How the law affects the industry, your organization and your future

There is little doubt that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes sweeping changes to how Medicare pays physicians and other clinicians for the services they provide. More than simply addressing physician payments, the law aims to dramatically improve patient outcomes and reduce health costs by rewarding medical professionals for the overall quality of care they provide, rather than the number of services and procedures they perform.

Passed by large majorities in both houses of Congress, MACRA repeals the Medicare physician sustainable growth rate (SGR) formula, largely unpopular among doctors because of 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 the Centers for Medicare and Medicaid Services (CMS) for more than a decade — that is, moving the majority of fee-for-service payments to a system based on value and quality of care, and in the process, accelerating health care transformation in the United States.

The new payment approach — which CMS calls its Quality Payment Program — will base compensation to providers on patient health outcomes, activities that improve their clinical practices, efficient use of medical resources, and the meaningful use of certified Electronic Health Records (EHRs). Doctors will be paid either under the new Merit-based Incentive Payment System or based on their participation in and adoption of Advanced Alternative Payment Models (APMs). CMS will offer incentives for

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clinicians participating in Advanced APMs who exceed goals tied to patient outcomes and population health. While the MACRA provisions offer the potential for improved patient health and more stable updates to the Medicare physician fee schedule payment rates, a larger percentage of physician revenue will be put at risk.

Further, while there is federal momentum for this shift to value-based payments, it is hard to predict what will happen under the new administration. While it’s too early to tell how much the implementation of MACRA may change, policy makers on both sides of the political spectrum have agreed that value-based payment in general is a must if the U.S. is to contain health care cost growth. Thus, while full implementation of MACRA may be slowed as new health care policy takes shape, the overall direction of fostering collaboration to improve care delivery and population health is likely to continue.

For now, MACRA offers strategic and financial opportunities for most health care organizations. Specifically, providers should begin to take the steps that will provide long-term stability. These steps could include:

• Developing a glide path toward Advanced APMs: Take steps to develop provider and payer partnerships, data management and analytics capabilities, and effective risk modeling
• Innovating care management: Create or evolve care transition programs, care management strategies, and collaborative models for complex patients
• Managing unit costs: Apply evidence-based practice and proactive clinical management techniques, especially for high-risk patients
• Integrating technology, data and analytics
• Using MACRA as a catalyst for growth: Expand patient panels and volume over time to achieve a scale that can be leveraged into future Advanced APMs

To make the most of their chances, health care providers and payers must acquire the capabilities to comply with the law as it takes hold and exposes them to greater risk. Finding the best way to comply with MACRA will afford organizations the stability and freedom to gain market share in the new health care economy. This paper will discuss the implications of MACRA, gaps that organizations may need to close and how all stakeholders can work together to make the most of the law.

MACRA, QPP, MIPS and APM: What does it all mean?

Although MACRA’s provisions focus on Medicare physician reimbursement, the law has implications for the entire health care industry. Physicians, facilities, health systems and payers will need to work together to determine the best course of action. How should they adjust their short- and long-term strategies in response to MACRA’s new requirements? How are competitors reacting to MACRA and what effect will this have on their organization? What are the near-term tactical decisions required to be successful?

To understand MACRA’s reach, we must understand what it does. The law authorized the Quality Payment Program (QPP) for providers and offers two pathways: Merit-based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs).

MIPS replaces several CMS measurement protocols with 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.

Some questions to ask regarding MACRA:

• Should you adjust your short-term and long-term strategies as you respond to the law’s new requirements?
• How are your competitors reacting to MACRA, and what effect will this have on your organization?
• What are the near-term tactical decisions you need to make to be successful?
Advanced APMs 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 offering not only the potential for increased payment for improving quality and containing costs, but also potential downside penalties for failing to achieve financial and quality targets.

