

## MACRA – ESSENTIAL STRATEGIES IN ECONOMIC REFORM

Adele Allison, Director of Provider Innovation Strategies  
November 7, 2016



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## LEARNING OBJECTIVES



### • Participants will be able to:

- **LO1:** Identify strategies to implement in your personal practice that will prepare you for the transformations coming your way as a result of MACRA legislative mandated changes.
- **LO2:** Describe the role of effective data capture to determine the value of services and healthcare reimbursement under emerging population-based payment (PBP) models being applied effective in 2019.
- **LO3:** Implement changes in improved data capture that aligns with essential documentation within the primary care group practice and among organizational leaders.

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**AGENDA** D|S|T

- Healthcare Reform
- Population-Based Payment
- Impact MACRA
- Performance Measurement
- Your Data is Your Voice
- Questions



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**TRIPLE AIM OF HEALTHCARE REFORM** D|S|T



**Lower Costs**



**Better Care**



**Better Health**

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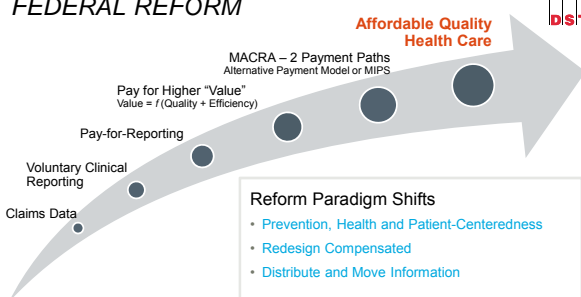
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**FEDERAL REFORM** D|S|T



MACRA – 2 Payment Paths  
Alternative Payment Model or MIPS

Pay for Higher "Value"  
Value = f (Quality + Efficiency)

Pay-for-Reporting

Voluntary Clinical Reporting

Claims Data

**Affordable Quality Health Care**

**Reform Paradigm Shifts**

- Prevention, Health and Patient-Centeredness
- Redesign Compensated
- Distribute and Move Information

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### VBP INDUSTRY TRENDS

|   |  |  |  |
|---|--|--|--|
| <p><b>MIPS</b></p> <ul style="list-style-type: none"> <li>676,722 clinicians in 2019</li> <li>\$199-\$321 million in adjustments</li> <li>\$500 million in "exceptional perform."</li> </ul> <p><b>Advanced APM</b></p> <ul style="list-style-type: none"> <li>70,000-120,000 clinicians in 2019</li> <li>\$333-\$571 million APM incentives</li> </ul> <p><b>CMS Policy</b></p> <ul style="list-style-type: none"> <li>Mandatory Bundles → Ortho and Cardio</li> </ul> | <p><b>UnitedHealth Group</b></p> <ul style="list-style-type: none"> <li>Category 2 P4P rewards → PCPs</li> <li>UHC Medicare and Retirement Ops</li> <li>1,900 PCPs rewarded</li> <li>\$148 million in physician bonuses</li> <li>Ranges             <ul style="list-style-type: none"> <li>1,350 &lt; \$50,000</li> <li>250 between \$50K-\$99K</li> <li>200 between \$100K-\$499K</li> <li>35 between \$500K-\$999K</li> <li>15 &gt; \$1 million</li> </ul> </li> </ul> | <p><b>BCBS Plans VBP</b></p> <ul style="list-style-type: none"> <li>350 Programs in 49 States</li> <li>&gt; 155,000 PCPs, &gt; 60,000 SCPs</li> <li>&gt; 24 million members</li> <li>37 Plans             <ul style="list-style-type: none"> <li>237 ACOs in 41 states and DC – 93,000 MDs</li> <li>63 PCMH initiatives in 48 states, DC and Puerto Rico with &gt; 36,000 MDs</li> </ul> </li> </ul> | <p><b>Medicare Advantage</b></p> <ul style="list-style-type: none"> <li>Seeking data on 4 categories of VBP</li> <li>VBID model 2017 → 5 years in 7 states; 2018 → 5 years in 3 states</li> </ul> <p><b>Managed Medicaid</b></p> <ul style="list-style-type: none"> <li>5 state approaches</li> <li>MCOs used state developed VBP model</li> <li>% of payments must be VBP</li> <li>Evolving VBP over years</li> <li>Multi-payer VBP alignment</li> <li>State approved VBP pilots</li> </ul> |
|---|--|--|--|

Sources: CMS MACRA Final Rule; Forbes UHC Article, Aug. 4; BCBS Press Release, Mar. 2016; MA Call Letter; CHCS Brief, Feb. 2016

