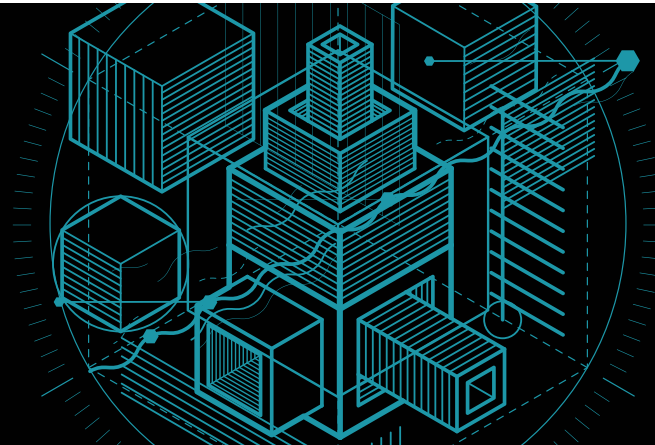


Rebuilding the foundation of health care under MACRA

Summary of the convening co-hosted by the Deloitte Center for Health Solutions and the Network for Excellence in Health Innovation

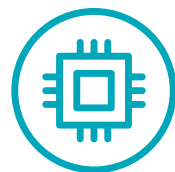


Executive summary

On March 29, 2017, the Deloitte Center for Health Solutions and the Network for Excellence in Health Innovation (NEHI) convened 31 senior leaders from across the health care industry—providers, health plans, and biopharmaceutical (biopharma), and medical technology (medtech) companies—to discuss implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Most US health care organizations have built their foundation—poured concrete—on the financial incentives in fee-for-service (FFS) payment models. Changing their systems and processes to respond to MACRA's very different incentives will take time and is likely to pose challenges for many health care stakeholders. But findings from our cross-industry convening suggest that many health care organizations are ready to come together and begin rebuilding their foundation based on new clinical delivery and payment models.

Convening executives agreed that, under MACRA:



Technology and data are paramount. Stakeholders will need technology and data solutions to produce and synthesize insights across the delivery system, as MACRA will require organizations to use data

to report on physicians' performance, gain insight into what can be done differently, and determine how

to improve performance. Collaboration models that share disparate data sources in ways that integrate and harmonize different data sets and make data actionable could enhance these insights. However, many executives questioned how data sharing will happen and who should have and control access.



Change will be hard, especially taking on risk. Many health system leaders said they want to take on more risk, but doing so is a challenge for their organizations as well as for individual clinicians. Many clinicians

worry that they lack the tools and capabilities needed to change clinical models.



Everyone should be at the table.

MACRA's fast-paced rollout and broad reach will require organizations across the health care system to work together; however, many executives said they are hindered by

organizational, competitive, and regulatory barriers.



Patients should be front and center.

Patient outcomes and experience need to be a core focus for all health care organizations; this will likely require new patient and clinician engagement models.

As organizations begin to implement MACRA, many health care providers, health plans, life sciences companies, and regulatory and legislative bodies will need to work together to overcome barriers. As the health care industry begins to take apart its old payment system and rebuild the foundation based on value, stakeholders may consider the following:

Health care providers

- Invest in technology that allows organizations to connect and integrate data. Data capabilities will be critical not only for reporting under MACRA, but also for reviewing and shifting the way health care is provided to improve performance. Providers also should consider investing in data and decision-support tools that can be used to transform data into point-of-care information for physicians.
- Review and/or develop new relationships, as data held by traditional and non-traditional partners could become critical components of tracking patient outcomes. Relationships with specialists and post-acute care providers are likely to be key in identifying cost-saving opportunities within the system.
- Engage with the US Centers for Medicare and Medicaid Services (CMS) and other federal partners such as the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
- Get experience in risk-based contracts, regardless of whether they qualify as advanced alternative payment models (APMs) under MACRA.
- Change clinical models to direct the right work to the right worker and/or setting, and to move from a focus on achievement to one of improvement.

Health plans

- Bring deep analytics and actuarial experience to relationships with providers as they look for ways to integrate more data into their decision-making, and to bolster population health initiatives.
- Review care and disease management programs as providers develop more capabilities to manage population health, and improve coordination with providers to ensure these services complement and support physicians and care teams.

- Assess providers in each market to better understand to what degree they are ready to take on risk, as MACRA will influence the structure of commercial and Medicaid payment arrangements. Plans also might consider partnering with organizations that are willing to take on and lead change for those who are not already cost-effective.

Life sciences companies

- Work with providers to use real-world evidence (RWE) in daily practice, as doing so could help them understand which products work best, identify how to create greater efficiency in care delivery, and update clinical pathways to make more cost-effective treatment decisions.
- Monitor progress to understand how quickly the transformation to value will impact different markets, how to segment customers, and where to align sales and support operations.
- Engage with providers to develop clinical measures that gauge outcomes beyond the short term as patients look for ways to ensure that their long-term needs are met.

Government

- Send data and feedback more frequently and in actionable formats to help providers track performance and adjust care models as needed.
- Continually review information technology (IT) upgrades that the Office of Inspector General (OIG) recommended CMS make to provide the data and feedback providers need to succeed under MACRA.
- Develop regulatory solutions to prevent data blocking among electronic health record (EHR) vendors and others in the system, and to continue making progress toward interoperability.
- Share information and develop more educational and outreach materials to inform providers about initiatives such as PTAC and the Accountable Health Communities model, and share detailed lessons from successful and unsuccessful projects.
- Continue to identify new delivery and payment models to further encourage stakeholder participation as the government works toward implementation and adheres to the principles laid out in the law.

