MACRA: Looking Ahead - Implications Across the Care Continuum
May 16, 2016/ 12:00-1:00 PM EST
Today’s Presenter

Melinda Hancock
Partner, DHG Healthcare
- Leads a team in developing DHG Healthcare’s next generation financial modeling products and services related to a variety of revenue transformation business issues, including the transition from fee-for-service to non-FFS payment models
- More than 22 years of healthcare experience in the public and private industry sectors
- A member of HFMA since 1994, Melinda’s involvement has been at the National and Chapter levels in a variety of leadership positions and she is currently the National Chair.

Craig Tolbert
Principal, DHG Healthcare
- Works in the DHG Alternative Payment Model team with navigating new payment and delivery structures such as CMS’s Bundled Payments for Care Improvement demonstration and Accountable Care Organization initiatives
- 22 years of experience in the healthcare industry
- He provides strategic and analytic support to a broad array of clients including hospitals and post-acute providers in both current and future care delivery and payment reform environments.

Doral Davis-Jacobsen
Senior Manager, DHG Healthcare
- Leads clients through next generation managed care contracting, operations assessment, revenue cycle assessments, physician-hospital integration, financial analysis and operations management
- More than 20 years of healthcare experience in managerial consulting
- Regularly assists ACOs/CINs, medical practices and hospital systems in navigating current payment reform environment and preparing for the future.
1. The Big Picture: Connecting the Dots
2. Current CMS Quality Initiatives
3. MACRA: Quality Payment Program
   Key Elements
4. Stakeholder Impact
5. Summary – Next Steps
The Big Picture: Connecting the Dots
The Tipping Point at Altitude

1. Impact of Purchaser Pressure
2. When will our market tip?
3. How will you develop your Transformational Agility?

PROVIDER NET REVENUE

TIME

.VALUE BASED PAYMENT

risk capable
The framework situates existing and potential APMs into a series of categories.

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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<td>Condition-Specific Population-Based Payment</td>
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<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>APMs with Upside Gainsharing</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
<td>Comprehensive Population-Based Payment</td>
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<td>Rewards and Penalties for Performance</td>
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Work Group’s Goals for Payment Reform

MACRA moves us closer to meeting these goals...

The new Merit-based Incentive Payment System helps to link fee-for-service payments to quality and value.

The law also provides incentives for participation in Alternative Payment Models in general and bonus payments to those in the most highly advanced APMs.

New HHS Goals:

- **2016**
  - 30% of payments linked to quality and value

- **2018**
  - 50% of payments linked to quality and value
  - 90% of payments to those in the most highly advanced APMs under MACRA

- **All Medicare fee-for-service (FFS) payments (Categories 1-4)**
- **Medicare FFS payments linked to quality and value (Categories 2-4)**
- **Medicare payments linked to quality and value via APMs (Categories 3-4)**
- **Medicare Payments to those in the most highly advanced APMs under MACRA**

Source: CMS MACRA presentation Spring 2016
Polling Question #1

Do you believe that MACRA will move us closer to meeting the new HHS goals?

a) Yes, it is a step in the right direction
b) No, there is room for better policies
c) Maybe
d) Not sure
Pulling it all together: Value Based Future

**Advanced APMs**
- CPC+
- MSSP Tracks 2 & 3
- Next Gen ACO
- Oncology Care 2 Side Risk
- Comprehensive ESRD Care Model

**Degree of Integration**

- **MIPS**
  - Performance-Based Contracts
  - Bundled Payments
  - Shared Savings
  - Shared Risk
  - Global Payments

**Level of Financial Risk**

- Fee for Service
Connecting the Dots—Better performance in each program positively impacts initiatives across the continuum of care.
Becoming Risk Capable

**CORE ELEMENTS**
- Enterprise Intelligence
- Revenue Transformation
- Clinical Enterprise Maturity

**FOUNDATIONAL CATALYSTS**
- Innovation Acceleration
- Clinical Assets
- New Infrastructure
- Population Health
- Scenario Planning & Dynamic Financial Modeling
- Leadership & Culture
- Governance
Current CMS Quality Initiatives
### Impact Year

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<td>Value Modifier Groups &gt; 100 Eligible Professional (EPs)</td>
<td>(-1.5%) to 9.8%</td>
<td>(-2%) to 2(15)%</td>
<td>(-4%) to 4(x*)%</td>
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#### Maximum Adjustments

-4%  -5%  -7%  -9%  4%  5%  7%  9%

**Bonus calculated for monies generated from penalty pool**  
**High Performers eligible for additional $ pool = $500 million**
Polling Question #2

Does your organization clearly understand the financial implications that go along with MACRA?

a) No, we are still developing our understanding
b) Yes, we have started to develop our strategy for MACRA
c) N/A
Value Modifier

Major Components

– Applied by Tax ID and patients by PCP and/or plurality
– Quality, Cost & Claims Based Outcome Scores (60%+ of MIPS)
– Quality and Resource Use Reports (QRURs)