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### AGENDA

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### 4 CATEGORIES OF VALUE-BASED PAYMENT (VBP)

|  |  |   |   |
|--|--|---|---|
| <p><b>You Are Here</b></p>  | <p>1. Pay for Infrastructure &amp; Operations<br/>2. Pay-for-Reporting<br/>3. Pay-for-Performance<br/>4. Performance Rewards and Penalties</p>  | <p>1. Alternative Payment Models (APMs) with Upside Gainssharing<br/>2. APM with Upside Sharing &amp; Downside Risk</p>  | <p>1. Condition-Specific Population-Based Payment<br/>2. Comprehensive Population-Based Payment</p>  |
| <p><b>Category 1</b><br/>FFS No Link to Quality &amp; Value</p>  | <p><b>Category 2</b><br/>FFS Linked to Quality &amp; Value</p>   | <p><b>Category 3</b><br/>Alternative Payment Built on FFS Architecture</p>  | <p><b>Category 4</b><br/>Population-Based Payment (PBP)</p>   |

**Advancing Provider Alignment Creates Data and Operational Complexities**

Sources: HHS Health Care Payment Learning & Action Network, Financial Benchmarking White Paper, Feb. 2016

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**PREDOMINANT PAYMENT REFORM MODELS** 

|                        |   |              |
|------------------------|---|--------------|
| FFS + Quality Measures | • Medical Home Incentives               | ← Category 2 |
|                        | • Care Management Fees                  |              |
|                        | • Value-Based Payment Modifier (VBPM)   |              |
|                        | • Pay-for-Performance/Incentives        |              |
| Risk-Bearing           | • Shared-Savings with PCMH / ACOs       | ← Category 3 |
|                        | • Accountable Care Organizations        |              |
|                        | • Bundled Payments                      | ← Category 4 |
|                        | • Episodes of Care Groupers             |              |
|                        | • Full/Partial Capitation + Performance |              |

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**ESSENTIAL STRATEGY #1** 

- **Assess:**
  - When did you last review your payer agreements?
    - List all payers with whom you are contracted
    - What category of payment is the agreement?
  - Also, do you know the health status of all the patients you serve?
- **Result: You are here**
- **Establish Ongoing Reassessment**




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**ESSENTIAL STRATEGY #2** 

- **Recognize:** How are majority health plans prioritizing health management?
  - Identify payers from "Strategy 1" list
  - Contact provider relations rep
  - Ascertain PBP strategies, programs and timelines
- **Result: Strategic Roadmap**
- **Align actions with top revenue sources**




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**AGENDA**

- Healthcare Reform
- Population-Based Payment
- **Impact MACRA**
- Performance Measurement
- Your Data is Your Voice
- Questions

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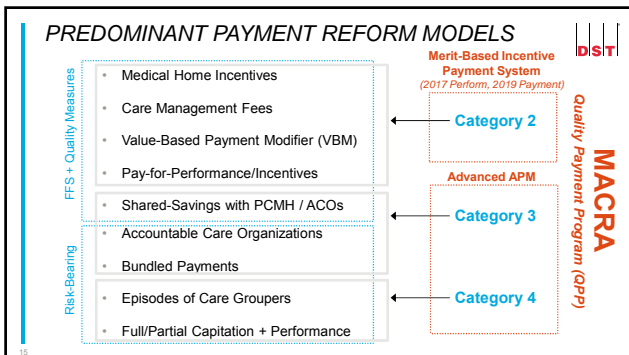
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### MACRA – PROGRESS TO CATEGORY 3 & 4 D|S|T

**Mature Category 3 and 4**

**Advanced APM / Other Payer Advanced APM**

- Use CEHRT, MIPS-like measures, > Nominal Risk
- APM-related Rewards + 5% Part B Incentive Payment

**Early Category 3 and 4**

**MIPS Alternative Payment Model (APM)**

- E.g., Medicare Shared-Savings Program "Track 1 Plus"
- MIPS Payment Adjustments + APM-related Rewards

**Category 2**

**Merit-Based Incentive Payment System (MIPS) Only**

|                      |                          |
|----------------------|--------------------------|
| Year 1 (2019) - ± 4% | Year 2 (2020) - ± 5%     |
| Year 3 (2021) - ± 7% | Year 4 and beyond - ± 9% |

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### MACRA – PROGRESS TO CATEGORY 3 & 4 D|S|T

**Mature Category 3 and 4**

**Advanced APM / Other Payer Advanced APM**

- Use CEHRT, MIPS-like measures, > Nominal Risk
- Incentive third 2024
- APM-related Rewards + 5% Part B Incentive Payment

**Early Category 3 and 4**

**MIPS Bonus**

**APM Opportunity**

**Payment Model (APM)**

- Medicare Shared-Savings Program "Track 1 Plus"
- MIPS Payment Adjustments + APM-related Rewards

**Category 2**

**MIPS Bonus**

**Merit-Based Incentive Payment System (MIPS) Only**

|      |                          |
|------|--------------------------|
| ± 4% | Year 2 (2020) - ± 5%     |
| ± 7% | Year 4 and beyond - ± 9% |

*Benefits*

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### FFS TO RISK-BEARING – MENTAL SHIFT D|S|T

**Category 2**

**Category 3 – Bundle Payment**  
**Category 4 – Global PBP**

The diagram shows a transition from a traditional FFS model (left) to risk-bearing models (right). The FFS model is represented by a cube with icons for a doctor, a patient, and a hand holding a dollar sign. The risk-bearing models are represented by a cube with icons for a hospital, medications, and diagnostics, with a plus-minus sign above it.