CMS has declared 2017 a transition year for physicians, offering them five participation options. Physician participation and performance in 2017 will be reflected in their 2019 payments:

- **MIPS: Test the Quality Payment Program** — Eligible providers submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity); this avoids a negative payment adjustment for 2019 but does not qualify physicians for additional bonus payments

- **MIPS: Participate for part of the calendar year** — Physicians submit QPP information for at least 90 consecutive days of 2017; this keeps payment neutral or earns small positive adjustment for 2019 (these participants are also eligible for an exceptional performer bonus)

- **MIPS: Participate for the full calendar year** — Physicians submit QPP information for the full 2017 calendar year; this will earn them a moderate positive payment adjustment for 2019 (these participants are more likely to earn an exceptional performer bonus)

- **Advanced APM: Physicians participate in an Advanced APM in 2017** — If a physician has a large enough percentage of Medicare payments or patients to meet the required thresholds, then the physician will qualify for a 5 percent lump-sum incentive payment in 2019

- **Don’t participate** — Does not send any 2017 data to Medicare; physicians are penalized with a 4 percent negative payment adjustment in 2019

CMS anticipates that about half of the physicians who treat Medicare patients will meet the participation standards of the QPP during the 2017 performance year. That means qualifying physicians will be putting their revenue at risk based on cost and quality measures. As a result, the following developments will likely follow QPP implementation:

*More Medicare-specific, payer ACOs/Advanced APMs will emerge.* Financial models point to Advanced APMs being the most attractive for physicians. Because APMs often involve hospitals, health systems and payers, as well as physicians, the QPP will be a catalyst for bringing more of the health care industry under the value-based-care umbrella.

Over the next few years, the market is likely to see more “provider collaboratives” developing risk-bearing ACO models to qualify for Advanced APM payments by 2020. Collaboratives could join Medicare programs such as MSSP Track 1+, Track 2, Track 3 or the Next Generation ACO model. In addition, the industry will see CMS develop more pathways to Advanced APMs.

*Health system/physician alignment and collaboration will continue to grow.* Physicians, especially those in small-to-midsize practices, will look to hospitals and health systems to help them with the QPP. Smaller practices typically don’t have the resources to support the people, processes and technology needed to create or participate in Advanced APMs or to be successful under the various paths of MIPS.
Payer support and collaboration are expected to increase. Because providers in Advanced APMs require timely quality and cost data to be successful, commercial payers are looking to become better partners, including improving the sharing of claims data and other intelligence to help provider organizations achieve their goals. Timely and accurate data is a key component of value-based care, because data is essential to collaboration.

In a similar vein, providers will need payers to work with them to define measurable outcomes. It can be difficult to gain consensus when choosing outcome measures that are credible to all stakeholders and will make the greatest difference. For example, readmissions seem like an outcome that is easy to define and measure. But for some tertiary care hospitals with high readmission rates, the more important outcome is their ability to keep patients alive who may not have survived had they been treated at a typical community hospital.

Consolidation will likely continue. Given its operational and strategic complexities, the QPP will be burdensome on independent and small practices that see a high volume of Medicare patients. While some will do their best to succeed under the QPP, others will avoid altogether the investment of time and money needed to participate and will instead integrate their practice into a larger organization that can support these requirements.

Medicare Advantage (MA) plans may see greater physician engagement. Medicare Advantage may serve as a haven from MACRA. That’s because MA doesn’t fall under the QPP. CMS doesn’t adjudicate MA claims (physicians are paid by MA contractors, not directly by Medicare), so CMS can’t measure physician performance. Therefore, physicians who see a high percentage of Medicare Advantage patients may not meet the minimum standards for participation in the QPP. Physicians who are hoping to avoid MIPS reporting requirements may shift their focus to MA.

CMS is setting the standard in value-based reimbursement with its investment in quality reporting programs, its development of alternative payment models and its willingness to promote provider success. With CMS taking the lead, commercial payers are following.

For providers, that means the QPP is likely to be the tip of the iceberg. While MIPS may seem to be a reporting regimen, it may also reasonably be viewed as a training ground for the reporting and collaboration required under Advanced APMs. MIPS may be the easiest and most lucrative option for high-performing groups in the short term, but the direction of Medicare is clear: the federal provider of health insurance for senior citizens is increasingly about risk and reward, with Advanced APMs offering the greatest odds for long-term financial success.
The MACRA pathway to alternative payment models

An Optum analysis of how qualified physicians will likely engage with the QPP during the 2017 transition revealed that most will end up in the 2019 payment year within MIPS with a fee schedule adjustment between 0 percent and 1 percent. Some clinicians may achieve the exceptional performer bonus, and approximately 9 percent of MACRA-eligible clinicians will qualify under the Advanced APM umbrella for the 5 percent bonus payment. See Figure 1.

