MACRA and Medicare Advantage
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Caveats and limitations

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This presentation reflects our combined experience working with provider organizations and health plans. Each organization’s circumstances, beneficiaries, and infrastructure are unique. We present general information about Medicare Advantage and MACRA that is not intended to be a specific actuarial opinion or advice.
Overview

- Background
- MACRA Overview
- MA Synergies: Advanced APMs and QP Status
- Quality Overlap
Key questions

- How will MACRA affect MA plans’ provider payments?
- What synergies exist between MACRA’s quality scoring and the MA Stars quality program?
- How can MA plans help providers achieve Qualifying Participant (QP) status?
- What incentives exist under MACRA for providers to improve risk score coding?
- How are MA plans in the market responding to MACRA?
Background
2015 Medicare expenditures

Sources:
- https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/x8va-z7cu
Current situation

- MA plans have significant flexibility in structuring provider contracts
  - Ability to negotiate contracts
  - Design benefit plans that steer members toward specific providers
- Contracts utilize FFS reimbursement, risk-sharing, and global capitation
  - Mainly FFS reimbursement
  - Increasing movement towards risk-based contracts and capitation
  - MACRA may accelerate this movement
## MACRA timelines

<table>
<thead>
<tr>
<th></th>
<th>Up to 2018</th>
<th>2019</th>
<th>2020-2024</th>
<th>2025</th>
<th>2026+</th>
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<tbody>
<tr>
<td>Medicare Fee</td>
<td>+0.5%</td>
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<td>No fee schedule</td>
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<td>+0.25% (Non QP)</td>
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<tr>
<td>Schedule Updates</td>
<td></td>
<td></td>
<td>increases</td>
<td></td>
<td>+0.75% (QP)</td>
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<td><strong>MIPS Adjustments</strong></td>
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<td>-4% to +12% (2019)</td>
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<td>-9% to +27% (2022+)</td>
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<td>+10% exceptional</td>
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<td>performers</td>
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<td><strong>Advanced APM</strong></td>
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<td>APM Adjustments</td>
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</tr>
<tr>
<td>QP bonus +5%</td>
<td></td>
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<td>QP and Partial QP</td>
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<td>status avoid MIPS</td>
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<td>penalties</td>
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Advanced APMs and QP Status
# Alternative Payment Models (APMs)

<table>
<thead>
<tr>
<th>Medicare APMs</th>
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<tbody>
<tr>
<td><strong>CMS Innovation Center Model</strong> (under section 1115A, other than Health Care</td>
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<tr>
<td>Innovation Award)</td>
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## Advanced APMS

*To be an advanced APM, the APM must meet all three of the following:*

1) **EHR**: The APM must require participants to use certified EHR technology.

2) **Quality**: The APM must provide for payment for covered professional service based on quality measures comparable to those in the quality performance category under MIPS.

3) **Nominal Risk**: Must assume at least “nominal risk.”
Advanced APM specific risk criteria

Revenue-based Standard
>= 8% of avg. est. Med. A/B revenues of Participating APM entities (2017/2018 only)

OR

Benchmark-based Standard
3% of all expenditures for which APM entity is responsible under the APM

Capitation
Full capitation generally qualifies

Advanced APM

Medical Home
Minimum % that entity could owe CMS (2.5% A/B Revenue in 2017)
Qualifying APM Participants
Decision tree – 2021+ All Payer

- Medicare QP threshold met
- All Payer Medicare QP threshold met
- All Payer Non-Medicare QP threshold met
  - QP
    - All Payer PQP thresholds met
      - PQP
      - MIPS EC
      - PQP
      - MIPS EC
    - All Payer PQP thresholds met
      - MIPS EC
## Current ACOs/APMs

<table>
<thead>
<tr>
<th></th>
<th>MSSP Track 1</th>
<th>MSSP Track 1+</th>
<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>Next Gen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced APM?</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Shared Savings</strong></td>
<td>50% × Quality Score</td>
<td>50% × Quality Score</td>
<td>60% × Quality Score</td>
<td>75% × Quality Score</td>
<td>80% (Track A) / 100% (Track B)</td>
</tr>
<tr>
<td><strong>Shared Loss</strong></td>
<td>0%</td>
<td>30%</td>
<td>One minus final sharing rate (minimum 40%, maximum 60%)</td>
<td>One minus final sharing rate (minimum 40%, maximum 75%)</td>
<td>80% (Track A) / 100% (Track B)</td>
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| **Maximum Loss (Loss Cap)** | 0% | Varies | PY1: 5%  
PY2: 7.5%  
PY3+: 10% | 15% | 5% – 15% |
2017 ACO Participation

