Ready Is Your Organization?

Five steps can ensure success under MACRA's Final Rule

1 Understand the Requirements of MACRA

- Educate executives, trustees, and clinicians on MACRA's Final Rule

2 Develop the Vision for a MACRA Strategy

- Evaluate the potential impact of MACRA on clinicians and the organization
- Answer the strategic questions that will frame the vision for a MACRA strategy

3 Evaluate the Current Organizational Context

- Assess the vulnerability of the current employed and affiliated clinician network
- Identify MACRA-specific gaps in current capabilities

4 Assess the Organization's MACRA Options

- Determine the strategic path(s) that are best for the organization in the short and long term
- Test the strategic and financial implications of selected path(s)

5 Implement the MACRA Strategy

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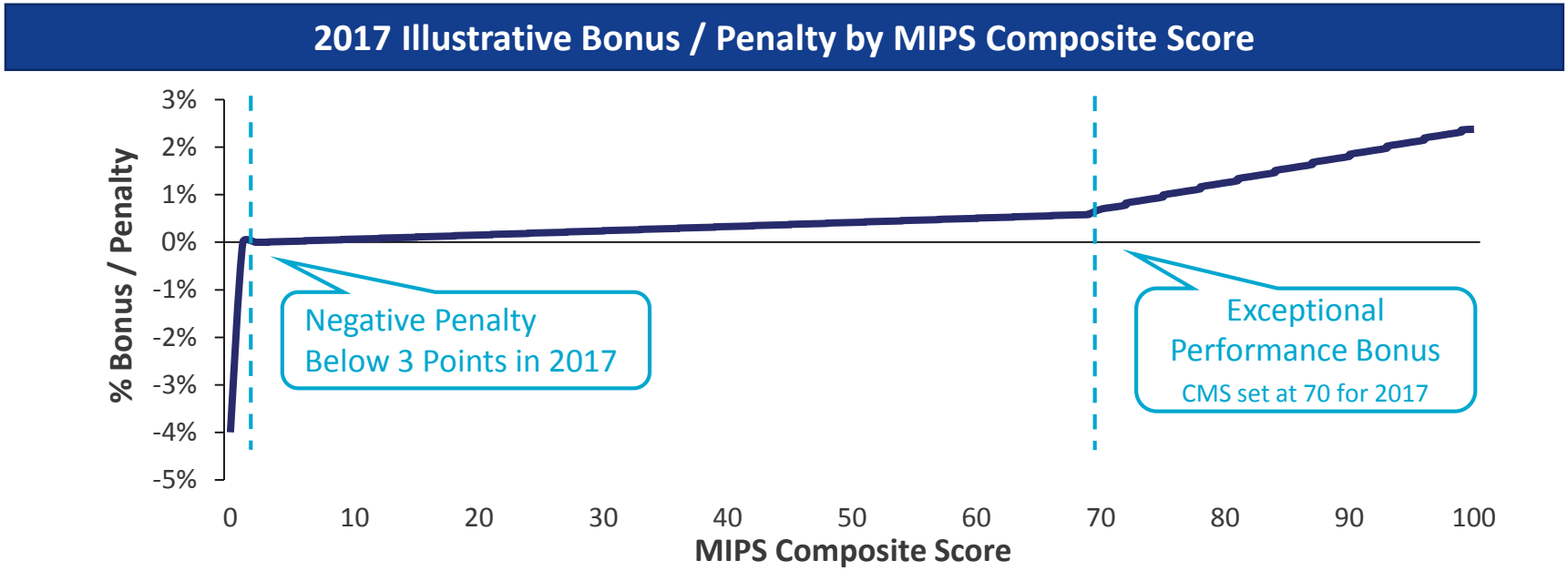
2017 Is a Transitional Year

2017 offers a **"pick your pace" program** characterized by:

- Shorter reporting period requirements
- Lower threshold to avoid MIPS penalty

CMS estimates **~95% of MIPS participants will avoid penalty in 2017**. Due to budget neutrality, CMS anticipates **lower bonuses for participants above the threshold**



Note: Graph is for illustrative purposes only and is based on CMS Final Rule.