Impact to Medicare Reimbursement 2016

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<tr>
<th></th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
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<td><strong>Low Cost</strong></td>
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<td>0% adjustment (6)</td>
<td>+15.92% adjustment¹ (35) $12,825,784</td>
<td>+31.84% adjustment² (0)</td>
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<td></td>
<td>+31.84% adjustment² (38) $37,785,744</td>
<td>+31.84% adjustment³ (0)</td>
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<td><strong>Average Cost</strong></td>
<td>-1% adjustment⁴ (37) -$1,820,182</td>
<td>0% adjustment (8,201)</td>
<td>+15.92% adjustment¹ (35) $14,151,039</td>
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<td>+31.84% adjustment² (20) $14,690,631</td>
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<tr>
<td><strong>High Cost</strong></td>
<td>-2% adjustment⁴ (2) -$1,047,873</td>
<td>-1% adjustment⁴ (20) -$2,214,069</td>
<td>0% adjustment (1)</td>
</tr>
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¹2016 Adjustment Factor ²Calculated as 2.0x Adjustment Factor for High Risk Beneficiaries ³Calculated as 3.0x Adjustment Factor for High Risk Beneficiaries ⁴TINs with 10-99 Eligible Physicians do no receive downward adjustments under quality-tiering in 2016

Source: CMS 2016 VM Overview PDF Memo, CMS 2016 VM OACT Adjustment Factor PDF Memo
MACRA: Quality Payment Program Key Elements
• MACRA:
  – Ended the **Sustainable Growth Rate** (SGR) formula for determining Medicare Part B payments for health care providers’ services
  – Establishes a new framework the Quality Payment Program which rewards health care providers for giving better care not more just more care (MIPS and APM)
  – Sunsets existing programs – PQRS, VM, MU, eRX
  – Provides consistent physician fee schedule increases (0.5% from 2015 through 2019)
  – Establishes a technical advisory committee for assessing Physician Focused Payment Model (PFPM) proposals
  – Proposed rule open for comment until June 27, 2016
Quality Payment Program: MIPS or APM?

Starting in 2019, all medical practices will fall into one of two categories under the Quality Payment Program established MACRA:

### Merit Incentive Based Program (MIPS)

Portion of practice Medicare Revenue at risk at the Tax Identification Number or individual level based on performance in these categories:

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<tr>
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<tbody>
<tr>
<td>Quality (aka PQRS)</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost - Resource Use (aka VM)</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information (aka MU)</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities (CPIA)</td>
<td>15%</td>
<td>15%</td>
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HHS may revise weights

### Advanced Alternative Payment Models (APMs)

No downside risk on Physician Fee Schedule if a significant portion of Medicare Revenue flows through an Advanced APM (Qualified Participant = QP):

<table>
<thead>
<tr>
<th>*THRESHOLDS</th>
<th>2019 to 2020</th>
<th>2021 to 2022</th>
<th>2023 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Payments</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>% Patients</td>
<td>20%</td>
<td>35%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Starting in 2021 - can include non Medicare Revenue/Patients

Proposed Models:
- Comprehensive Primary Care Plus (CPC+)
- MSSP Tracks 2 & 3
- Next Generation ACO
- Oncology Care Model Two-Sided Risk Arrangement (OCM - available 2018)
- Comprehensive ESRD Care (CEC) Model

* Awaiting final rule and partially qualifying APM status is available
Getting from Here to There

Everyone in MIPS year one
Performance period 2017 adjustment impact 2019

Existing Medicare Part B Quality Reporting Programs

PQRS (+)
Value Based Payment Modifier (+)
Meaningful Use

Advancing Care Information

Clinical Practice Improvement Activities (CPIA)

Resource Use
15% YR 2
30% YR 3

Quality
50% YR 1
35% YR 2
30% YR 3

25% each YR
15% each YR
10% YR 1
MIPS

QUALITY (old PQRS)

• 50% of total score in YR 1 – 30% YR 3
• Replaces the PQRS
• Replaces Quality Composite VM Program
• Some direct reporting required
• Points: 80 – 90 available (Group size dep.)
  – Choose to report six measures versus the nine measures currently required under the PQRS
  – Category gives clinicians reporting options to choose from to accommodate differences in specialty and practices
  – Outcomes/Population measures claims based
MIPS

Resource Use (old VM Cost Composite)

• 10% of total score in YR 1 – 30% YR 3
• Replaces the cost component of the VM Program
• No direct reporting required
• Points: Avg Score Cost Measures / patient sample
  – Score based on Medicare claims data
  – Uses more than 40 episode-specific measures to account for differences among specialties
  – Per Capita Cost and Medicare Spend Per Beneficiary (MSPB) included
Advancing Care Information (old MU)

- 25% of total score all YRS
- Replaces Meaningful Use (MU)
- Direct reporting required
- Points: 100 maximum
  - 50 base pts, 80 performance pts + bonus pts
  - Choose to report customizable measures that reflect how they use electronic health record (EHR) technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange.
  - Unlike MU, this category would not require all-or-nothing EHR measurement or quarterly reporting.
Clinical Practice Improvement Activities

- 15% of total score all YRS
- New Category
- Direct Reporting Required
- Points: maximum 60