Assuming QPP participation in 2018, Optum analysis predicts that an equal distribution of clinicians will receive positive and negative fee schedule adjustments under MIPS in the 2020 payment year. A small percentage will receive the exceptional performer bonus. Expect to see more Advanced APM-qualified clinicians receiving the 5 percent bonus. See Figure 2.
As QPP physician reimbursement impacts become more apparent, incentives point to additional providers and group practices seeking to qualify for Advanced APM status. In the 2024 payment year, the market will likely see about half of providers in the QPP qualify for Advanced APM status and thus receive performance bonuses in the 5 percent range. The other half will remain in MIPS, either enduring the performance penalties — up to a 9 percent negative adjustment — or reaping the performance rewards. See Figure 3.
An alternate 2024 possibility is illustrated in Figure 4, where there will likely be a smaller proportion of clinicians at the 5 percent bonus level. This scenario assumes far fewer organizations qualifying for Advanced APM status, due to either the inability of market participants to meet CMS requirements or an aversion to downside risk. In either case, the number of Advanced APMs would remain stagnant while more MIPS providers would experience equal representation for negative or positive performance.

![Figure 4](image_url)

**Funneling providers to Advanced APMs**

Providers have seen Medicare’s direction and have taken action. One such provider is Wilmington Health, a 170-physician multi-specialty group in Wilmington, North Carolina. Seven years ago, the group determined that fee-for-service revenues would continue to shrink while revenue based on shared risk would become more prevalent. The group developed internal capabilities focused on population health, creating a culture of transparency related to quality and building a lean management system. Wilmington Health has been participating in the Medicare Shared Savings Program since 2013.

Due to its preparation, Wilmington Health has positioned itself to accept downside risk as an Advanced APM or to compete for bonuses in MIPS.
“Our goal with the QPP was to be able to pick our path, and that is what we have done,” said Jeff James, CEO of Wilmington Health. The group applied for and was accepted into the Next Generation ACO model, which is an Advanced APM. However, for 2017, it decided to vie for MIPS and try for a maximum performance bonus.

“Because we’re prepared for downside risk, we feel very comfortable choosing a riskier model,” James said. “At the same time, we know we can be one of the more high-performing groups within the MIPS program.”

Wilmington leaders recognize, however, that being part of MIPS is risky. Medicare has set up the MIPS payment program to be a zero-sum game (outside of the exceptional performer bonus pool), meaning that providing positive payment adjustments requires taking revenue from other participants via penalties. Providers who choose MIPS can’t predict with certainty whether they will gain or lose revenue, because adjustments will be determined by the relative performance of all organizations in the program. While average fee schedule payments will go up by 0.5 percent per year through 2019, a 4 percent adjustment (positive or negative) will be introduced in 2019, with adjustments upward in later years.

Advanced APMs offer a much more defined path to stable Medicare fee schedules. Whereas MIPS payment disbursements are unpredictable, Advanced APMs are automatically given a 5 percent bonus just for participating. Advanced APMs may also earn upside revenue or suffer downside penalties unrelated to the bonus, based on quality and cost. Optum analysis found that most 2017 MIPS participants should anticipate anywhere from no percentage increase in Medicare revenue to an upper-level revenue increase of approximately 1 percent — much lower than the 5 percent promised to Advanced APMs. See Figure 5.

![Graph](https://optum.com/white-paper/making-the-most-of-macra)

**ADVANCED APM OFFERS MORE PREDICTABLE UPSIDE INCENTIVES**

**MIPS financial impacts**

- 2017: -12%
- 2018: -8%
- 2019: -4%
- 2020: 0%
- 2021: 4%
- 2022: 8%

**AAPM financial impacts**

- 2017: 0%
- 2018: 4%
- 2019: 8%
- 2020: 12%
- 2021: 8%
- 2022: 4%

Figure 5: Revenue possibilities vary widely for MIPS, while Advanced APMs are guaranteed a 5 percent positive payment adjustment. MIPS exceptional performer bonuses — which will be rare — are not included here. “Expected MACRA” assumes 15 percent better performance than average.
CMS has indicated that MACRA will be implemented iteratively, with new provisions introduced in the upcoming years. Reading the tea leaves, we can confidently speculate that those new iterations of the QPP will continue to encourage providers toward Advanced APM structures. For providers who aren’t exempt from MACRA, participating in MIPS should be considered only a short-term solution. Providers should not focus only on MIPS success; they should also position themselves on a glide path toward participation in an Advanced APM.