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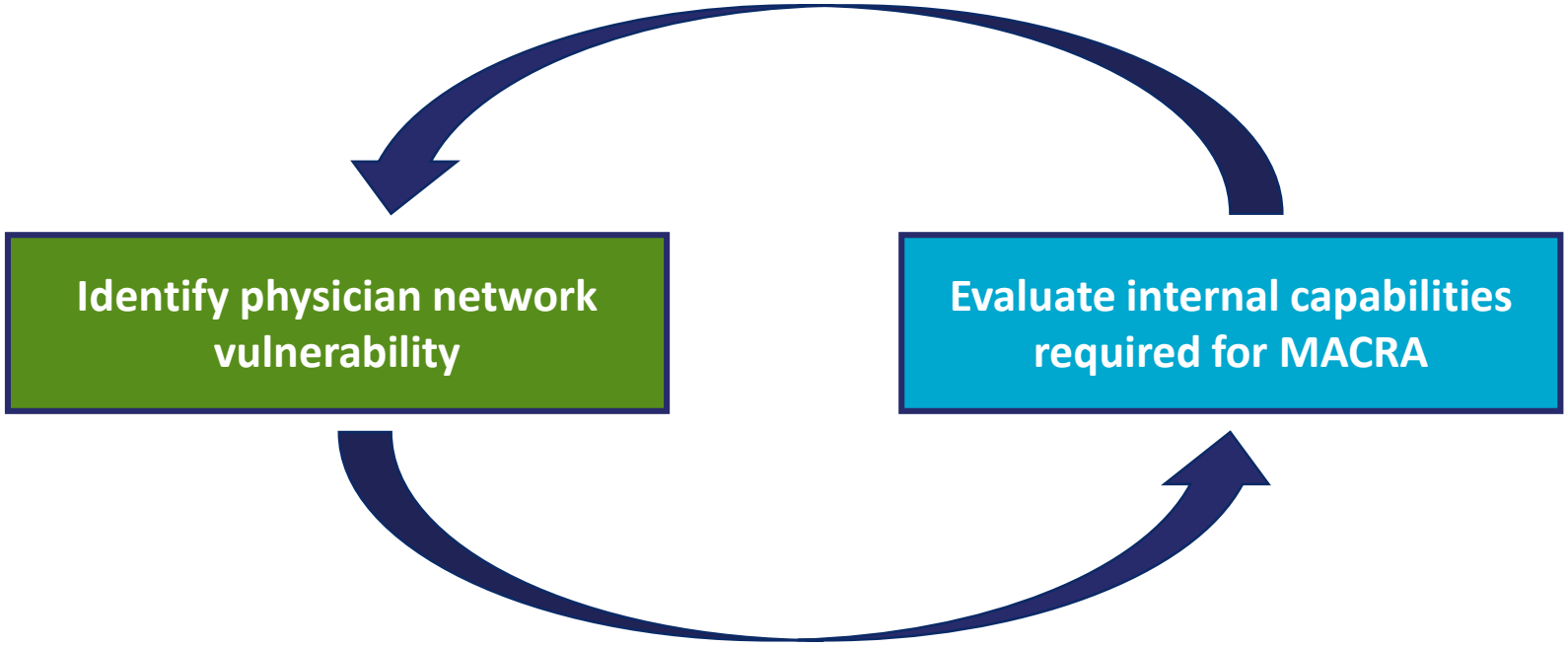
Two Components of Current MACRA Context Evaluation



Both assessments are critical in preparing for MACRA's new value-based environment

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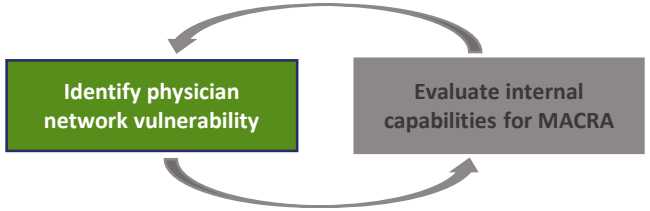
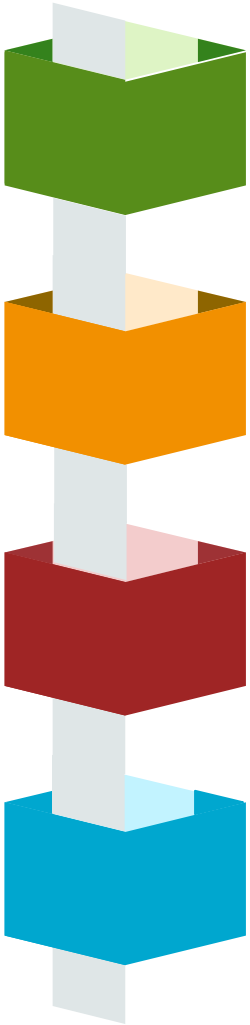
How Vulnerable Is Your Current Physician Network?





