MACRA – ESSENTIAL STRATEGIES IN ECONOMIC REFORM
Adele Allison, Director of Provider Innovation Strategies
November 7, 2016

DISCLAIMER
The enclosed materials are highly sensitive, proprietary and confidential. Please use every effort to safeguard the confidentiality of these materials. Please do not copy, distribute, use, share or otherwise provide access to these materials to any person inside or outside DST Systems, Inc. without prior written approval.

By making this presentation available to you, we are not granting any express or implied rights or licenses under any intellectual property right.

If we permit your printing, copying or transmitting of content in this presentation, it is under a non-exclusive, non-transferable, limited license, and does not constitute an agreement. By printing this presentation available to you, we are not granting any express or implied rights or licenses under any intellectual property right.

If you print, copy, transmit or distribute content from this presentation, you must include in any copy or electronic distribution the copyright notice printed or contained in this document. You may not create derivative works of this presentation or incorporate this presentation in any other publications, websites, or other materials. We reserve the right to terminate this license at any time. Any violation may result in legal action. Our trademarks and service marks and those of third parties used in this presentation are the property of their respective owners.

© 2016 DST Systems, Inc. All rights reserved.

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.
AGENDA

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

TRIPLE AIM OF HEALTHCARE REFORM

- Lower Costs
- Better Care
- Better Health

FEDERAL REFORM

- MACRA – 2 Payment Paths
- Alternative Payment Model or MIPS
- Pay for Higher “Value”
  \[ \text{Value} = f(\text{Quality} + \text{Efficiency}) \]
- Voluntary Clinical Reporting
- Pay-for-Reporting
- Claims Data

Reform Paradigm Shifts

- Prevention, Health and Patient-Centeredness
- Redesign, Compensated
- Distribute and Move Information
**VBP INDUSTRY TRENDS**

**MIPS**
- 676,722 clinicians in 2019
- $196-$321 million in ± adjustments
- $350 million in "exceptional performance"

**Advanced APM**
- 70,800-120,000 clinicians in 2019
- $333-$571 million APM incentives

**CMS Policy**
- Mandatory Bundles → Ortho and Cardio

**UnitedHealth Group**
- Category 2 APMS with PCPs
- UHC Medicare and Retirement Ops
- 1,600 PCPs rewarded
- $140 million in physical therapies

**SCBS Plans VBP**
- 382 Programs in 49 States
- 100,000 PCPs, > 60,000 SCPs
- > 24 million members

**Medicare Advantage**
- 37 Plans
- 100,000 PCPs, > 24 million members

**BCBS Plans VBP**
- 350 Programs in 49 States
- > 155,000 PCPs, > 60,000 SCPs
- > 24 million members

**Medicare Advantage**
- Seeking data on 4 categories of VBP
- VBID model 2017 → 5 years in 7 states, 2018 → 5 years in 3 states

**Managed Medicaid**
- 5 state approaches
- 4 categories of VBP
- 35% of payments must be VBP
- Evolving VBP over years
- Multi-payer VBP alignment
- State approved VBP pilots

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

4 CATEGORIES OF VALUE-BASED PAYMENT (VBP)

1. Category 1: FFS No Link to Quality & Value
2. Category 2: FFS Linked to Quality & Value
3. Category 3: Alternative Payment Built on FFS Architecture
4. Category 4: Population-Based Payment (PBP)


PREDOMINANT PAYMENT REFORM MODELS

- Medical Home Incentives
- Care Management Fees
- Value-Based Payment Modifier (VBPM)
- Pay-for-Performance/Incentives
- Shared-Savings with PCMH / ACOs
- Accountable Care Organizations
- Bundled Payments
- Episodes of Care Groupers
- Full/Partial Capitation + Performance

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**

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

PREDOMINANT PAYMENT REFORM MODELS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2</td>
<td>MACRA Quality Payment Program (2017 Performance, 2018 Payment)</td>
</tr>
<tr>
<td>Category 3</td>
<td>Advanced APM</td>
</tr>
<tr>
<td>Category 4</td>
<td>Category 4</td>
</tr>
</tbody>
</table>