Mirroring the limited scope of current performance measures, MIPS primarily incentivizes behavior. Physicians will be scored in varying degrees over the next several years on resource use, clinical practice improvement, EHR utilization and quality. The scoring weights will change in the coming years. For example, quality makes up 60 percent of the standard MIPS score in the 2017 reporting period, but it decreases to 50 percent in the 2018 performance year and 30 percent in the 2019 performance year, while resource use increases from 0 percent to 30 percent by 2019. High performers will continue to be eligible for exceptional performer bonuses through the 2024 payment year.

MIPS streamlines three reporting programs — the Physician Quality Reporting System (PQRS), the Value-based Modifier program (VM) and Meaningful Use (MU) — into one. But its reporting demands could still be burdensome. While the health care system seems to be moving toward greater measurement, the measurements are typically in service of something bigger. But MIPS metrics aren’t likely to accelerate the delivery of value-based care.

Additionally, MIPS measurements may be quite punitive. As the program is currently structured, its performance target score resets every year, meaning that past performance will be no guarantee of future success. Physician groups that aren’t improving as fast as their peers will be further disadvantaged in subsequent reporting periods. Because MIPS will generate both winners and losers, it will lead to competition on metrics. That type of structure has inherent limitations, and although MIPS will include a measure of resource use in future years, it won’t necessarily drive down overall cost of care.

Advanced APM requirements are more meaningful. In addition to incentivizing high performance and penalizing poor performance, Advanced APM structures encourage providers to collaborate across the continuum of care, bear financial risk for episodes and populations, and more proactively engage patients.

MIPS has more short-term revenue upside — due to the exceptional performer adjustment — for physician groups that excel at measuring and reporting. But while those groups will receive the lion’s share of MIPS bonuses, they will represent a disproportionately small percentage of MIPS participants. Over the long haul, Advanced APMs are designed to drive the most revenue for physicians, the highest quality of care and the lowest overall cost of care.

MIPS should be a short-term solution for the majority of providers. Strategic organizations will prepare for a glide path like the one shown in Figure 6 to position themselves for sustainable long-term Medicare revenue.
MACRA’s impact will resonate across health care

Of course, MACRA has implications that go beyond revenue. Those implications reach into the very models providers and payers use to conduct business and provide care for patients.

Take hospitals and health systems, for instance. It would be easy for hospitals to dismiss MACRA as a physician problem or for health systems to relegate it to their physician group leadership. But MACRA will change the way physicians practice and the way they refer, which will have a direct impact on hospital admissions. Because physician referrals are critical to a facility’s bottom line, health systems should use the opportunity MACRA gives them to become more valuable partners with physicians and be a connector for all providers across the continuum of care (e.g., ambulatory, acute, post-acute, rehab, etc.).

Many physicians will turn to hospitals for help in complying with whichever payment pathway they choose. Buying physician practices is one path some systems will take to help doctors deal with the QPP. A larger organization can scale its administrative infrastructure, and the providers can focus on clinical improvement.

Systems that aren’t on a path to acquisition have other — and sometimes better — choices. If working with physicians who are content with MIPS, health systems can use their administrative assets to create a managed-services organization that will take care of MIPS reporting and other functions. Providing such an option will give physicians valuable assistance to promote greater loyalty and establish or strengthen referral relationships.
For physicians who want to explore an Advanced APM model, many will look to hospitals and health systems as collaborators, and to act as partners in risk management. Setting up an Advanced APM takes capital and capabilities that many physician practices don’t have. Facilities, on the other hand, may possess some of the functions necessary for APM success:

- Population health management (PHM) applications that include clinical and claims data and sophisticated analytics
- High-risk care management programs
- Tools that enable clinical integration and collaboration across care settings, including settings external to the system
- Community outreach programs