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**FINAL RULE – 2017 TRANSITION YEAR** 

| Options      | 1 MIPS – Penalty Avoidance  | 2 MIPS – Delayed Start   | 3 MIPS – Ready to Go  | 4 Advanced Alternative Payment Model  |
|--------------|---|--|---|---|
| Requirements | <p><b>Submit by Mar. 31, 2018</b></p> <ul style="list-style-type: none"> <li>- 90 days of data between Jan. 1 and Oct. 2, 2017</li> <li>- 1 Quality Measure, 1 Clinical Practice Improvement Activity, or 5 required Advancing Care Information measures</li> </ul>  | <p><b>Submit by Mar. 31, 2018</b></p> <ul style="list-style-type: none"> <li>- 90 days of data between Jan. 1 and Oct. 2, 2017</li> <li>- &gt; 1 Quality Measure, &gt; 1 Improvement activity, and/or &gt; 5 required Advancing Care Information measures</li> </ul>  | <p><b>Submit by Mar. 31, 2018</b></p> <ul style="list-style-type: none"> <li>- "Full Year" of data</li> <li>- 6 Quality Measures (1 outcome) – MIPS APM Groups report 15;</li> <li>- 4 Improvement activities; or 2 for small, rural, HPSA or non-patient facing</li> <li>- Required or up to 9 of advancing care information measures</li> </ul>  | <p><b>Significant portion of Medicare patients or payments</b></p> <ul style="list-style-type: none"> <li>- Qualified Participant (QP) determination "snapshot" and inclusive</li> <li>- Driven by patient or pay thresholds</li> </ul>   |

CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule. Released to Office of Federal Register, October 14, 2016.

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**ADVANCED ALTERNATIVE PAYMENT MODELS** 

- **MACRA → Alternative Payment Model (APM) Definition**
  - CMS Innovation Center Model (non-award projects only)
  - Medicare Shared-Savings Program (MSSP)
  - Demo under Health Care Quality Demonstration Program
  - Demonstration required by federal law
- **And, must meet 3 criterion**
  - Use Certified EHR Technology (CEHRT)
  - Use measures comparable to MIPS
  - Bear "more than nominal financial risk," or is an expanded Medical Home under CMS Innovation Center

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**ADVANCED ALTERNATIVE PAYMENT MODELS** 

- **Advanced APMs specifically included in 2017**
  - Medicare Shared-Savings Programs – Tracks 2 and 3
  - Next Generation ACO Model
  - Comprehensive ESRD Care (CEC)
  - Comprehensive Primary Care Plus (CPC+) → **Advanced Medical Home Model**
  - Oncology Care Model (OCM) – 2-sided risk starting in 2018
- **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** → 11-member MACRA established advisory committee, reviews/recommends APM models to HHS

HR 2, 114<sup>th</sup> Congress, Medicare Access and CHIP Reauthorization Act, <https://www.congress.gov/bills/114/hr/2/text>  
 CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule. Released to Office of Federal Register, October 14, 2016.

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### APM GROWTH



- **2016 Public and Private National Health Plan Survey**
- **Participants** → > 128 million Americans, ~ 44% of Market
  - Commercial → 26 health plans, 90 million lives, 44% of market
  - Medicare Advantage → 23 health plans, 10 million lives, 58% of MA market
  - Managed Medicaid → 28 health plans and 2 states, 28 million lives, 39% of Medicaid

**2015**

- Legacy Payments (Category 1)
- FFS linked to Quality (Category 2)
- APMs (Category 3 & 4)

**2016**

- Commercial
- Medicare Advantage
- Managed Medicaid

Sources: HHS Health Care Payment Learning and Action Network, 2016 Fall Summit, APM Measurement, October 25, 2016

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### ESSENTIAL STRATEGY 3



- **Identify:** What are the essential data-points you need?
  - Is there overlap between payers/needs?
  - Is data being captured consistently?
  - How do you “measure up” today?
- **Result: Critical Data Identification**
- **Position for workflow redesign**




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### AGENDA



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- Your Data is Your Voice
- Questions




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**AGENDA**

- Healthcare Reform
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- **Your Data is Your Voice**
- Questions

