MACRA – ESSENTIAL STRATEGIES IN ECONOMIC REFORM

Adele Allison, Director of Provider Innovation Strategies
November 22, 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.

This proprietary, confidential presentation is for general informational purposes only and does not constitute an agreement. 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 you must include or refer to the copyright notice contained in this document. You may not create derivative works of this presentation or its content without our prior written permission. Any reference in this presentation to another entity or its products or services is provided for convenience only and does not constitute an offer to sell, or the solicitation of an offer to buy, any products or services offered by such entity, nor does such reference constitute our endorsement, referral, or recommendation.

Our trademarks and service marks and those of third parties used in this presentation are the property of their respective owners.

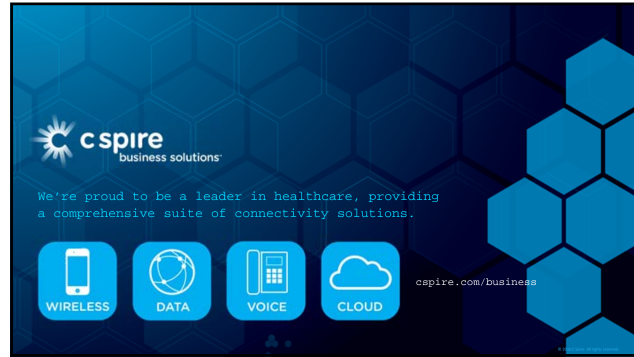
© 2016 DST Systems, Inc. All rights reserved.

2

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.
  - **LO3:** Implement changes in improved data capture that aligns with essential documentation within the primary care group practice and among organizational leaders.