Developing new relationships with new physician groups is important, because MACRA — and value-based care in general — creates further, implicit emphasis on growth. One of the ways value-based models keep costs down is by structuring care to prevent hospitalizations. Under Advanced APM models, reducing the number of patients in hospitals is rewarded, since more “heads in beds” can lead to higher overall costs and could expose provider organizations to downside losses. The golden key in this equation is for facilities to increase the denominator of the patients for whom they are responsible. By doing that, hospitals can backfill those empty beds and still manage to keep per-capita spending lower. By expanding physician group relationships, hospitals will be drawing referrals from a broader space, which also leads to new relationships with payers.

Physicians, of course, are at the center of MACRA. But the law has put many of them in a difficult place. Since the ACA was passed, value-based care has been positioned as a good idea rather than a requirement. But MACRA put the weight of law behind value-based care for most physicians. This will put care delivery transformation on the fast track. But like most transformations, going from volume to value won’t be painless.

For physicians, the pain associated with MACRA stems from more than just transforming care patterns; it hits them in the pocketbook. MACRA, like the SGR before it, doesn’t take inflation into consideration. While its effects aren’t nearly what the SGR’s could have been, Medicare fee-for-service revenues in inflation-adjusted dollars will still decrease for most eligible providers. So regardless of which path physicians choose, the revenues for many may not keep up with inflation. Physicians will thus lose money long term, all else being equal. That’s not much of a choice.

But while choices are limited, they still exist. Some physicians may limit the number of fee-for-service beneficiaries they see, replacing those patients with either Medicare Advantage or commercial patients.

Others will join a larger practice or a health system. While that won’t absolve them from the reporting requirements or from the need to transform care delivery, it can bring to bear the resources that larger organizations typically employ. Some organizations will provide physicians with a pathway to Advanced APMs, ensuring that revenues can stay more constant and putting physicians on a fast track to value.

Finally, physicians can join an Advanced APM or start their own. While independent practitioners will not have the resources to spearhead their own APM, they can partner with organizations that can invest. For larger providers who have more mature capabilities around value — such as reporting experience and participation in risk programs — they are more likely to be successful in an Advanced APM.
Payers find themselves in a position similar to health systems. While they are not directly affected by MACRA, the law’s effect will cast a shadow on health plans if they don’t proactively respond. Payers, with their administrative expertise, could help providers by offering measurement and payment frameworks that reinforce and promote the development of Advanced APMs.

It’s possible that the change in administrations in 2017 could slow payers’ interest in aligning with MACRA. But MACRA represents an opportunity for payers. Working with providers on MACRA gives health plans a platform to accomplish other important goals: capturing data for risk adjustment; promoting greater HEDIS and STARS performance; and further spreading the cost of health care management capabilities.

MACRA may also open the door for more payers to partner with a high-performing integrated health system. Such partnerships have resulted in focused, cost-effective health plans that feature the system’s facilities and physicians. Many larger payers are already using this strategy, but systems may look at more of these arrangements as a path to creating an Advanced APM.

The market is ripe for more innovations around Advanced APMs. Today’s APMs are typically total-cost-of-care contracts built on a fee-for-service foundation. But future APMs could focus on chronic conditions that are prevalent within certain communities. Using data, clinical analytics and predictive modeling, payers and providers could work together to improve the health of a sub-population and dramatically drive down the cost of care.

Another payer innovation may be to master the art of mimicry. Most payers are concerned about differentiation. Whether it’s their network management philosophy, their claims process, or some other key metric their purchasers or providers care about, health plans are always looking for a way to stand out. MACRA may give them another opportunity to do that by aligning with CMS in terms of the QPP. If CMS is setting a precedent with the QPP, health plans can build networks around the same set of expectations. Such networks will give physicians fewer payer requirements to juggle and ease their compliance burden — something physician practices will appreciate.

**The QPP should have providers thinking beyond 2017**

With 2017 being a transitional year under the QPP, physicians, hospitals, health systems and payers should consider their 2017 course of action to be transitional as well. Decisions made today will have long-term consequences.