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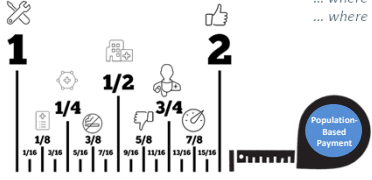

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**WHAT GETS MEASURED ...**

**... Gets Done!**

- Measurement means tracking ...
- ... where we have been
- ... where we are
- ... where we are going

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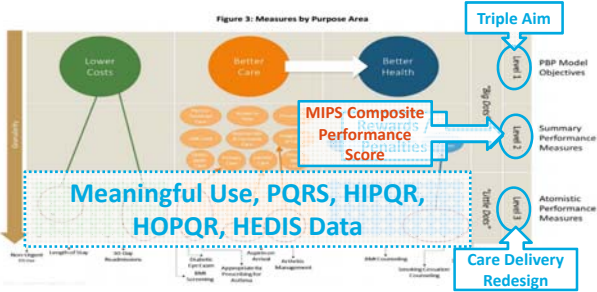
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**HCPLAN 2016 – PERFORMANCE MEASURES**

Figure 3: Measures by Purpose Area



Meaningful Use, PQRS, HIPQR, HOPQR, HEDIS Data



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**HEALTH PLANS AND MEASUREMENT** 



Health Plan quality measurement has driven revenue for years

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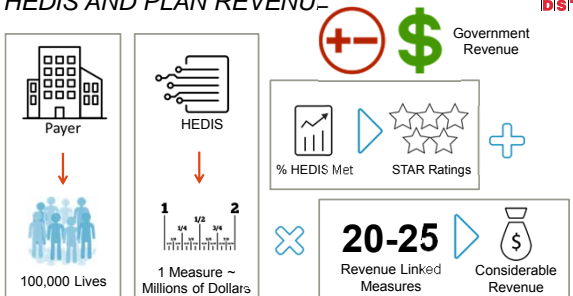
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**HEDIS AND PLAN REVENUE** 



100,000 Lives

1 Measure ~ Millions of Dollars

20-25 Revenue Linked Measures

Government Revenue

Considerable Revenue

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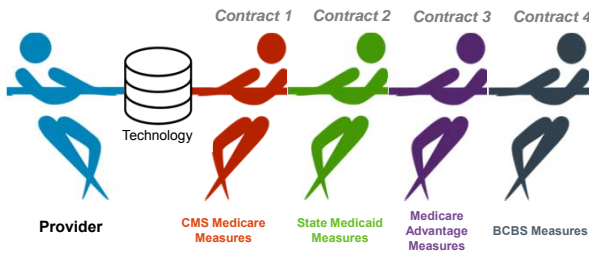
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**REDUCING THE REPORTING BURDEN** 



Provider

Technology

Contract 1: CMS Medicare Measures

Contract 2: State Medicaid Measures

Contract 3: Medicare Advantage Measures

Contract 4: BCBS Measures

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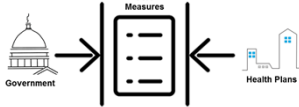
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### CMS AND AHIP HARMONIZE

- 2014 – CMS and AHIP form the **Core Quality Measures Collaborative (CQMC)**
- February 2016 – CQMC releases **7 core measure sets** for quality improvement and reporting
  - ACO, PCMH and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Orthopedics
  - Obstetrics and Gynecology



Core Measure download available at [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Quality\\_Measures/Core-Measures.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Quality_Measures/Core-Measures.html)

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### CONSENSUS CORE SET – ACO AND PCMH

| NQF # | Title                       | Description   | Measure Steward | Comments                                       |
|-------|-----------------------------|---|-----------------|--|
| 0018  | Controlling High BP         | Patients 18-85 with HTN diagnosis adequate control (<140/90)  | NCQA            | Physician-Level Use                            |
| NA    | Controlling High BP (HEDIS) | Patients 18-85 with HTN diagnosis adequately controlled as follows: <ul style="list-style-type: none"> <li>18-59 = &lt;140/90</li> <li>60-85 with Diabetes = &lt;140/90</li> <li>60-85 without Diabetes = &lt;150/90</li> </ul> | NCQA            | Health Plan or Integrated Delivery Network Use |



#### Blood Pressure Control

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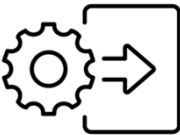
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### CLINICAL DOCUMENTATION IMPROVEMENT



↑ Documentation = ↑ Performance

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**ESSENTIAL STRATEGY #4** 

- **Redesign:** Apply the “5-Rights”
  - **Right** Information
  - **Right** Person Capturing
  - **Right** Data Format
  - **Right** Technology Channel
  - **Right** Time in the Patient Workflow
- **Result:** Strong Data → Strong Performance
- **Train for consistent data capture; report for ongoing improvement**



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**THANK YOU** 

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