Background

On March 29, 2017, the Deloitte Center for Health Solutions and NEHI convened 31 value-based care (VBC) and strategy leaders from across the US health care industry—health care providers, health plans, and biopharmaceutical (biopharma) and medical technology (medtech) companies—to discuss implementation of the MACRA (see page 21 for a list of participants). We challenged these leaders to identify the changes each sector may need to make to help the industry accomplish the goals outlined by MACRA (see sidebar).

MACRA's first performance period is already underway, and many health care organizations across the country

are beginning to experience and comprehend its complexity and challenges. To begin tackling these challenges, we focused the discussion on four key themes: technology, clinical care models, collaboration and partnerships, and consumer engagement.

Moderated table discussions, with representation from each of the sectors in attendance, were followed by a larger consensus-building discussion with the entire group. Four key themes emerged from the discussion, which we address below.

Payment basics under MACRA

MACRA replaces Sustainable Growth Rate (SGR) formula for payments under the Medicare Physician Fee Schedule (PFS) with fixed annual payment updates for all years in the future.

MACRA creates separate paths for payments under the Medicare PFS:



APMs

- From 2019-2024, **lump sum payments** equal to 5 percent of all reimbursement for services rendered under the Medicare PFS
- Beginning in 2026, annual payment updates of **0.75 percent** to the Medicare PFS
- CMS has indicated which Accountable Care Organizations (ACOs) and models under the Center for Medicaid and Medicare Innovation will likely be considered Advanced APMs

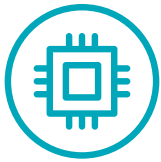


Merit-based Incentive Payment System (MIPS)

- For 2019 and subsequent years, **positive or negative** payment adjustments based on clinicians' performance relative to scores of their peers across four categories: quality, cost, clinical performance improvement activities, and advancing care information
- Beginning in 2026, annual payment updates of **0.25 percent** to the Medicare PFS
- Eligible clinicians who do not achieve the APM revenue or patient thresholds will participate in MIPS and be subject to certain reporting requirements

Beginning in 2019, clinician Medicare payment adjustments each year will depend on which track the clinician's medical group falls into.

Source: Public Law 114-10 (April 16, 2015)



**Technology and data
will be paramount**

Many stakeholders will need technology and data solutions to produce and synthesize insights across the delivery system, as MACRA will require organizations to use data to report on physicians' performance, gain insight into what can be done differently, and determine how to improve performance. Collaboration models that share disparate data sources in ways that integrate and harmonize different data sets and make data actionable could enhance these insights. However, many executives questioned how data sharing will happen and who should have and control access.

At the beginning of the convening event, we polled participants to determine which aspect of their business they thought would be most disrupted by MACRA. The majority of participants predicted that MACRA would impact collaboration and partnerships most significantly. At the end of the day—after table discussions—participants had new perspectives and suggested that technology would be most affected by MACRA. Collaboration and partnerships, however, remained a close second.

Providers feel they will bear the brunt of implementation costs, as technology will be critical for their success under MACRA.

Technology will be a cornerstone of MACRA for providers—from collecting data and tracking patient outcomes and physician performance, and using the data to change the way they administer care and submit the metrics required under MIPS or advanced APMs. This fundamental requirement has not escaped many providers' notice as they begin to implement MACRA. That imperative, stakeholders say, will require investments in new and more sophisticated IT and analytics platforms. The technology costs associated with the law could create new financial burdens, especially for rural providers and other small or medium-sized practices that desire to remain independent.

Every sector possesses a piece of the data puzzle on performance, but fitting them together is challenging due to systems, regulatory, and competitive issues.

Currently, no authoritative entity determines how US health care system participants should collect, aggregate, access, and govern data. Rather, each data source exists in its own silo. For example, providers have clinical data; health plans have claims data; pharmacy benefit managers have drug prescription, fulfillment, and medication adherence data; and medtech companies have clinical monitoring data. Some life sciences companies have begun to mine real-world data on how their products are being used (or not used) to determine care patterns and interactions; many are also starting to track the effectiveness and safety of those products and are engaging stakeholders across the system to develop a complete picture.

Under MACRA, these and other data will be needed to begin reporting performance information to CMS and to gain insights to help make better treatment decisions. However, breaking down these data siloes could be among the most challenging implementation barriers, as several issues are preventing stakeholders from aggregating and using the myriad data sources that exist.

Systems issues: The attendees identified many issues with existing EHRs; for example, that they have limited interoperability and can be burdensome for clinicians. As a result, many providers have turned to “add-on” technologies to support their needs. But systems issues for MACRA performance improvement efforts may go beyond EHRs. Many health systems today lack standardization and operations processes for tracking information, and few have figured out how to aggregate all of the data in one place and analyze it to give clinicians actionable feedback they can use at the point of service.

Among specific EHR challenges are that the EHR systems do not speak the same language and physicians find them burdensome. More than 600 EHR companies supply certified health IT to 337,000 providers. Although five companies provide technology services to more than 60 percent of the market, different definitions from myriad vendors make it difficult to synthesize and compare data by setting or provider.¹ According to Deloitte's 2016 Survey of US Physicians, three-out-of-four surveyed physicians said EHRs increase costs for their practices, and seven-out-of-10 said EHRs negatively impact their productivity.² Many clinicians said they want health IT that aligns with or is not disruptive to their workflow. As care models change, EHR systems will likely need to change with them.

Many health systems that have adopted integrated EHR systems recognize that today's EHRs are merely a means to capture data and do not provide actionable intelligence. And even if EHRs contain clinical data, "extracting that data is painful," said a representative from a health plan that owns a health system.

Customizing health IT can be costly, however, and risks turning health systems into "IT shops," which many say they do not want to become. A lot of health systems rely on off-the-shelf care coordination platforms but these may not integrate with existing technology, creating inefficient workflow for clinical practices. While some EHR systems have add-on modules to support care coordination, these modules may be expensive, often lack the care management features for true population health management, and are normally focused on patient populations with specific conditions (e.g., diabetes, chronic obstructive pulmonary disease). Therefore, such modules often do not support the types of performance improvement efforts needed under MACRA.