3

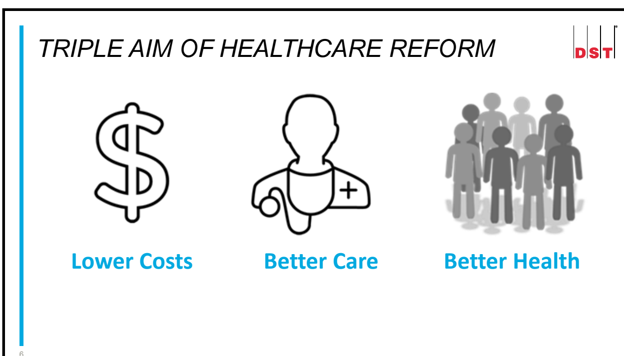


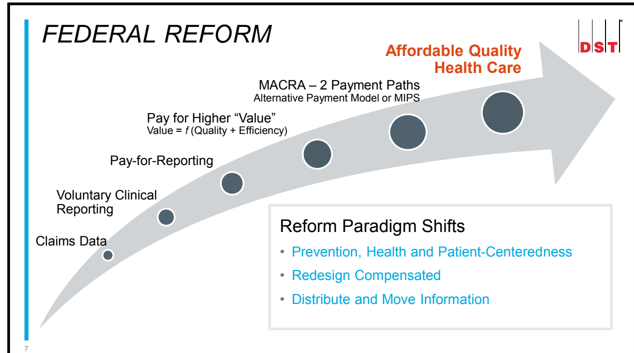
AGENDA

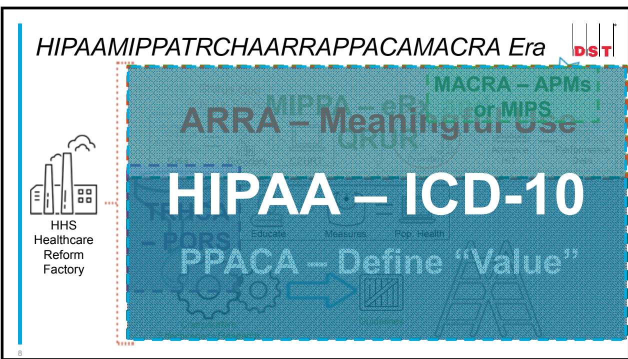
DST

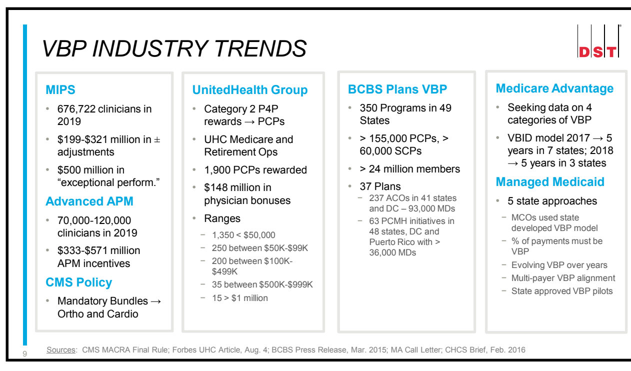
- Healthcare Reform
- Population-Based Payment
- Impact MACRA
- Performance Measurement
- Your Data is Your Voice
- Questions

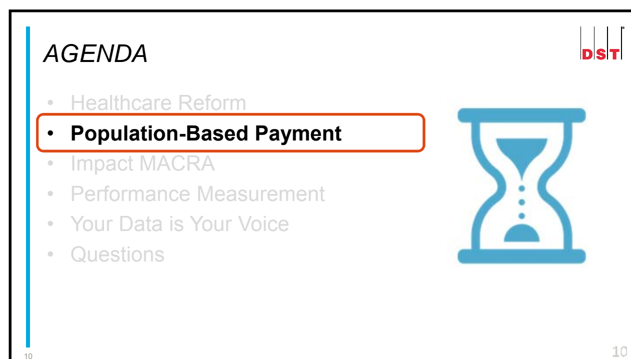
5

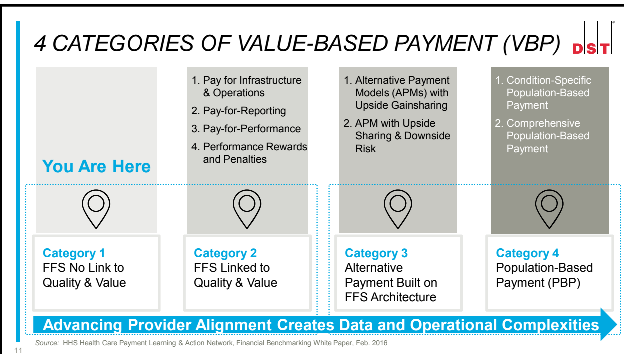


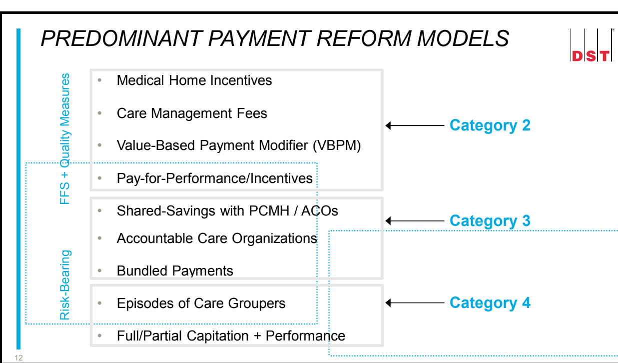

FEDERAL REFORM
DST
Affordable Quality Health Care
MACRA – 2 Payment Paths
Alternative Payment Model or MIPS
Pay for Higher "Value"
Value = f (Quality + Efficiency)
Pay-for-Reporting
Voluntary Clinical Reporting
Claims Data
Reform Paradigm Shifts
Prevention, Health and Patient-Centeredness
Redesign Compensated
Distribute and Move Information
7


HIPAAMIPPATRCHAARRAPPACAMACRA Era
DST
MACRA – APMs or MIPS
ARRA – Meaningful Use
HIPAA – ICD-10
PPACA – Define "Value"
Educate
Measures
Pop. Health
HHS Healthcare Reform Factory
8