- Medical Home Incentives
- Care Management Fees
- Value-Based Payment Modifier (VBM)
- Pay-for-Performance/Incentives
- Shared-Savings with PCMH / ACOs
- Accountable Care Organizations
- Bundled Payments
- Episodes of Care Groupers
- Full/Partial Capitation + Performance
MACRA – PROGRESS TO CATEGORY 3 & 4

Mature Category 3 and 4
Advanced APM / Other Payer Advanced APM
- Use CDWIT, 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%

MACRA – PROGRESS TO CATEGORY 3 & 4

Mature Category 3 and 4
Advanced APM / Other Payer Advanced APM
- Use CDWIT, MIPS-like measures, + Nominal Risk
- 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 Bonus + 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%

FFS TO RISK-BEARING – MENTAL SHIFT

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

[Diagram showing categories and shifts]
### FINAL RULE – 2017 TRANSITION YEAR

<table>
<thead>
<tr>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. MIPS – Penalty Avoidance</strong></td>
</tr>
<tr>
<td>Submit by Mar. 31, 2018</td>
</tr>
<tr>
<td>- 90 days of data between Jan. 1 and Mar. 31, 2017</td>
</tr>
<tr>
<td>- 1 Quality Measure, 1 Clinical Practice Improvement Activity, and/or 5 required Advancing Care Information measures</td>
</tr>
<tr>
<td><strong>2. MIPS – Delayed Start</strong></td>
</tr>
<tr>
<td>Submit by Mar. 31, 2018</td>
</tr>
<tr>
<td>- 90 days of data between Jan. 1 and Mar. 31, 2017</td>
</tr>
<tr>
<td>- 1 Quality Measure, 1 Improvement Activity, and/or 5 required Advancing Care Information measures</td>
</tr>
<tr>
<td><strong>3. MIPS – Ready to Go</strong></td>
</tr>
<tr>
<td>Submit by Mar. 31, 2018</td>
</tr>
<tr>
<td>- Full year of data</td>
</tr>
<tr>
<td>- 6 Quality Measures (1 outcome) – MIPS APM Groups report 15; 2 improvement activities, or 2 for small, rural, HPSA or non-patient facing</td>
</tr>
<tr>
<td>- Required or up to 9 of advancing care information measures</td>
</tr>
<tr>
<td><strong>4. Advanced Alternative Payment Model</strong></td>
</tr>
<tr>
<td>Significant portion of Medicare patients or payments</td>
</tr>
<tr>
<td>- Qualified Participant (QP) determination “snapshot” and inclusive</td>
</tr>
<tr>
<td>- Driven by patient or pay thresholds</td>
</tr>
</tbody>
</table>

---

### 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

---

### 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
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

2016

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

AGENDA

- Healthcare Reform
- Population-Based Payment
- Impact MACRA
- Performance Measurement
  - Your Data is Your Voice
  - Questions
MIPS COMPOSITE PERFORMANCE SCORE

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Resource Use or Cost</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Replaces PQRS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Replaces ACA’s Value-Based Modifier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• POEM gets full credit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 65 activities available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Some weighted higher than others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Some align with Advancing Care Information measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Replaces MU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 15 total measures (up to 90%); 5 required (50%); 2 bonus measures (up to 15%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Some providers may not have to submit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MIPS – CPS PAYMENT ADJUSTMENTS

- Positive / Negative adjustments are CMS budget neutral
- Scoring → “Points” earned under each category, 0-100 points
- Eligible Clinicians (ECs) → perform all or none of categories
- ECs performing none → Composite Performance Score (CPS) of zero and subject to maximum negative adjustment

<table>
<thead>
<tr>
<th>Final Score Points</th>
<th>MIPS Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0 – 0.75</td>
<td>Replaced MU</td>
</tr>
<tr>
<td>0.8 – 2.9</td>
<td>Negative Adjustment = -0.1 * CPS on a linear sliding scale</td>
</tr>
<tr>
<td>3.0</td>
<td>0.0% adjustment</td>
</tr>
<tr>
<td>3.1 – 69.9</td>
<td>Negative MIPS payment adjustment = 0.8% to 5.0% on a linear sliding scale</td>
</tr>
<tr>
<td>70.0 – 100</td>
<td>Positive MIPS payment adjustment of 4.0% AND additional MIPS bonus for “exceptional performance” of 0.5% to 10.0% on a linear sliding scale</td>
</tr>
</tbody>
</table>