More importantly, few health systems have the ability to identify all of the third-party data sources to which they have access. And even if a provider has collected the data and combined it in one place, the organization still needs analytics talent and processes to track or improve performance under MACRA. Some basic issues, such as a unique patient identifier, provider-patient matching and attribution, and provider identification remain challenging—as providers and patients traverse different health plans, practice arrangements, and locations.

Finally, clinical data registries will be an integral reporting tool under MACRA, as clinicians can use qualified clinical data registries to report their quality, clinical practice improvement, and advancing care information measures. Registries can hold a great deal of important information, such as data on patients from all payers, not just Medicare. They also can help providers track outcomes across specific diseases and compare the performance of clinicians against one another. Benchmarking data that allow clinicians to compare their performance will be critical under MACRA, given that the bar on performance and bonuses will rise or lower annually. However, some vendors block integration with separate registries or charge additional fees to access them.

As care models change,
EHR systems will likely
need to change with them.

Regulatory issues: Unless CMS begins to provide more frequent updates on clinician and health system performance, health system leaders said it will be difficult to comply with MIPS requirements and optimize performance under the program. Obtaining quality and resource use data is likely to be the most challenging issue for providers because this information is not easily gathered from one source and CMS typically does not communicate it to providers more than once a year.

CMS has begun to address this issue, easing some of the reporting requirements for the first performance year and establishing grants to assist providers during the transition. The OIG at the US Department of Health and Human Services (HHS) has said that while CMS has made meaningful progress toward implementing MACRA, the agency needs critical systems upgrades to effectively report, score, and adjust payments under the program.³

MACRA's Other Payer Option may drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare

Beginning in 2021, health care professionals can qualify for APM incentive payments through Other Payer Advanced APM thresholds. To qualify in 2021 and 2022, Qualifying APM Participants (QPs) must receive at least 50 percent of the sum of payments by Medicare and other payers through Advanced APMs and Other Payer Advanced APMs. As part of this option, CMS will evaluate Medicare Advantage (MA) contracts to determine if they meet the EHR, quality measure, and nominal risk requirements to qualify as Advanced APMs. CMS's emphasis on including other payer options means that health plans—both in MA and commercial lines of business—may see pressure to align payment arrangements with MACRA requirements to help clinicians meet qualifying thresholds for incentive payments.

On the life sciences front, many medtech and biopharma companies work with health plans to help establish prices for their products, and they interact with providers when discussing treatment protocols for specific diseases. Collaboration among these stakeholders could be significantly enhanced under MACRA. APMs, for example, create incentives for physicians to use products that help them achieve their quality and cost goals. Moreover, under the Other Payer Option (see sidebar), health plans will have a role in establishing payment arrangements with providers that meet MACRA requirements.

To try to be successful under MACRA, biopharma and medtech companies will need to share economic and value information about their products—but legal barriers currently prevent them from doing so. For example, the US Food and Drug Administration (FDA) has regulations regarding off-label marketing, including limiting drug companies' ability to proactively communicate some economic evidence. Moreover, the federal Anti-Kickback Statute prohibits entities from offering, soliciting, or accepting any type of gifts or remuneration in exchange for referring, ordering, or otherwise making arrangements for the provision of health care services payable by Medicare or Medicaid.

Value-based agreements that include services offered by manufacturers, including those around data collection and analysis required to track outcomes, or incentives for providers to increase drug utilization, such as adherence programs, might be considered inducements under this law.⁴

Competitive issues: Sector stakeholders may need to be amenable to sharing information so that the industry as a whole can work collaboratively to help providers improve their performance. Information sharing can help to track a patient through the entire health care system and ensure quality and cost efficiency. While fragmented IT systems may prevent some of this sharing, many health plan and life sciences companies are leery of sharing data with providers for fear it might get into competitors' hands.

CMS: A critical partner along the MACRA journey

Dr. Patrick Conway is the Deputy Administrator for Innovation and Quality and the Director of the Center for Medicare and Medicaid Innovation at CMS. He opened the convening with remarks about where CMS is in the implementation of MACRA, which he noted had strong bipartisan support when it passed.

Dr. Conway anticipated the following would likely happen as MACRA is implemented in the coming years:

- CMS is likely to add new advanced APM options for providers wishing to opt out of MIPS.
- The administration will remain focused on enhancing clinical practice improvement activities, and making sure that they do not become “check-the-box” activities for providers. CMS wants to make sure the improvement activities remain meaningful for clinicians and their practices.
- CMS will continue to encourage private payers to join providers on the journey to value under MACRA. Indeed, CMS estimates 30 percent of traditional Medicare is under APMs. MA and commercial managed care arrangements are behind that, as fewer contracts are under alternative payment arrangements in those markets. There is more work to be done to align the health plan community and providers on this journey.
- CMS aims to enhance quality measurement. Over time, the goal is to have measures that are more common, comparable, and outcomes-focused.
- PTAC is viewed as a critical piece to fill gaps in models, especially specialty physician models. Dr. Conway remarked that CMS wants health care stakeholders from across the industry to suggest scalable ideas to PTAC.

“When technology works well, it is in the background.”

—Dr. Patrick Conway, CMS



Smart first steps: Health care providers

Invest in technology and analytical capabilities to convert data into actionable information. CMS requirements will change over time, and systems and processes will need to change with them. This reality may require looking beyond the traditional EHR system, as many physicians believe that EHRs are useful for capturing data but not as helpful in supporting value-based care or clinical outcome improvements.⁵ Health systems will likely need analytics platforms that enable data-sharing and aggregation—both internally and with third parties—and that help them track patients over time. Investing in collaboration platforms could enable care providers inside and outside of the health system to communicate with each other about patient care—including making sure everyone knows when a patient is discharged from the hospital or is readmitted for a serious complication.