VBP INDUSTRY TRENDS
DST
MIPS
676,722 clinicians in 2019
$199-$321 million in ± adjustments
$500 million in "exceptional perform."
Advanced APM
70,000-120,000 clinicians in 2019
$333-$571 million APM incentives
CMS Policy
Mandatory Bundles → Ortho and Cardio
UnitedHealth Group
Category 2 P4P rewards → PCPs
UHC Medicare and Retirement Ops
1,900 PCPs rewarded
$148 million in physician bonuses
Ranges
1,350 < $50,000
250 between $50K-$99K
200 between $100K-$499K
35 between $500K-$999K
15 > $1 million
BCBS Plans VBP
350 Programs in 49 States
> 155,000 PCPs, > 60,000 SCPs
> 24 million members
37 Plans
237 ACOs in 41 states and DC – 93,000 MDs
63 PCMH initiatives in 48 states, DC and Puerto Rico with > 36,000 MDs
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
MCOs used state developed VBP model
% of payments must be VBP
Evolving VBP over years
Multi-payer VBP alignment
State approved VBP pilots
Sources: CMS MACRA Final Rule; Forbes UHC Article, Aug. 4; BCBS Press Release, Mar. 2015; MA Call Letter; CHCS Brief, Feb. 2016
9


AGENDA
DST
Healthcare Reform
Population-Based Payment
Impact MACRA
Performance Measurement
Your Data is Your Voice
Questions
10


4 CATEGORIES OF VALUE-BASED PAYMENT (VBP)
DST
You Are Here
1. Pay for Infrastructure & Operations
2. Pay-for-Reporting
3. Pay-for-Performance
4. Performance Rewards and Penalties
1. Alternative Payment Models (APMs) with Upside Gainsharing
2. APM with Upside Sharing & Downside Risk
1. Condition-Specific Population-Based Payment
2. Comprehensive Population-Based Payment
Category 1
FFS No Link to Quality & Value
Category 2
FFS Linked to Quality & Value
Category 3
Alternative Payment Built on FFS Architecture
Category 4
Population-Based Payment (PBP)
Advancing Provider Alignment Creates Data and Operational Complexities
Source: HHS Health Care Payment Learning & Action Network, Financial Benchmarking White Paper, Feb. 2016


PREDOMINANT PAYMENT REFORM MODELS
DST
FFS + Quality Measures
Risk-Bearing
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
Category 2
Category 3
Category 4