For example, some providers will choose the “do nothing” path. In fact, CMS anticipates that about 10 percent of physicians will take a business-as-usual approach and not report anything under MIPS. If they do that, nothing will change over the next two years. But in the 2019 payment year (which is based on the 2017 performance year), their Medicare fee schedule will decrease by 4 percent. In addition, their scores under MIPS will be made public. Having scores of zero in MIPS related to quality performance and clinical practice improvement may turn off some fee-for-service beneficiaries. They could also hurt the physician’s long-term prospects for network inclusion. Payers look at quality ratings, too. They will be wary about associating with physicians who have poor rankings.

Partially participating in MIPS, rather than outright ignoring the QPP, is a better option for many providers in the 2017 performance year. Providers can test their ability to adhere to the MIPS reporting regime, either by submitting one quality measure or one improvement activity or by participating for 90 days. The payment adjustments rise from neutral to moderate depending on the level of participation, but it’s better than losing 4 percent for doing nothing.
Modeling performance under MIPS is difficult, since performance bonuses in MIPS will be based not only on how well a provider performs but also on how they compare to others. Such information isn’t readily available. Plus, the performance bonus bar is likely to rise as the program matures and providers improve. As the performance target resets each year, if a provider doesn’t improve as fast as others, this could result in lower MIPS adjustments or penalties in later years.

Uncertainty around MIPS payment adjustments and the relatively small adjustments that most providers will receive should convince providers that MIPS is not a long-term solution. But MIPS is also the path of least resistance for physicians who are already reporting in PQRS, VM and MU. Because there is more money at stake, metric selection becomes more important. But once providers make their selections, they can simply manage to those metrics. In the short run, these physicians may not consider Advanced APMs to be the most efficient use of their time. But that attitude will shift down the road, especially as MIPS performance scores improve and it becomes more difficult to achieve bonuses. For most physicians affected by the QPP, MIPS should be just a starting point or an interim strategy. In the long run, Advanced APMs are a more stable, progressive and reinforcing option.

Advanced APMs reward ongoing, incremental improvement year over year in a way that MIPS doesn’t. To succeed, Advanced APM models require that providers establish healthy protocols and reduce variation in care. MIPS, on the other hand, does not reinforce all the behaviors that other payers are expecting of providers.

Still, many provider organizations are ambivalent toward APMs. Alternative payment models are a work in progress. Most Track 1 MSSPs have not qualified for shared savings. More than 70 percent of the original Pioneer ACO model participants have dropped out of the program. APMs have room for improvement in part because they are still viewed and operated as largely bilateral arrangements — physician-to-hospital, payer-to-provider, etc. Sustainable APMs will involve multiple payer arrangements, and will require multi-lateral provider collaboration. That means hospitals, physician groups, post-acute care, laboratories, pharmacies and community health organizations need to have open dialogue in terms of data sharing, best practices, quality improvement and accountability.

To understand the QPP’s impact and develop the best short- and long-term strategies, practices need to consider their ability to manage risk and prioritize investments over the next five years.

For most organizations, MIPS will be the starting point. But determining how they will transition to an Advanced APM needs to happen soon. Staying in MIPS will present increasing risk exposure after the 2017 “transitional year.” Becoming an Advanced APM requires cultural and operational changes that will tie clinical operations to quality of outcomes and the ability to manage total cost of care. This could include embracing telemedicine or some other new enabling technologies. Other changes include implementing risk stratification and providing proactive care to patients at greatest risk for high utilization or poor outcomes. Provider organizations will need to assess their market demographics to know which lines of business they need to emphasize, determine how much risk they can bear based on their current outcomes and utilization, and gauge the readiness of their clinical infrastructure.

Based on this assessment, provider organizations will determine their transition strategy. They will decide the type of Advanced APM they want to become and identify the levers they need to pull to get there. This will require an informed understanding of the direction the health care industry — and their specific market — is taking. Their
strategic decision-making will result in a blueprint for the investments they will make and a roadmap of the paths to innovation they will take. Finally, organizations will need to conduct ongoing maintenance to ensure they are on track in their journey to Advanced APMs, and that exceptions are addressed and risks are mitigated.