Enhance the use of partnerships to integrate the continuum of care. Traditional and non-traditional partners can help facilitate seamless care coordination across settings. For example, retail health clinics could act as an extension of primary care, not as a replacement for it, and could serve as additional care access points beyond the traditional doctor's office or hospital.⁶ Moreover, moving patients to lower-cost settings after they are discharged from the hospital may be critical under risk-based arrangements where the health system is accountable for the entire episode and total cost of care. Home health agencies, in particular, can be a more cost-effective setting for patients who do not need the intensive care provided in traditional post-acute care facilities.⁷ One potential key to success with these relationships will be to clearly define how patient data will be shared between care settings.

Take advantage of Quality and Resource Use Reports (QRURs). Under MIPS, clinicians and health systems billing on their behalf will need to analyze quality and resource use performance against the national benchmarks. In many cases, they will need to select which measures to report on, and change practice patterns to avoid payment reductions and low scores in public reports. Providers can begin by looking at their performance under the Physician Quality Reporting System, which can indicate their likely MIPS performance and how it compares to others nationally. QRURs can also help systems identify beneficiaries who are driving performance on cost and quality measures, and determine which ones might need higher levels of care coordination.

Get experience taking on risk and evaluate the value of signing up for risk-based programs, even if they do not qualify as advanced APMs. For one, many risk-based programs qualify as MIPS APMs, allowing participating clinicians to score higher on performance metrics under MIPS. More importantly, APMs such as the Medicare Shared Savings Track 1, can help providers test risk-sharing programs. These CMS-guided APMs can supply providers with data they need to gain performance-tracking experience.

Review M&A strategies given new demands: Technology can be expensive, and keeping up-to-date is not optional for providers that want to perform well under MACRA. Health systems that have made sound technology investments are expected to fare better on cost and quality measures because they will have the data and processes necessary to improve performance. Small physician groups, as well as larger ones that cannot afford technology investments, might seek safety by merging with larger, better-funded organizations.



Smart first steps: Health plans

Enhance data-sharing and transparency practices. Health plans can bring deep analytics and actuarial expertise to their provider relationships. For health plans, the value-add is in finding provider partners that are willing to take on risk and reduce spending over the long term. This process might start with understanding what providers need to supplement the data they are already receiving under MIPS. For example, CMS will send providers data, whether or not they are participating in MIPS or advanced APMs, but this data only encompasses Medicare Part A and B. MA plans' utilization and drug data can help health systems develop a more complete picture of physicians' spending and practice patterns.

Consider investing in data management and analytics capabilities. Many providers have contracts with several health plans and, thus, are looking for claims data that is not specific to one plan. In response, health plan business units may have to invest in data warehouses and analytics capabilities. Several health plans have invested in units that collect data from multiple health plans across the US and offer a more comprehensive perspective on population-level trends than data from one health plan could.



Smart first steps: Life sciences companies

Work with providers to use real-world evidence (RWE) more broadly. RWE is secondary analysis of observational data from the health care system and, increasingly, patients themselves. RWE on biopharma and medtech products can help providers understand which products work best with which patients, and can help identify opportunities for greater efficiency in health care delivery. In turn, manufacturers can use RWE to discover, generate, and optimize their products' value. If both health systems and manufacturers work together to collect and organize such data, it could foster future collaborations. Note that RWE collaborations will require stakeholders to integrate different information sources—from clinical data to socioeconomic data—into their current systems.

Work with providers to enhance their use of mobile health (mHealth) solutions. MACRA creates an opportunity for medtech companies to sell their mHealth solutions to providers. Today, providers must have a specific reimbursement code to be encouraged to use mHealth products. The more physicians' compensation is based on outcomes, though, the more they may be willing to invest in mHealth solutions outside of traditional reimbursement mechanisms.



Smart first steps: Government

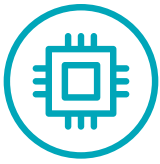
Send data more frequently. To truly improve performance, physician and operations leaders need timely data on cost and quality performance, and they need it more frequently than CMS has proposed, according to convening attendees. Private payers typically can share data more frequently than CMS but CMS is the only entity with Medicare FFS data, and this information is key for tracking performance under MACRA. Per the HHS OIG report, updates to CMS's back-end IT systems will be critical to the success of this program.

Work with providers and payers to develop meaningful ways to track patient experience. Providers may seek data that can help them assess aspects of patient care that may affect outcomes. For example, having access to Part D data can help providers track medication adherence within their patient populations. Such data is now siloed with various industry stakeholders but CMS can help break down those siloes to provide actionable patient data.

Find regulatory solutions to prevent EHR vendors from blocking providers from accessing registries. Providers need better integration with registries in general and more information on qualified clinical data registries. Data-blocking is a large barrier to more cohesive interaction between registries and EHR data. The Office of the National Coordinator for Health Information Technology (ONC) has said new regulation will be needed to address this issue.⁸

Examine policy levers that could be adjusted to make communication and data-sharing easier among life sciences companies and other stakeholders. The 21st Century Cures statute is a step forward, as it includes provisions for more flexibility around what kinds of discussions biopharma and medtech companies can have with providers and payers.