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**

13

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**

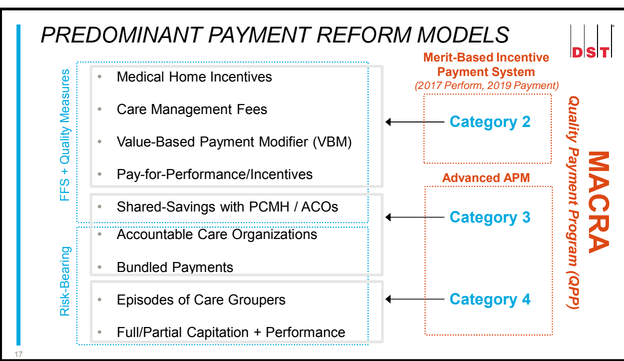
14

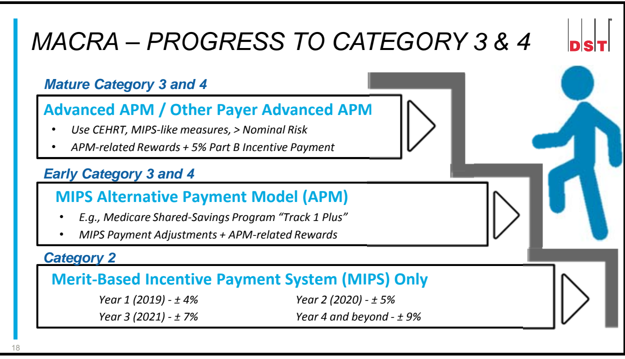
AGENDA

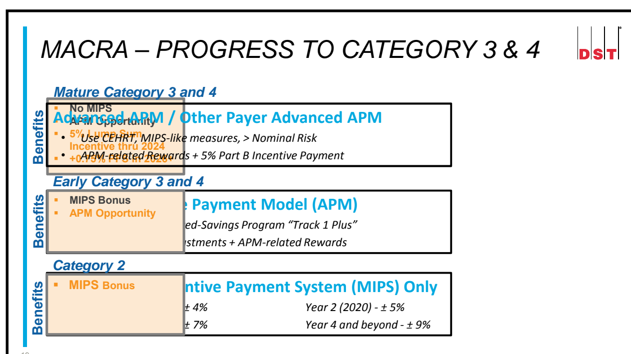
- Healthcare Reform
- Population-Based Payment
- **Impact MACRA**
- Performance Measurement
- Your Data is Your Voice
- Questions

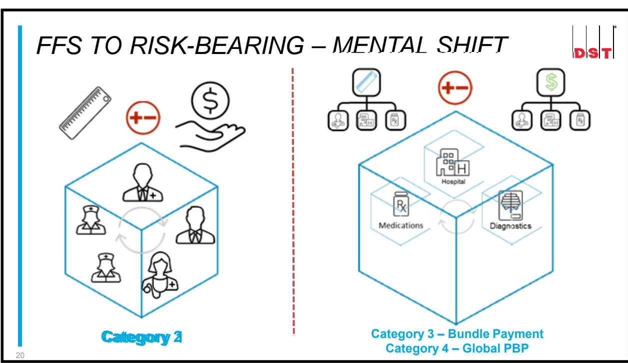
15

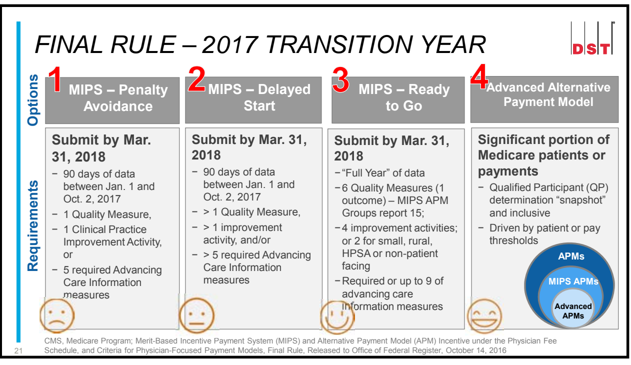
Quality Payment Program


PREDOMINANT PAYMENT REFORM MODELS
DST
FFS + Quality Measures
Risk-Bearing
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
Merit-Based Incentive Payment System
(2017 Perform, 2019 Payment)
Category 2
Advanced APM
Category 3
Category 4
Quality Payment Program (QPP)
MACRA
17


MACRA – PROGRESS TO CATEGORY 3 & 4
DST
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%
18


MACRA – PROGRESS TO CATEGORY 3 & 4
DST
Mature Category 3 and 4
Benefits
No MIPS
Advanced APM / Other Payer Advanced APM
Use CEHRT, MIPS-like measures, > Nominal Risk
Incentive thru 2024
APM-related Rewards + 5% Part B Incentive Payment
Early Category 3 and 4
Benefits
MIPS Bonus
APM Opportunity
Payment Model (APM)
ed-Savings Program “Track 1 Plus”
stments + APM-related Rewards
Category 2
Benefits
MIPS Bonus
ntive Payment System (MIPS) Only
± 4%
Year 2 (2020) - ± 5%
± 7%
Year 4 and beyond - ± 9%
19


FFS TO RISK-BEARING – MENTAL SHIFT
DST
Hospital
Medications
Diagnostics
Category 2
Category 3 – Bundle Payment
Category 4 – Global PBP
20