MIPS ESTIMATED IMPACT YEAR 2019

<table>
<thead>
<tr>
<th>Clinician Specialty or Type</th>
<th>Total MIPS Eligible TIN / NPIs</th>
<th>Total Allowed Charges</th>
<th>Estimated Aggregate +/- Adjustment</th>
<th>Per TIN / NPI Average MIPS Negative Adjustment &lt;= 1.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL SPECIALITIES</td>
<td>678,722</td>
<td>$78,454,000,000</td>
<td>± $301,000,000</td>
<td>$-5,845,000</td>
</tr>
<tr>
<td>Cardiology</td>
<td>24,657</td>
<td>$5,172,000,000</td>
<td>± $17,000,000</td>
<td>$-9,317,000</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>71,073</td>
<td>$5,802,000,000</td>
<td>± $26,000,000</td>
<td>$-6,421,000</td>
</tr>
<tr>
<td>General Surgery</td>
<td>18,118</td>
<td>$1,734,000,000</td>
<td>± $8,000,000</td>
<td>$-5,134,000</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>3,044</td>
<td>$371,000,000</td>
<td>± $2,000,000</td>
<td>$-7,717,000</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>60,811</td>
<td>$9,520,000,000</td>
<td>± $30,000,000</td>
<td>$-5,741,000</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>51,004</td>
<td>$1,763,000,000</td>
<td>± $11,000,000</td>
<td>$-7,379,000</td>
</tr>
<tr>
<td>Obstetricians</td>
<td>18,578</td>
<td>$487,000,000</td>
<td>± $2,000,000</td>
<td>$-2,447,000</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>42,402</td>
<td>$1,284,000,000</td>
<td>± $6,000,000</td>
<td>$-8,589,000</td>
</tr>
</tbody>
</table>

26
AGENDA

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

WHAT GETS MEASURED …

... Gets Done!
- Measurement means tracking …
  ... where we have been
  ... where we are
  ... where we are going

HCPLAN 2016 – PERFORMANCE MEASURES

Meaningful Use, PQRS, HIPQR, HOPQR, HEDIS Data
Health Plan quality measurement has driven revenue for years.

HEDIS AND PLAN REVENUE

100,000 Lives

1 Measure ~ Millions of Dollars

20-25 Revenue Linked Measures

Considerable Revenue

REDUCING THE REPORTING BURDEN

Contract 1  Contract 2  Contract 3  Contract 4

Provider  Technology  CMS Medicare Measures  State Medicaid Measures  Medicare Advantage Measures  BCBS Measures
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
  1. ACO, PCMH and Primary Care
  2. Cardiology
  3. Gastroenterology
  4. HIV and Hepatitis C
  5. Medical Oncology
  6. Orthopedics
  7. Obstetrics and Gynecology

### CONSENSUS CORE SET – ACO AND PCMH

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Title</th>
<th>Description</th>
<th>Measure Steward</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0018</td>
<td>Controlling High BP (HEDIS)</td>
<td>Patients 18-85 with HTN diagnosis adequately controlled (≤140/90)</td>
<td>NCQA</td>
<td>Physician-Level Use</td>
</tr>
</tbody>
</table>
| NA    | Controlling High BP (HEDIS) | Patients 18-85 with HTN diagnosis adequately controlled as follows:  
  - 18-59 = ≤140/90  
  - 60-85 with Diabetes = ≤140/90  
  - 60-85 without Diabetes = ≤150/90 | NCQA | Health Plan or Integrated Delivery Network Use |

**Blood Pressure Control**

### CLINICAL DOCUMENTATION IMPROVEMENT

↑ Documentation = ↑ Performance
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

THANK YOU

Adele Allison
AMBenson@DSTHealthSolutions.com
@Adele_Allison