Continue to monitor progress toward MACRA's interoperability requirements. MACRA made it a national objective to achieve widespread health care system interoperability by December 31, 2018, and required the ONC to establish measures to determine if and when this goal is met. In July 2016, the ONC announced that it had established two measures of progress toward this goal: 1) the proportion of providers that are "electronically engaging" in the core competencies of interoperable exchange of health information; and 2) the proportion of providers that report using information obtained from outside providers and other sources to guide clinical decision-making. While ONC will focus its short-term efforts on boosting interoperability among meaningful users of health IT, it plans to expand efforts more broadly in the future.⁹ ONC has received pledges from vendors in the EHR community that they are committed to providing consumer access, ceasing data-blocking activities, and implementing national interoperability standards.¹⁰ Federal oversight may be needed to ensure that these pledges are fulfilled.



Change is hard, especially taking on risk

Many health system leaders said they want to take on more risk but doing so is a challenge for their organizations, as well as for individual clinicians. Many clinicians worry that they lack the tools and capabilities needed to change clinical models.

Physicians are trained to be in control. Giving up some of that control under new value-based care models can be challenging, especially if physicians are not given the right tools and capabilities to manage the transition. While financial incentives could help bring providers on board, they might not be large enough to inspire widespread, lasting change. Even individual clinicians who want to take on more risk—and improve their performance—can face barriers. For example, a physician might not be able to extract actionable patient information from EHRs. This lack of data may hinder their ability to understand performance and improve upon it.

Existing clinical models do not fit physician needs under MACRA

Many clinicians lack actionable information about patient outcomes and their performance. Physicians need information, and they need it to be timely, reliable, and actionable. As discussed earlier, few health systems are able to aggregate data to help providers get a 360 degree view of their patients and help manage their care and outcomes across the continuum. Moreover, clinicians need the data to display only the most critical information for each patient; current systems are often set up more as a “data dump,” making it difficult for clinicians to quickly see the actions their patients require.

Few clinicians are documenting and coding in ways that accurately and completely reflect patient acuity, and when they are, clinical documentation is often not integrated into workflow. Success under either MACRA track may depend upon appropriate clinical documentation to yield accurate risk-adjustment scores. Risk adjustment, such as the hierarchical condition category, increases the impact of documentation practices and requirements, and may increase or decrease reimbursement. It requires that all chronic conditions in the patient population be documented annually to properly estimate a population’s risk score. In the risk adjustment model, complications and comorbidities are weighted higher but many of these conditions go undocumented. One of the main reasons for this is because clinical documentation is often not integrated into clinician workflow, which creates a burdensome

process. Documentation also will be critical to demonstrate progress in clinical practice improvement and quality under MACRA’s episode-based performance measurements.

Clinicians generally are not focused on patients’ total cost of care. The cost measure under MIPS will require clinicians to understand the cost of each episode across Medicare Parts A and B, and determine which patients and specialists are driving costs in the system. The result may shift financial incentives for clinicians and require them to spend more time providing care to the most challenging and highest-cost patients, while patients that require routine, less-intensive care are shifted to mid-level providers. Moreover, adjusting referral protocols to emphasize high-quality, cost-effective specialists will be important.

Existing provider organizations are often siloed. The focus on total cost of care for patients also will require clinicians to understand the cost implications of referrals. Right now, providers generally do not consider the cost or quality of specialists or post-acute care providers to whom they frequently refer patients—a reality that is likely to change under MACRA as clinicians become accountable for the total episode of care.

Some clinicians are more cost-effective than others. Clinical variation exists within the smallest practices. Two surgeons who perform the same work under the same roof might have dramatically different utilization patterns. There are a number of reasons for this variation. For example, “preference” cards, on which physicians express their procedural preferences, in effect cater to physicians’ needs rather than patients’. Moreover, few physicians have individualized information about their own practice, which can make it difficult to evaluate individual performance and make improvements using comparative data.

“What drives the cost performance is how you manage the sickest five percent.”

—Health care provider leader



Smart first steps: Health care providers

Invest in analytics and other wrap-around IT solutions to identify high-cost and at-risk enrollees and utilization patterns; ensure that bedside tools allow physicians to understand these patterns; and give physicians clinical decision-support tools.

Data and decision-support tools that can transform data into usable information for physicians should be readily available, easy to use, and offer appropriate detail. Many physicians distrust the data they receive or find it difficult to integrate it into their daily practices. They are more likely to use real-time data that is incorporated in workflow—and accompanied by reliable benchmarks and goals.

Update processes and workflows to support clinical documentation and accuracy.

Patient acuity should be documented in detail and integrated into clinical decision-making tools, as quality metrics are based on outcomes. Clinicians may need to make process and workflow changes to begin documenting and measuring patient acuity. Health systems should consider analyzing current workflows to determine whether they facilitate efficient and consistent data capture; revising workflows to enable easier data capture, clinical decision support, and other automated features that promote desired behaviors; and training physicians and communicating expectations about their use of EHRs to capture relevant data elements in a structured format.

Move from a focus on achievement to one of improvement.

CMS will be shifting its measurement focus to prevent providers from picking only “easy” reporting measures. Care pattern reports can help physicians identify variation in how they deliver care and how their care patterns compare to those of their peers or to quality benchmarks. Health systems should consider establishing a management structure to continually review quality performance and make informed decisions to investigate and improve results.

Evaluate clinician readiness. Health systems should consider adopting technology systems and processes that allow them to evaluate clinician readiness as they determine which clinicians to enroll in specific APMs. These decisions should be based largely on which providers will improve overall APM performance and position the APM for an incentive payment under MACRA.

Change physician compensation models, not just reimbursement models.

According to Deloitte’s 2016 Survey of US Physicians, at least 20 percent of a physician’s compensation should be tied to performance goals. Current financial incentive levels for physicians are not adequate and should be increased to give physicians greater motivation to improve quality and cost.

Engage with PTAC as it reviews scalable solutions and recommends potential new APMs to HHS.