- MSSP Track 1 - 83.4%
- MSSP Track 2 - 1.1%
- MSSP Track 3 - 6.9%
- NextGen - 8.6%
Synergies with Medicare Advantage
Potential synergies

Quality metrics

Medicare Advantage and CMS Advanced APMs

Medicare Advantage provider contracts

Fee schedule impacts

Provider/payer partnerships
## Quality metrics

<table>
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<tr>
<th>Program</th>
<th>Stars Weight</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Stars measures – Part C overall</td>
<td>51.0</td>
<td></td>
</tr>
<tr>
<td>Stars measures – Part C excluding the Health Plan Quality Improvement factor</td>
<td>46.0</td>
<td>100%</td>
</tr>
<tr>
<td>Next Generation ACO</td>
<td>20.5</td>
<td>45%</td>
</tr>
<tr>
<td>Medicare Share Savings Program (MSSP)</td>
<td>20.5</td>
<td>45%</td>
</tr>
<tr>
<td>MIPS</td>
<td>30.0</td>
<td>65%</td>
</tr>
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- Significant overlap of metrics
- Providers can choose from hundreds of metrics
- MA plans may be able to help steer providers towards mutually advantageous choices
Medicare Advantage and CMS Advanced APMs

MSSP/Next Gen objectives are becoming more closely aligned with Medicare Advantage program

Risk adjustment opportunity under Next Gen and Medicare Advantage

Quality overlap with STAR ratings

Care management programs can impact MSSP, Next Gen, and Medicare Advantage
Medicare Advantage provider contracts

Likely provider movement towards Advanced APMs (All-Payer criteria for QPs)

MA plans should review contracts vs. Advanced APM criteria

Consider costs/benefits of developing, maintaining, and administering contracts
Medicare Advantage provider reporting/support

Opportunity for provider reporting:

Reporting package can help providers assess their performance on an ongoing basis

Assist providers in projecting their MIPS adjustment, monitoring QP status, and evaluating relative risk/reward of QP status/Advanced APMs

High-performing providers: In future years, identify high value/high quality providers for potential contracting by reviewing Provider Compare summaries
Fee schedule impacts

Impacts of flat Part B fee schedules
- Pressure on Part B providers; providers may look for contract changes
- Downward pressure on FFS costs may drive down MA capitation rates

Definition of “FFS Medicare”
- What does “FFS Medicare” mean in a MACRA world?
- Include or exclude MIPS adjustments and QP bonus?
- Impact on high-performing vs. low-performing providers

Related Party Considerations
- Inclusion/exclusion of MACRA bonuses
- Additional clarification will be needed
Provider/payer partnerships

Providers increasingly moving towards risk arrangements

Providers are looking for partners

- Financial protection: providers considering stop loss protection, due to downside risk arrangements
- Network considerations: Next Gen allows for changes to contractual reimbursement (i.e., not all at FFS reimbursement levels)
- Education: attribution, risk models, financial opportunities
- Care management, risk score improvement, quality metric submission
- Legal issues: ACO setup, legal documents, CMS applications, compliance with Fed/State regulations

Potential leveraging of MA health plan capabilities
What can health plans do for providers?

- Provide assistance with organizational framework (ACO structure, legal issues)
- Provide care management education and functions
- Insulate providers from downside risk
- Share upside savings with providers
- Financial modeling, benchmarking
Key points

1. Quality: Emphasis on quality metrics has high ROI, due to overlap.

2. QP Status: MA contracts can count towards All-Payer Advanced APM status (if meet criteria).

3. Medicare Fee Schedules: Nuances will have ripple effects across multiple areas.

4. Provider/Payer Partnerships: Good opportunities for partnership, leveraging of provider and payer strengths and experiences.
Questions?

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https://tinyurl.com/MACRA-Milliman
https://tinyurl.com/MACRA-Synergies