Physician Network Makeup

- What percentage of your network is independent? What percentage is employed?
- What is the mix of hospital-/ambulatory-based, primary care/specialty?
- Does your network include non-patient-facing physicians?

Physician Alignment

- What vehicles or structures are used to align your physicians today?
- What incentive/compensation programs are in place to support value-based care?

Competitive Response

- How have competitors in the market integrated their employed and independent physicians?
- What vehicles do they offer local clinicians?

Provider Awareness and Engagement

- How aware are physicians of the impending changes?
- How have they been engaged to prepare?
- How have they been engaged to lead change initiatives?

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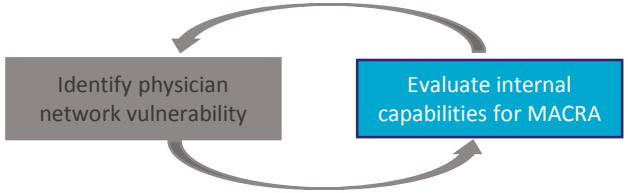
Capabilities Required for MACRA



	Capabilities	Key Questions
Clinical / Operational Components	Clinical Alignment	• How vulnerable is the physician network? • How aligned are the physicians (employed and independents)? • What structures are currently in place to improve alignment (e.g., CIN, ACO models)?
	Care Management	• What formal care management programs are in place to tackle unwarranted clinical variation? • How are providers developing and implementing appropriate protocols and pathways to standardize performance?
	Clinical Documentation	• What CDI compliance programs are in place today to ensure accurate reporting?
	Incentive and Compensation Model	• How much of current physician compensation is tied to quality, access, and resource-use metrics?

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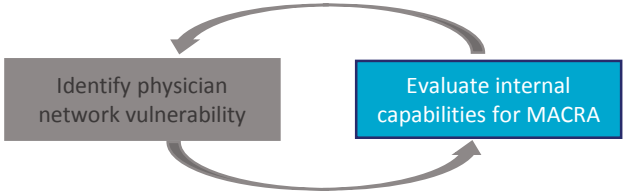
Capabilities Required for MACRA



	Capabilities	Key Questions
Infrastructure	**Technology and Analytics**	• Have you participated in Meaningful Use (MU)? • What are the HIE/information exchange capabilities across the network? • How patient-friendly is the current IT platform? • How secure is the IT platform today?
	Reporting/ Compliance	• What services are currently offered to clinicians for reporting requirements? • What is the level of experience with PQRS and MU reporting? • How are QRUR (Quality Resource Utilization Report) reports used today?

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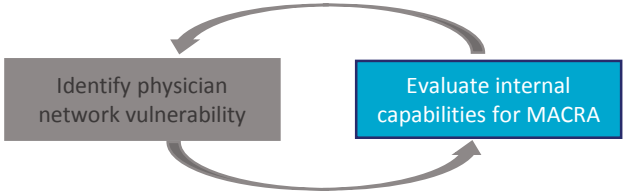
Capabilities Required for MACRA



	Capabilities	Key Questions
Leadership	**Organization and Physician Leadership**	• Has the organization developed a process to identify the optimal MACRA path? • How has the organization involved and engaged physician leaders in the selection of this path?
	Provider Engagement	• What types of care improvement and value-based programs are offered today? • What is the level of current physician participation in these programs? • What process is in place to educate providers on the MACRA Final Rule?