MACRA created PTAC to review physician-focused payment models that might meet advanced APM requirements and suggest their adoption to HHS. PTAC uses ten criteria to assess proposed models: value over volume, flexibility, quality and cost, payment methodology, scope, ability to be evaluated, integration and care coordination, patient choice, patient safety, and health IT. As of April 2017, PTAC has reviewed three proposed models and recommended that two of them be scaled and tested through the Innovation Center.

Assign the right work to the right worker and/or setting.

Physicians’ attention should be focused on the most expensive or complicated patients. Those needing more routine care should go to midlevel providers, such as physician assistants or nurse practitioners. In addition, clinicians should determine the most appropriate setting for the patient—inpatient or outpatient, home health or skilled nursing facility, the physician’s office, or the patient’s home. Pairing segmentation and care pathways can help physicians optimize the site of care.

Engage with specialists and develop or refresh referral protocols.

MACRA’s focus on cost and quality will require hospitals and health systems to rethink how they engage with specialists. For example, organizations may need to change referral protocols to emphasize cost-efficient and high-quality specialists.

Examine relationships with post-acute care companies, including home health care.

More than one-in-five Medicare patients discharged from a hospital receives post-acute care.¹¹ As more health systems begin to manage and be financially accountable for full care episodes, they should consider reviewing data on readmissions, acute care, and post-acute care length of stay, and discussing performance with their top post-acute referral destinations.



Smart first steps: Health plans

Review strategies to complement provider services. Many health plans provide services beyond adjudicating and paying claims. For instance, care management and disease management have become critical aspects of the business as health plans

work to control costs. As providers develop more capabilities to manage population health, health plans may need to improve coordination with providers to ensure these services complement and support physicians and care teams.



Smart first steps: Life sciences companies

Use RWE to help providers update clinical pathways and make cost-effective treatment decisions. Life sciences companies can play a meaningful role in helping providers

standardize and personalize care by working with clinicians to understand how patients are responding to specific treatments and devices.



Smart first steps: Government

Supply more information about how CMS will support providers as they move in and out of the MIPS or APMs tracks. The final MACRA rule was published only a few months before the first performance period began. The rule was comprehensive, but it also generated provider questions about how the program works—especially how CMS will treat the interaction between APMs and MIPS. For example, many clinicians may move back and forth between MIPS and APMs depending on

their patient revenue and thresholds. More information is needed on the other payer option, as well: The convening session's cross-stakeholder group was curious about how commercial, MA, and Medicaid will be treated under MACRA.

Give providers more education about PTAC. Additional outreach efforts should focus on how PTAC works and how providers can submit new models for consideration.



Everyone should
be at the table

MACRA's fast-paced rollout and broad reach will require organizations across the health care system to work together; however, many executives said they are hindered by organizational, competitive, and regulatory barriers.

Not all stakeholders are fully on board...

The provider, health plan, and life sciences sectors will need to reconsider their traditional roles in the health care ecosystem as MACRA shifts the focus from volume to value and patient outcomes.

Many provider representatives said they need to educate some health plans about MACRA. In the fall of 2016, Deloitte surveyed health care industry leaders to understand their progress in preparing for MACRA. Only half of the health plan respondents said they were very or extremely familiar with MACRA's potential bonuses and provider payment cuts.¹² As physicians and health systems begin to evaluate how MACRA will impact their business models, they may look to health plans for the actuarial and analytics experience they currently lack.

Health plans have resisted shifting risk to providers.

In the past, many commercial health plans were reluctant to establish risk-bearing arrangements with providers because they perceived that providers lacked the necessary volume, capital, systems, and processes to succeed. MACRA's implementation gives providers financial incentives to ask commercial health plans for payment arrangements that look like APMs under Medicare. For example, some providers might request to report quality measures and attribute patients in a manner that aligns with MACRA requirements. Still, representatives of health plans that are aware of MACRA—and have broader value-based care strategies—said they remain concerned about how to balance providers' requests with the competitive nature of doing business in different markets.

High-performing health systems see limited value in MACRA. Providers are at different levels of maturity in their adoption of value-based reimbursement models. Some health systems that are veterans of pay-for-performance see limited value in a program that rewards organizations based on improvement. A health system that has already significantly reduced costs and has been reporting quality measures for several years might find it more difficult to show improvement.

One health system executive suggested that MA needs to be included under MACRA. Such a move, he said, would create the potential to benefit from the health system's previous investments in care redesign. Under current MACRA rules, MA revenue does not count towards APM thresholds until the 2019 performance year, or 2021 payment year. In many markets, MA is more prevalent than traditional Medicare. Moreover, many MA contracts are risk-based. Participating providers that have made significant investments in MA have commented that these arrangements should count toward APM thresholds sooner.

Community partners, such as organizations that provide economic development, housing, and social services, are a vital but rarely used resource.

Community organizations never touch clinical care, but many are knowledgeable about sociodemographic factors that have a direct impact on clinical outcomes, such as employment, housing, and caregiver or family support. Although such information can impact outcomes, few stakeholders have tapped community partners as a resource. From a risk perspective, community partners could play an essential role in improving population health.

Lack of clarity is keeping life sciences companies from engaging in conversations about sharing risk.

Many biopharma and medtech companies are unclear about the role they can play under MACRA. Many companies recognize that the law is early in the implementation process and wonder if it is too soon to start conversations with health plans and providers. They are also unclear about how they can make an impact in the reporting process, and whether they have the capabilities to help providers and plans navigate MACRA's requirements. Moreover, although MACRA impacts Medicare physician payments broadly, providers will develop their own specific arrangements with health plans under APMs, making it critical for life sciences companies to develop market-specific strategies.

...But some stakeholders have begun to come around

Some forward-thinking providers have reinvested money saved through prevention efforts into secondary and primary prevention.