FINAL RULE – 2017 TRANSITION YEAR
DST
Options
Requirements
1 MIPS – Penalty Avoidance
Submit by Mar. 31, 2018
– 90 days of data between Jan. 1 and Oct. 2, 2017
– 1 Quality Measure,
– 1 Clinical Practice Improvement Activity, or
– 5 required Advancing Care Information measures
2 MIPS – Delayed Start
Submit by Mar. 31, 2018
– 90 days of data between Jan. 1 and Oct. 2, 2017
– > 1 Quality Measure,
– > 1 improvement activity, and/or
– > 5 required Advancing Care Information measures
3 MIPS – Ready to Go
Submit by Mar. 31, 2018
– “Full Year” of data
– 6 Quality Measures (1 outcome) – MIPS APM Groups report 15;
– 4 improvement activities; or 2 for small, rural, HPSA or non-patient facing
– Required or up to 9 of advancing care information measures
4 Advanced Alternative Payment Model
Significant portion of Medicare patients or payments
– Qualified Participant (QP) determination “snapshot” and inclusive
– Driven by patient or pay thresholds
APMs
MIPS APMs
Advanced APMs
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
21

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

22

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, 114th Congress, Medicare Access and CHIP Reauthorization Act, https://www.congress.gov/bill/114th-congress/house-bill/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

23

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

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

24

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**

25

AGENDA

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

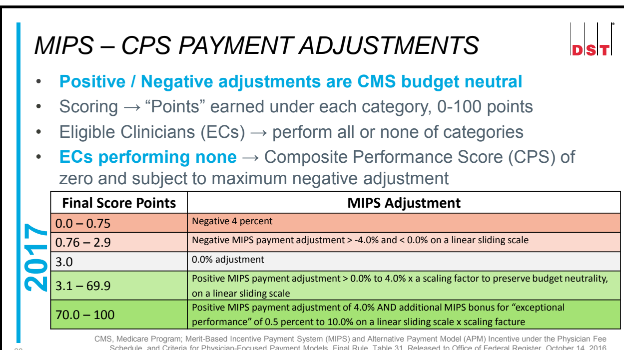
26

MIPS COMPOSITE PERFORMANCE SCORE

CPS Category	Quality Measures	Resource Use or Cost	Improvement Activities	Advancing Care Information
	• Replaces PQRS • Select 6 of 271, including 1 outcome measure • Groups using web interface → report 15	• Replaces ACA's Value-Based Modifier • Calculated from claims • Feedback only CY2017 • Weighting starts CY2018	• PCMH gets full credit • 93 activities available • Some weighted higher than others • Some align with Advancing Care Information measures	• Replaces MU • 15 total measures (up to 90%); 5 required (50%); 2 bonus measures (up to 15%) • Some providers may not have to submit
Perform Year 2017	60%	0%	15%	25%
Perform Year 2018	50%	10%	15%	25%
Perform Year 2019	30%	30%	15%	25%

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.

27



MIPS – CPS PAYMENT ADJUSTMENTS

DST

- **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

2017

Final Score Points	MIPS Adjustment
0.0 – 0.75	Negative 4 percent
0.76 – 2.9	Negative MIPS payment adjustment > -4.0% and < 0.0% on a linear sliding scale
3.0	0.0% adjustment
3.1 – 69.9	Positive MIPS payment adjustment > 0.0% to 4.0% x a scaling factor to preserve budget neutrality, on a linear sliding scale
70.0 – 100	Positive MIPS payment adjustment of 4.0% AND additional MIPS bonus for "exceptional performance" of 0.5 percent to 10.0% on a linear sliding scale x scaling facture

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, Table 31, Released to Office of Federal Register, October 14, 2016