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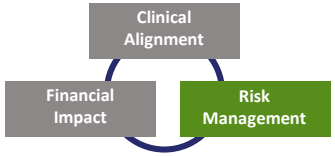
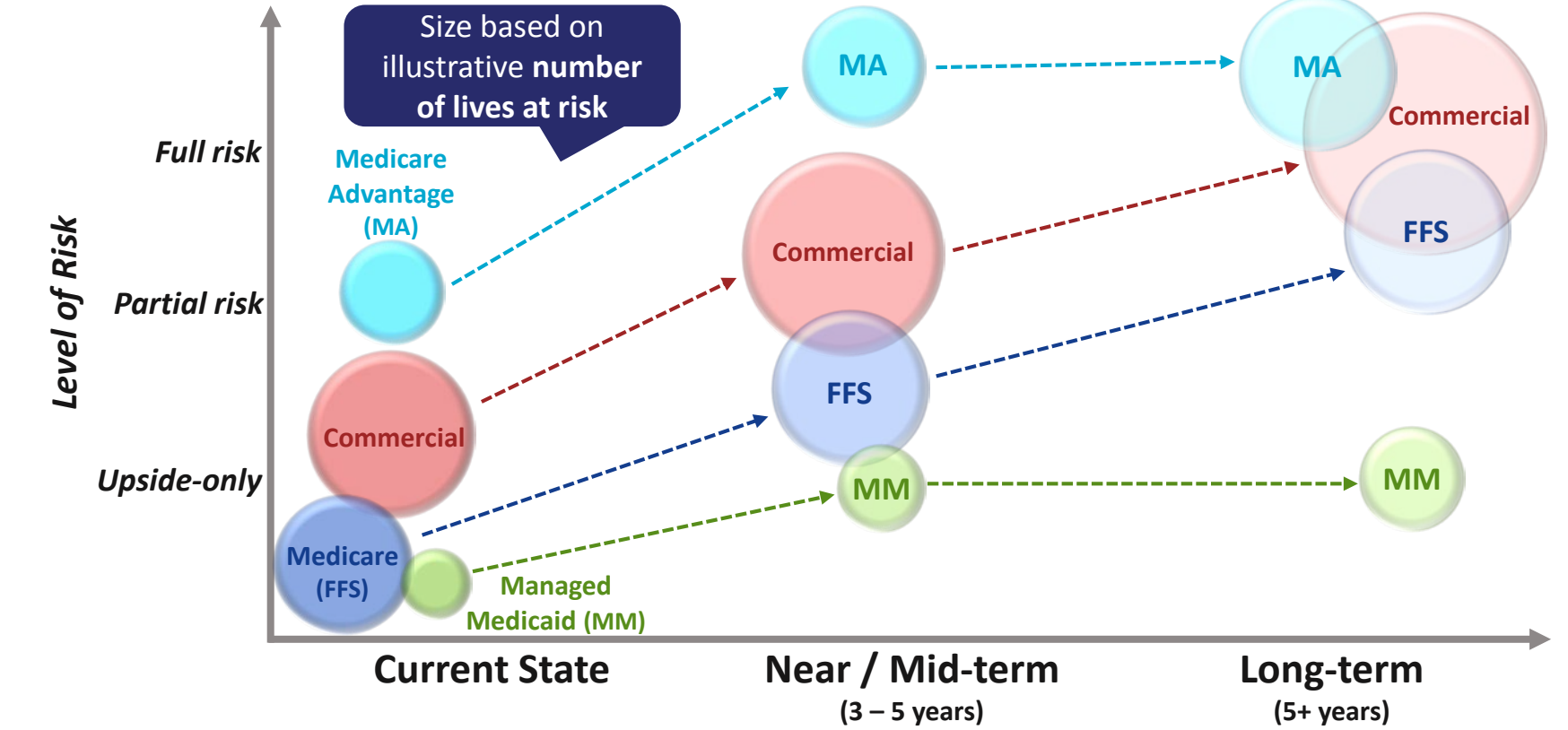
Organizational Risk Glide Path Across Products Will Need to Be Integrated into the MACRA Strategy



Illustrative Risk Glide Path Across Payer Types



The level of risk taken across public and private products can influence your long-term MACRA strategy, e.g., All-Payer Combination vs. ACOs, etc.

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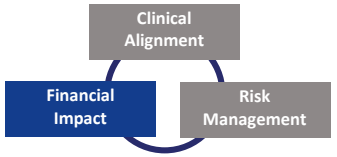
Financial Impact of MACRA



Potential Financial Benefits

Direct Benefits

- Enhanced provider Part B revenue

Indirect Benefits

- Improved total cost of care/efficiency performance
- Larger footprint and patient panels

Potential Financial Costs/Investments

Direct Costs

- Potential financial penalties/losses
- Investment costs for capabilities and competencies
- Clinician acquisition and alignment costs

Indirect Costs

- Downstream lost revenue related to network leakage and/or providers aligning with alternative systems or networks

Organizational leaders will need to quantify these impacts across a range of scenarios.