One provider representative said his organization started by identifying care cost drivers, and noticed that under the old models, money saved through prevention efforts typically benefited health plans. "Once we figured out a way to keep the money, we could invest in secondary prevention. Once we did that, we could invest in primary prevention. We started with managing variation, and where the money was, and then focused on keeping the money in the system for reinvestment." But importantly, he noted this scenario can only work under capitated models: "If you don't lock in the capitation before you make the change, you don't get the money," he added.

Some health plans are working well with their provider partners.

Some health plans have decided to join providers on the MACRA journey. As one health plan leader said, "As a payer we're focused on finding providers that are excited about going to the next level. This has empowered us to have discussions with other providers that aren't as far along, but we can bring them along," she said. "When providers are embracing risk, it's easier because we are on the same side. It's not provider versus payer; you're sitting on the same side of the table. Then we found that many doctors want to sell this partnership to employers and get more people in their network."

As an example, collaborations between health plans and health systems for provider-sponsored plans (PSPs) are growing in number. Interviews with health plan executives have revealed that these organizations are interested in collaborating with health systems to develop PSPs when the partner and market conditions are right.¹³ Health plans can bring considerable benefits to a PSP, including a large number of members, financial resources, enabling technologies, risk management, compliance processes, customer service, network contracting, and financial discipline. Such collaborations have generated innovative approaches in population health, member engagement, predictive analytics, and member retention. MACRA may prove transformational in spurring innovative health system approaches in the marketplace. Organizations that improve quality and reduce costs under a PSP model could be more likely to succeed under this new Medicare payment system.

"When providers are embracing risk, it's easier because we are on the same side. It's not provider versus payer; you're sitting on the same side of the table."

—Health plan leader



Smart first steps: Health care providers

Collaborate with community-based organizations outside the health care system. Research has found that social determinants of health can have significant impact on individuals' health status in addition to the provision of health care services.¹⁴ Understanding the situations that affect health outcomes and engagement—housing, socioeconomic status, and even access to healthful food—can help clinicians understand some of the

barriers their patients face in their treatment. Engaging with community-based organizations such as churches, community centers, aging organizations, and others can help providers strengthen that understanding and engage more effectively with patients. CMS has begun to work with these types of organizations through its Accountable Health Communities model (AHC).



Smart first steps: Health plans

Align with strong performers that are willing to take on risk. In each market, assess where providers sit along the risk spectrum. Consider partnering with providers that are willing to take on risk; many will want to begin developing risk-based contracts with plans when the other payer option comes online in 2019, even if they have been reluctant to tackle risk in the past. When a health plan has an existing relationship with a provider, renewed interest in risk-based contracts under MACRA may require the plan to restructure contractual roles and responsibilities. Getting an early start in these negotiations may help. Health plans may also need to monitor each provider's operational strategies, as many could decide to consolidate, employ physicians, or launch new provider-sponsored plans in light of the demands they face under MACRA.

Review network and product strategies. As health care providers begin to shift focus under new payment models, many will demand that their contracts with health plans align with MACRA requirements. This could be a sea change for health plans. For example, core technology investments might need to change to accommodate the new emphasis on care episodes versus FFS. Health plans also may consider accelerating their push to narrow networks and adopt contracting strategies based on clinicians' MIPS performance. Moreover, as payment arrangements become more standardized under MACRA, market differentiation could become more difficult for health plans, requiring organizations to underwrite, price, and market products in new ways.



Smart first steps: Life sciences companies

Develop a relationship of collaboration and trust with health plans and providers. Health plans and providers that enter into value-based contracts will likely need robust infrastructure to track individual patients, their treatments, and outcomes. Life sciences companies should consider focusing on the outcomes that are most important to the patient and the payer, and working with health plan and provider stakeholders to determine a definition of value that they can attribute to the drug therapy or device. One example is a demonstrated endpoint from clinical trials, an outcome that provider organizations are actively measuring under quality initiatives.

Review market strategies. Local markets move at different speeds and have different characteristics, so life sciences companies will likely need to understand which markets may change more quickly, how to re-segment customers, and how to appropriately align sales and support operations.

Work with providers and plans to identify and prevent non-treatment factors from influencing outcomes and spending. Variables that can impact drug or device outcomes include patient factors (e.g., co-morbidities and adherence), physician factors (e.g., device user errors or drug prescribing errors), and reimbursement factors (e.g., use of utilization management tools like step therapy or cost sharing). Life sciences companies should consider how they can become both an innovative product supplier and an insightful partner in delivering value. Forging these new relationships may require developing “beyond the pill/metal” solutions, such as assistance with tracking patients’ adherence to medications. Life sciences companies also should consider defining innovation and value holistically and having differentiated value propositions and evidence—clinical and non-clinical aspects of patient benefits and experience and economic impact—for at-risk providers.

Help providers review diagnostics utilization. To help drive cost savings in the system, medtech companies can help providers understand underuse and overuse of diagnostics to improve patient outcomes.



Smart first steps: Government

Share lessons learned from programs and demonstrations with providers. Under the AHC model, CMS gave grants to 32 organizations across the US to test how to link community-based services and clinical services.¹⁵ Organizations in the assistance track will help connect high-risk beneficiaries to available services, while organizations in the alignment track will help partners coordinate services to meet the beneficiaries’ needs in

their community. All of the organizations are expected to work with local clinical delivery sites, such as physician practices and hospitals, to ensure that they are making referrals to community services that can address patients’ social needs. The model will run for five years, and results are expected to help bridge the gap between patients’ social and clinical needs.



**Patients should
be front and center**

Patient outcomes and experience should be a core focus of all health care organizations; this may require new patient and clinician engagement models.