28

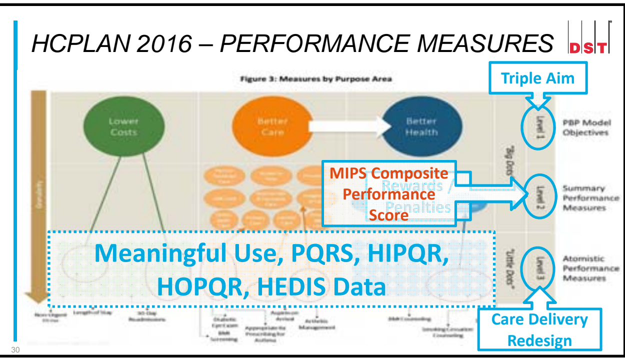
MIPS ESTIMATED IMPACT YEAR 2019

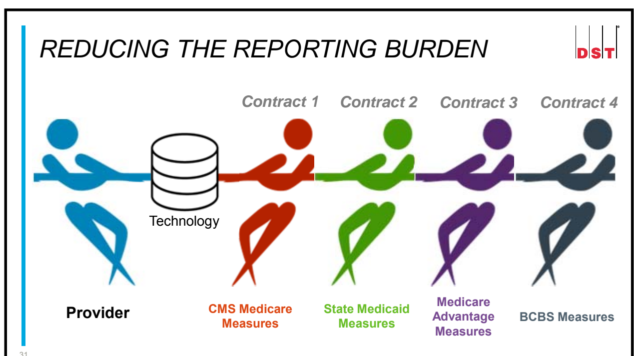
DST

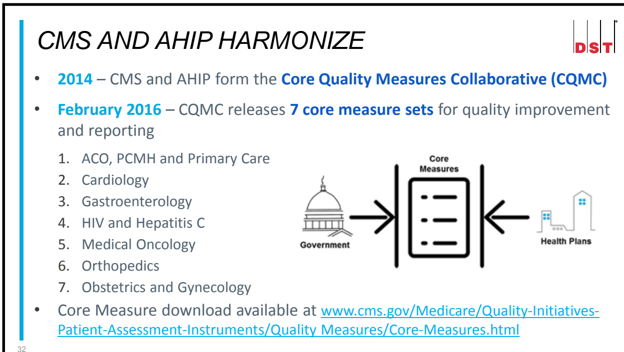
Clinician Specialty or Type	Total MIPS Eligible TIN / NPIs	Total Allowed Charges	Estimated Aggregate +/- Adjustment	Per TIN / NPI Average MIPS Negative Adjustment (Up To)
ALL SPECIALITIES	676,722	$78,454,000,000	± $321,000,000	- $5,846.00
Cardiology	24,657	$5,172,000,000	± $17,000,000	- $9,317.00
Family Medicine	71,073	$5,802,000,000	± $26,000,000	- $4,631.00
General Surgery	18,118	$1,734,000,000	± $8,000,000	- $5,134.00
Internal Medicine	80,871	$9,320,000,000	± $39,000,000	- $5,741.00
Orthopedics	19,360	$3,286,000,000	± $17,000,000	- $7,379.00
Neurology	12,540	$1,405,000,000	± $9,000,000	- $7,717.00
Ob/Gyn	18,578	$487,000,000	± $2,000,000	- $2,447.00
Urology	8,956	$1,924,000,000	± $6,000,000	- $8,589.00

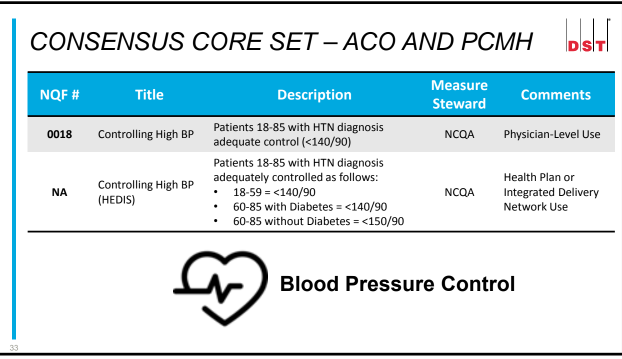
CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Table 61, Released to Office of Federal Register, October 14, 2016