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The Spectrum of Support Services Ranges From Traditional to "Evolving" Services Required for Success in Value-Based Care

Traditional → **Evolving**

Practice Management

Practice Management
- Operations Contracts
- Recruitment
- Customer Service

Graduate Medical Education

Staff Development and Training

Management Services

Revenue Cycle

Finance/Accounting/Billing

Supply Chain/Procurement

Human Resources

Legal

Infrastructure
- Telecom, information systems
- Property management
- Marketing / communication
- Maintenance, housekeeping, etc.

IT / Clinical Systems & Data Intelligence
- ICD-10, MU, connectivity, etc.
- Data analysis and tracking, outcome measures, etc.

Medical Management

Quality Services
- Reporting and monitoring
- Clinical pathways standardization

Medical Management
- Utilization management
- Referral management
- Case management/discharge planning

Clinical Operations
- Pharmacy
- Laboratory Services
- Radiology

Managed Care Services

Managed Care
- Payer relationships
- Risk contracting
- Risk distribution mechanisms
- Quality and performance incentives

Advanced APMs (and any "full risk" model) will require a greater emphasis on such services

Not all services need to be developed by your organization.
Identify the best build/buy/partner options for your provider network.

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Advanced APM Model: What Does Financial Risk Mean?

Advanced APM Model For Performance Year 2017 & 2018	All-Payer Combination Option For Performance Year 2019+

Financial Risk Standards for Advanced APM

If actual spend > expected spend, the APM Entity will need to:

1. **Withhold** payment for services
2. **Reduce** payment rates
3. **Owe** payment to CMS (or relevant payer)

How Much Risk? More than "Nominal"[1]

For Performance Years 2017 and 2018, at least:

- **8%** of the estimated average total Parts A & B revenue; or
- **3%** of the expected expenditures for which an APM is responsible under the APM

How Much Risk? More than "Nominal"[2]

For Performance Periods 2019+, All-Payer Combination must include:

- Marginal Risk Rate >= **30%**
- Total Potential Risk >= **3%**
- Minimum Loss Rate <= **4%**

1) Full capitation arrangement meets the Advanced APM financial risk criterion.
2) CMS indicates the possibility for a lower total potential risk threshold, but rule is subject to change by 2019. (CMS Final Rule, page 1780). Current regulatory language vacillates between 3-4% risk standard in current form of Final Rule.

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Concluding Remarks

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Concluding Comments

- The healthcare marketplace is experiencing dramatic change
- A paradigm shift is occurring in the payer space
- Every stakeholder will be impacted
- Providers must respond proactively to meet the challenges of a changing market
- Competing on value will be required
- Preparing for value/risk-based contracts will require planning, new skills, and a different and possibly phased approach
- Physician involvement and leadership is essential
- Socialization of contract importance needs to occur across the organization

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Appendices

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Value-Based Capability by Type of Contract

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Operational Considerations

Category	Issue	FFS	FFS +	P4P	Case Rates	Partial Risk	Full Risk	Health Plan
Contracting	• Correct contracting resources	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	• Existing and new payer relationships	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	• Administration of contract terms/capability	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	• DOFR	N/A	N/A	N/A	Maybe	Yes	Yes	Yes
	• Network Depth	N/A	N/A	N/A	Maybe	Yes	Yes	Yes
Governance	• Downstream provider management	Maybe (CI or ACO)	Maybe (CI or ACO)	Maybe (CI or ACO)	Yes	Yes	Yes	Yes
	• Clear delineation of roles/responsibilities across all stakeholders	Maybe	Maybe	Maybe	Yes	Yes	Yes	Yes
Data Infrastructure, IT and Billing	• Bidirectional data flow necessity	Maybe (CI or ACO)	Maybe (CI or ACO)	Maybe (CI or ACO)	Yes	Yes	Yes	Yes
	• Business intelligence capabilities	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	• Reporting							
	• Accreditation and permits							