Today's patient interactions are based on encounters, not episodes

Patients can become frustrated or lost in a health care system that does little to guide them from Point A to Point B. Unfortunately, providers often lack the necessary people and services to help people navigate the complex health care environment. For instance, many patients are interested in outcomes and experience and less concerned about individual encounters. Deloitte's 2015 Survey of US Health Care Consumers found that patient expectations regarding engagement, transparency, quality, and the overall health care experience have been increasing. More than 50 percent of respondents said they would switch hospitals due to inadequate information-sharing, communication, and difficulty in reaching a health professional by phone or email.¹⁶

Many quality measures fail to gauge what truly matters to patients

Consumers and clinicians tend to have different definitions of "positive outcomes." The US health care

system often struggles with quantifying what the patient wants and determining how to measure overall quality of life. Patient-reported outcomes and patient-centered outcomes generally are not fully developed, nor are there incentives for providers to focus on them under FFS payment models. When surveyed as part of the 2016 Deloitte Survey of Consumer Priorities in Health Care, what patients value most are meaningful interactions with their providers, a higher level of financial rationality and choice, and convenience or access.

Patients do not have access to information or technology that helps them navigate the system

Consumers are increasingly engaged in their health care. But they do not always have the correct information, tools, or insight into their care. Consumers often lack the data necessary to make cost-effective decisions about treatments and drugs. Moreover, doctors do not always have these data either, which can keep them from helping patients make high-value decisions about their care. Under MACRA, consumers will gain more transparency into how clinicians perform. MIPS Composite Performance Score (CPS) results will be made public, and transparency will expose the good and the bad. This could fundamentally change how consumers view their clinicians in the future.



Smart first steps: Health care providers

Hire patient advocates, navigators, social workers, and/or home health workers to assist with patient coordination and help patients navigate the system. Reconfiguring roles within the health care work force may require retraining physicians to focus on new patients and acute cases while mid-level clinicians take responsibility for more chronically ill patients that are following predetermined protocols for their specific diseases. It also may require coordinating with health plans to prevent overlapping services.

Invest in the patient experience. Providers may need to redesign workflow and processes to become patient-centric rather than provider-centric. They also may need to invest in the mechanisms, tools, and technology necessary to better engage patients and enhance the patient experience—from making appointment scheduling easier, to increasing shared decision-making, to offering convenient payment processes and effective care follow-up. These investments could pay off in the long run. Research suggests that hospitals with better patient-reported experience perform better financially.¹⁷



Smart first steps: Health plans

Develop better tools for patients to access cost information about treatments and drugs. As patients become more like consumers, tools that allow them to access accurate information about coverage, quality, and costs will help them make more informed decisions about their own care. The tools that exist today are often difficult to use and might contain inaccurate information about the true cost of care. Physicians

should be made aware of and be familiar with these tools, as patients often turn to their care provider first with questions about cost-effective treatments.¹⁸ Moreover, as physicians begin to understand resource use measures under MIPS, they might rely more on patients to be partners in choosing cost-effective procedures and treatments.



Smart first steps: Life sciences companies

Engage providers and health plans in discussions to expand clinical measures beyond the short term. Many care episodes evaluate performance within a short timeframe; for example, 30 to 90 days post-discharge is common in bundled payments. These timeframes may be too short to measure the impact that various drug and device interventions have on clinical outcomes and patients' health. Biopharma and medtech companies can work with plans and providers to incorporate more clinical quality measures tied to long-term clinical outcomes in new payment models. Such steps could help shift the focus away from incremental health improvement toward long-term impact on the overall health of patients in the system.

Take an active role in helping stakeholders develop patient-centered measures. Incorporating patient-centered measures such as patient experience, quality of life, improvements in functional status, and evidence-based behavioral interventions could be transformative for the patient experience. Collaborating with patient advocacy groups could help expedite the development of patient-centered measures that reflect a broad-array of patient preferences.



Smart first steps: Government

Provide guidance on how patient-reported outcomes can be incorporated into the approval process for biopharma and medtech products. As consumers become more involved in their health care and clinicians begin to report on quality measures under MIPS, patient-reported outcomes will be an important factor when considering treatment effectiveness. 21st Century Cures requires the FDA to evaluate the use of patient-reported outcomes and ensure that patient experience is reflected in benefit and risk assessments for drugs and devices. The emphasis on patient experience and data collected

through the research and development process should carry through to quality measurement. Data on patient experience could help physicians understand which products are more likely to increase scores for existing quality measures. For example, a product that helps diabetic patients manage HbA1c better than other treatments or products—and is perceived positively among patient populations—may help clinicians obtain higher quality scores. In addition, the development of future quality measures should consider the outcomes that matter most to patients.

Conclusion

MACRA will fundamentally change many aspects of the health care system as we know it—from the way we gather and use data to the relationships between sector stakeholders that have been doing business the same way for decades. Uncertainty will be an inevitable part of this transition. Indeed, nearly half a year into MACRA's first performance period, it is still not fully clear how this law will be implemented or how quickly health care stakeholders will come on board. Health care organizations and CMS have more work to do.

Moreover, while MACRA is focused on Medicare payments to physicians, the intent of the law over time is to foster alignment around new payment models with other payers, including commercial health plans. The uncertainties around this transition will, in all likelihood, lead to heterogeneity at the local market level, with multiple types of arrangements among payers and providers and differential impact on patients.

The FFS foundation upon which the health care system was built began showing cracks years before the enactment of MACRA. The law and the new payment models that will emerge from it are laying a new financial and operational foundation that could transform the system for years to come.

MACRA will fundamentally change many aspects of the health care system as we know it—from the way we gather and use data to the relationships between sector stakeholders that have been doing business the same way for decades.

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MACRA is expected to drive care delivery and payment reform across the US health care system for the foreseeable future. To stay on top of what's next, visit and bookmark www.deloitte.com/us/macra.

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