29









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: • 18-59 = <140/90 • 60-85 with Diabetes = <140/90 • 60-85 without Diabetes = <150/90	NCQA	Health Plan or Integrated Delivery Network Use

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**

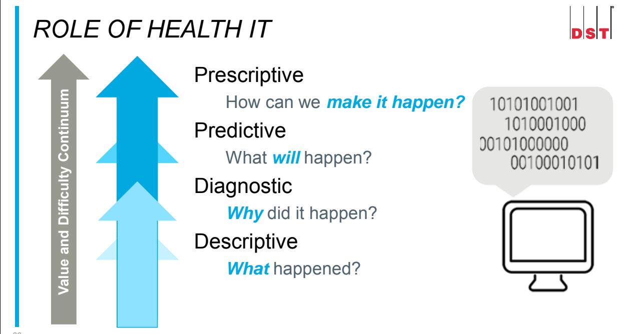
34

AGENDA

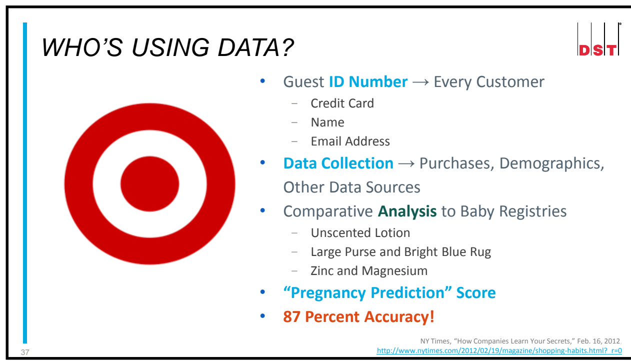
- Healthcare Reform
- Population-Based Payment
- Impact MACRA
- Performance Measurement
- **Your Data is Your Voice**
- Questions