Getting from MIPS to Advanced APMs will require sustained effort and specific capabilities. Actuarial and analytics expertise will provide an accurate picture of the financial risks. Experts in value-based care will help providers choose the best paths for a long-term, sustainable solution. Acquiring population health expertise will help them manage the clinical and financial risk over time.

Emphasis in specific areas will help organizations as they prepare to accept both upside and downside risk. As noted earlier, one of CMS’s implicit priorities is incentivizing providers to collaborate across the entire care delivery chain. Most organizations require collaborative relationships to develop and establish the skills, standards and scale necessary to succeed in Advanced APM models. While MIPS can be pursued alone, Advanced APMs require partners that can help each other:

• **Aggressively pursue population health and quality initiatives to boost patient engagement:** Excellence in PHM is the key to excelling in both upside and downside models. Without a high-performing PHM function, providers will be hard-pressed to apply care resources to the patients who need it most. With high-performing PHM capabilities such as care management programs, community outreach programs and quality improvement efforts, patient engagement and outcomes will improve.

• **Focus on improving care delivery and care transitions:** Focusing on care coordination across the continuum of care, from ambulatory to post-acute, will pay dividends. Clinical collaboration across care settings will help establish best practices and information sharing to enable the right care to be performed in the right setting at the right time.

• **Lead the market in cost performance:** In value-based arrangements such as Advanced APMs, driving down unnecessary utilization and improving quality are two sides of the same coin. To qualify for shared savings or succeed in a capitated arrangement, organizations need to concentrate on both quality and costs. Focus on cost improvement by establishing evidence-based practice, driving down variation in care, implementing telemedicine and proactively managing high-risk patients.

• **Widely integrate technology, data, analytics and operational assets:** While having the right technology and assets is important, making the critical outputs from these assets available across multiple organizations will help enable care delivery transformation.

• **Obtain the tools and expertise necessary to enable the transformation:** An initial assessment will help providers understand their current capabilities as well as their current weaknesses regarding value-based transformation. Based on the assessment, providers need a plan for obtaining the necessary people, processes and technology to enable their transformation.

For many providers, this is not business as usual, and blind spots can limit opportunities for improvement. Most providers don’t have the actuarial and financial expertise to help assess and manage QPP risk exposure. But acquiring this type of expertise can...
help organizations predict and manage risk, leading to stronger and more predictable performance results. Experienced actuaries can offer sharper understanding of risk exposure and help develop strategies for managing risk now and in the future.

Many organizations are limited in the data to which they have access, making it difficult to balance care delivery transformation with other priorities. Gaining access to industry benchmarks and integrating data across organizations will help providers evaluate and target where to invest for the best market position and the greatest financial return.

Some providers may be unclear on where and how they need to build out capabilities. Getting an outside perspective on where to concentrate efforts toward building an Advanced APM can give providers the roadmaps and the associated metrics they need to help them acquire and utilize the right capabilities.

**Use MACRA as a catalyst for growth**

To understand the business risks and choose the best QPP path for 2018 and beyond, physician groups need to apply financial models to their data.

A good starting point will be an assessment of their current and future financial position and exposure. Actuaries can review their options and “test drive” them using predictive models. This will help providers understand how various options affect their risk exposure and project financial impacts.

Such an assessment should lead to strategies based on business objectives and opportunities to lead. Providers need a roadmap that includes top priorities for success in mitigating risk and maximizing performance. They also need a view of their marketplace position from the outside in, not just from the inside out. Using benchmarking data, they can pinpoint and validate where they need to invest their resources.

Winning organizations will focus on growth that meets their business needs — growth in patient volume and/or growth in revenues. To maintain a growth focus in today’s regulatory environment, concentrate on the following:

- Define strategies to help you develop and operationalize an Advanced APM in the medium term
- Seek out collaborative relationships with other providers and payers in your market
- Devote sufficient resources to execute against and attain long-term stability in your chosen QPP model
- Take maximum advantage of the 2017 transition year to understand the near-, medium- and long-term implications of MACRA and the QPP

Today, growth hinges on improving health at a lower cost. Better quality and better pricing appeals to payers and patients, and that leads to greater market share. Such an appeal is essential, especially as per-capita payments come under pressure. How organizations respond to MACRA should begin and end with the short- and long-term effects of the law and its implications on viability.

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