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Financial Considerations

Category	Issue	FFS	FFS +	P4P	Case Rates	Partial Risk	Full Risk	Health Plan
Capital Resources for Infrastructure		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Regulatory Reserves	• State • Insurer	No No	No No	No No	No No	Maybe Maybe	Maybe Maybe	Yes N/A
Access to Capital		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Financial Reporting	• P&L • Statutory	Yes	Yes	Yes	Yes	Yes	Yes	Yes Yes
Unit Costing and Tracking	• All - Inpatient and Outpatient • Baseline/Ongoing Unit Cost and Volume • Timely unit costing and tracking to respond to high cost and outliers	No No No	Maybe Maybe Yes	Maybe Maybe Yes	Yes Yes Yes	Yes Yes Yes	Yes Yes Yes	Yes Yes Yes
Actuarial Assessment	• Risk versus Panel Size • Panel Selection • Analysis of Up/Down Reimbursement • Benefit Design • Stop Loss/Reinsurance • Competitive Pricing	No No No No No ?	No No Yes No No ?	No No Yes No No ?	No Yes Yes No Maybe ?	Maybe No Yes No Yes ?	Yes Maybe Yes No Yes ?	Yes Yes Yes Yes Yes yes

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Legal Considerations

Category	Issue	FFS	FFS +	P4P	Case Rates	Partial Risk	Full Risk	Health Plan
General	• Does acceptance of risk contradict charitable purpose	N/A	N/A	Maybe	Yes	Yes	Yes	Yes
	• Physician incentive plan regulations related to risk	N/A	Maybe	Yes	Yes	Yes	Yes	Yes
	• Regulatory review of anti-kickback, Stark, state	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	• Legal entity structure and risk mitigation	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Human Capital	• Existing staff expertise and availability	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	• New skills acquisition and dedicated staff/resources	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pre-contracting Investments	Comprehensive gap analysis and corresponding business and capital plan development	Maybe (CI or ACO)	Maybe (CI or ACO)	Maybe (CI or ACO)	Yes	Yes	Yes	Yes

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MACRA

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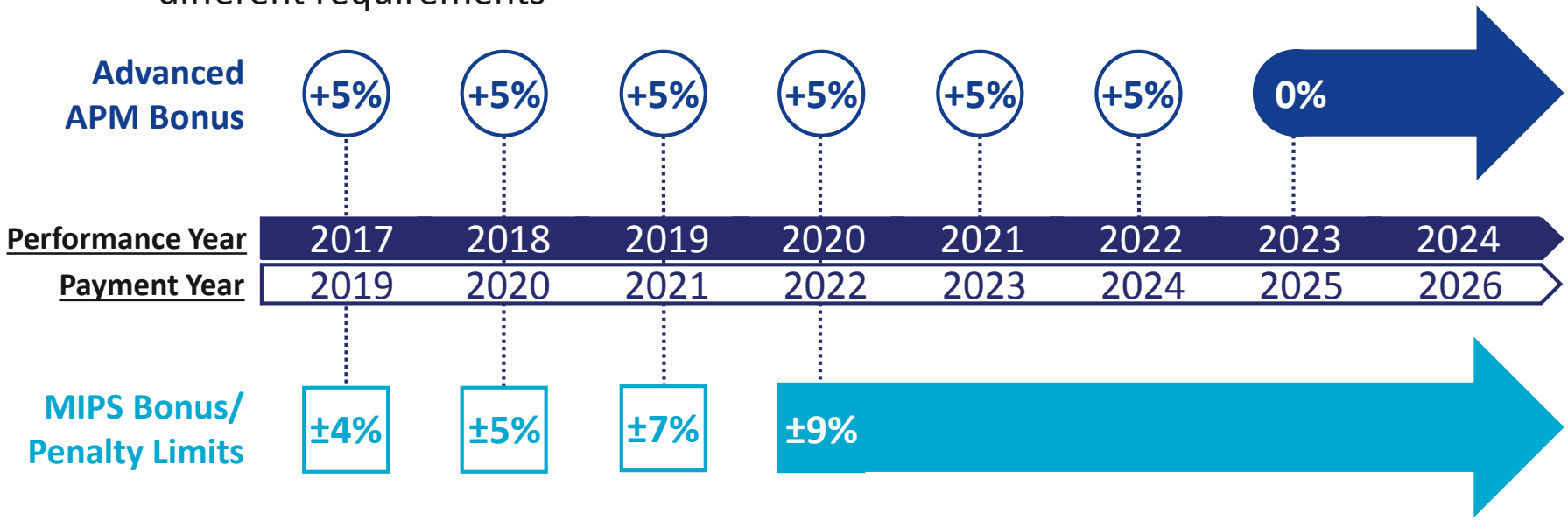
The MACRA Timeline