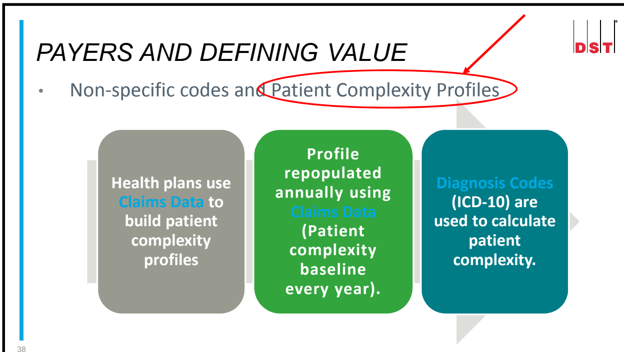
35

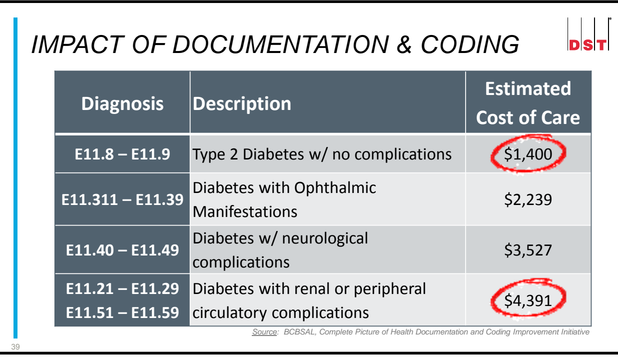
ROLE OF HEALTH IT



36



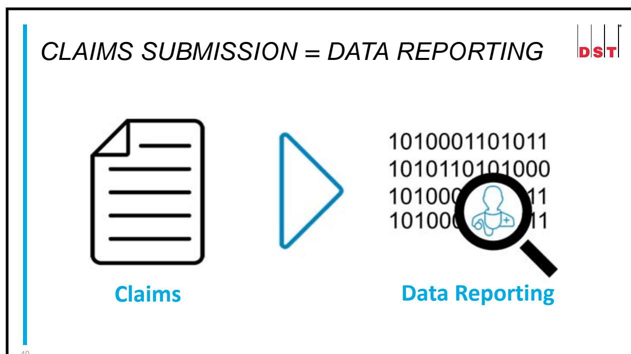


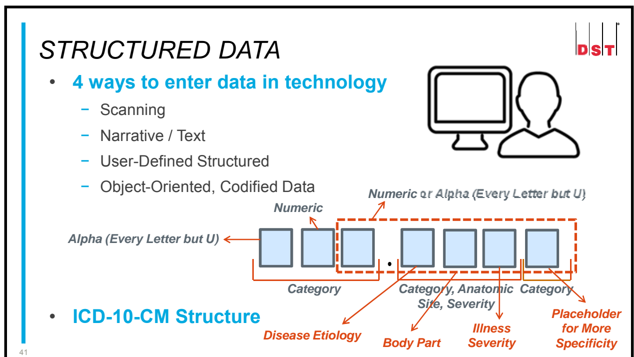


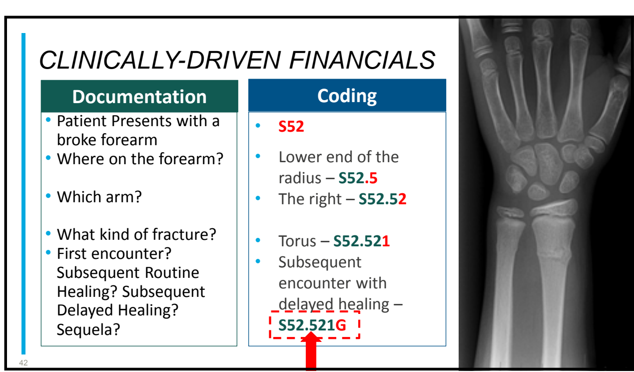
IMPACT OF DOCUMENTATION & CODING

Diagnosis	Description	Estimated Cost of Care
E11.8 – E11.9	Type 2 Diabetes w/ no complications	$1,400
E11.311 – E11.39	Diabetes with Ophthalmic Manifestations	$2,239
E11.40 – E11.49	Diabetes w/ neurological complications	$3,527
E11.21 – E11.29 E11.51 – E11.59	Diabetes with renal or peripheral circulatory complications	$4,391

Source: BCBSAL, Complete Picture of Health Documentation and Coding Improvement Initiative


CLAIMS SUBMISSION = DATA REPORTING
DST
Claims
Data Reporting


STRUCTURED DATA
DST
4 ways to enter data in technology
Scanning
Narrative / Text
User-Defined Structured
Object-Oriented, Codified Data
Numeric or Alpha (Every Letter but U)
Numeric
Alpha (Every Letter but U)
Category
Category, Anatomic Site, Severity
Category
ICD-10-CM Structure
Disease Etiology
Body Part
Illness Severity
Placeholder for More Specificity


CLINICALLY-DRIVEN FINANCIALS
Documentation
Patient Presents with a broke forearm
Where on the forearm?
Which arm?
What kind of fracture?
First encounter? Subsequent Routine Healing? Subsequent Delayed Healing? Sequela?
Coding
S52
Lower end of the radius – S52.5
The right – S52.52
Torus – S52.521
Subsequent encounter with delayed healing –
S52.521G

CLINICAL DOCUMENTATION IMPROVEMENT

DST

↑ Documentation = ↑ Performance

43

ESSENTIAL STRATEGY #5

DST

- **Engage**: Learn more about the Quality Payment Program and Alternative Payment Model movement
  - Access CMS website to determine "measures" relevant to your 2017 transition year at https://qpp.cms.gov/
  - Become a member or monitor the Health Care Payment Learning and Action Network (HCPLAN) resources at https://hcp-lan.org/
- **Result: Learn from others**
- **Share your lessons learned with others**

44

DST

THANK YOU

Adele Allison
AMAllison@DSTHealthSolutions.com
@Adele_Allison

45