Clinicians must move quickly toward one of the two tracks – both MIPS and Advanced APMs begin on January 1, 2017

- 2017 and 2018 performance years are designated as "transitional" periods with different requirements



Note: In 2017, both MIPS-eligible clinicians and Advanced APMs receive a 0.5% fee schedule increase. In payment years 2026+, MIPS-eligible clinicians receive a 0.25% fee schedule increase annually, while Advanced APMs receive a 0.75% increase annually.
Source: Centers for Medicare & Medicaid Services : www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

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With the Relaxed Standards, CMS Estimates 48% of Medicare Part B Clinicians Will Be Exempt from MACRA in 2017

Medicare Part B Clinicians Excluded from MACRA in 2017

Reason for Exclusion from MACRA	Medicare Clinicians (TIN/NPIs) Excluded	% of Clinicians Billing Medicare Part B (1.4 Million Clinicians)
Newly Enrolled Clinicians	85K	6%
Low-Volume Clinicians[1]	384K	28%
Ineligible Clinician Types[2]	199K	14%
Total Excluded from MACRA in 2017	**668K**	**48%**

Of the clinicians who will participate in MACRA in 2017, CMS predicts:

10% - 17% **will qualify for the Advanced APM track (70K – 90K)**

The remaining will fall into the MIPS track (592K – 642K)

1) The low-volume threshold includes clinicians billing Medicare Part B for up to $30,000 *or* providing care for up to 100 patients in one year.
2) Ineligible clinicians are all clinicians billing under Medicare Part B who are not physicians, physician assistants, nurse practitioners, clinical nurse specialists, or clinical nurse anesthetists (or a group that includes such clinicians).

Source: CMS Final Rule at https://qpp.cms.gov/docs/CMS-5517-FC.pdf, page 1,952 (non-scoring model CMS projections).

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Advanced APM Model: Current Options

Current Models for 2017+ Performance Periods

1. Medicare Shared Savings Program Track 2
2. Medicare Shared Savings Program Track 3
3. Next-Generation ACO
4. Comprehensive Primary Care Plus[1]
5. Comprehensive ESRD Care Model, Large Dialysis Organization (LDO)
6. Comprehensive ESRD Care Model, non- LDO[2]
7. Oncology Care Model, two-sided risk arrangement
8. Comprehensive Care for Joint Replacement (CJR – Track 1 CEHRT)[3]

or

Medical Home Model (MHM)[4]

1. CPC+ is a national advanced primary care medical home model specifically highlighted as qualifying by CMS as of October 25, 2016.
2. It is anticipated that the non-LDO qualification will only include the two-sided risk model.
3. Track 1 CJR eligibility announced 12/20/16 by CMS for 2017, when CJR participants will begin to take downside risk
4. Medical Home Models have additional requirements, such as primary care focus, empanelment approach, financial risk thresholds, as well as other value-based elements. Starting in 2018, only Medical Home Models with 50 or fewer eligible clinicians qualify.

Note: Vermont Medicare ACO Initiative also classified as Advanced APM (as part of Vermont All-Payer ACO Model)

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Evaluating Strategic Options: Summary Considerations

How **fragmented is the local provider market**? What are your **best vehicles to increase alignment and integration**?

How quickly can your organization progress down **its risk-glide path**? How does this compare to local market **competitors moving towards value-based care**?

What **infrastructure gaps must be addressed** to support your MACRA strategy? What technology, reporting, and analytic capabilities are in place today?

What other **local community factors** can affect the timing and direction of your MACRA strategy?

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Modeling MIPS Revenue Impact

Provider reimbursement depends both on **objective performance** and **relative score** compared to all MIPS participants

Four main factors affect the MIPS bonus/penalty:

Relative performance to MIPS peers
Quality, Resource Use, and the composite score are benchmarked against peer performance

APM eligibility
MIPS APMs receive preferential scoring and may be better equipped to compete for bonuses

Exceptional performance bonus
Additional high performer incentive of up to +10% of Part B revenue

Budget neutrality factor
Bonus multiplier of 0x to 3x, determined by CMS to balance penalties and bonuses annually

Source: CMS Final Rule at https://qpp.cms.gov/docs/CMS-5517-FC.pdf.

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