  - Rewards for clinical practice improvement activities such as activities focused on:
    - care coordination
    - beneficiary engagement
    - patient safety

  - Select from a list of over 90 options (these are weighted some heavier than others)

  - Receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes
Polling Question #3

Does your organization know what it needs to do to benefit from MIPS (Merit-Based Incentive Payment System) beginning in 2019?

a) Yes
b) No
c) N/A
Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)

\[
\text{CPS} = \left[ \left( \frac{\text{score}}{\text{weight}} \right) + \left( \frac{\text{score}}{\text{weight}} \right) + \left( \frac{\text{score}}{\text{weight}} \right) + \left( \frac{\text{score}}{\text{weight}} \right) \right] \times 100
\]
MIPS Penalty Projections 2019

MIPs Estimated Economic Impact 2019 by Group Size

- **Solo**: 87% Eligible Clinicians, 13% MIPS Penalty
- **2 to 9**: 70% Eligible Clinicians, 30% MIPS Penalty
- **10 to 24**: 59% Eligible Clinicians, 40% MIPS Penalty
- **25 to 99**: 45% Eligible Clinicians, 55% MIPS Penalty
- **100 or more**: 18% Eligible Clinicians, 81% MIPS Penalty

Standards for Advanced APMs

• Require participants to bear a certain amount of financial risk:
  – Total risk (maximum amount of losses possible under the Advanced APM) must be at least 4 percent of the APM spending target.
  – Marginal risk (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM Entity is responsible (i.e., sharing rate) must be at least 30 percent.
  – Minimum loss rate (the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM Entity has responsibility for losses) must be no greater than 4 percent.

• Base payments on quality measures comparable to those used in the MIPS quality performance category

• Require participants to use certified EHR technology.

• 2019 Advanced APM Menu:
  • Comprehensive Primary Care Plus (CPC+)
  • MSSP Tracks 2 & 3
  • Next Generation ACO
  • Oncology Care Model Two-Sided Risk Arrangement (available 2018)
  • Comprehensive ESRD Care Model
## Qualifying APM vs Partial Qualifying APM: Revenue Based

### MEDICARE OPTION

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<tr>
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<th>2019-2020</th>
<th>2021-2022</th>
<th>2023-2024+</th>
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<tbody>
<tr>
<td>Qualified</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
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<tr>
<td>Partially Qualified</td>
<td>20%</td>
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### ALL PAYER COMBINATION OPTION

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<th>2019-2020</th>
<th>2021-2022</th>
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<tbody>
<tr>
<td>Qualified</td>
<td>N/A</td>
<td>50%/25%</td>
<td>75%/25%</td>
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<tr>
<td>Partially Qualified</td>
<td>N/A</td>
<td>40%/20%</td>
<td>50%/20%</td>
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*(The second number is the required minimum Medicare threshold still mandated in the All Payer Combination Option)*
Decision Tree Revenue Based: Qualifying APM vs Partial Qualifying APM

- Per the Proposed Regulations 4/27/16

2019 – 2020
Medicare Option

Is Threshold Score ≥ 20%?

Yes
- MIPS EP

No
- Is Threshold Score ≥ 25%?
  Yes
- QP
  Yes
- MIPS EP
  No
- Partial QP
Decision Tree Revenue Based: Qualifying APM vs Partial Qualifying APM

- Per the Proposed Regulations 4/27/16

2021 – 2022
All-Payer Combination Option

Is Threshold Score ≥ 50%?

Yes

Is Medicare Threshold Score ≥ 25%?

Yes

Is All-Payer Threshold Score ≥ 50%?

Yes

Is Medicare Threshold Score ≥ 20%?

Yes

Is All-Payer Threshold Score ≥ 40% OR is Medicare Threshold Score ≥ 40%?

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Yes

Is Medicare Threshold Score ≥ 20%?
Qualifying APM vs Partial Qualifying APM: Patient Count Based

MEDICARE OPTION

<table>
<thead>
<tr>
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<th>2019-2020</th>
<th>2021-2022</th>
<th>2023-2024+</th>
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<tbody>
<tr>
<td>Qualified</td>
<td>20%</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>Partially Qualified</td>
<td>10%</td>
<td>25%</td>
<td>35%</td>
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</table>

OR

ALL PAYER COMBINATION OPTION

<table>
<thead>
<tr>
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<th>2019-2020</th>
<th>2021-2022</th>
<th>2023-2024+</th>
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</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>N/A</td>
<td>35%/20%</td>
<td>50%/20%</td>
</tr>
<tr>
<td>Partially Qualified</td>
<td>N/A</td>
<td>25%/10%</td>
<td>35%/10%</td>
</tr>
</tbody>
</table>

(The second number is the required minimum Medicare threshold still mandated in the All Payer Combination Option)
BOTTOM LINE: There are opportunities for financial incentives for participating in an APM, even if you don’t become an Advanced APM. Organizations that explore a variety of APM possibilities and incorporate non-Medicare lives are more likely to meet Advanced APM thresholds.
Polling Question #4

How far along is your organization in thinking through the MACRA decision tree?

a) Just beginning to think about MACRA
b) Have started strategic planning
c) Working on implementation of strategy
d) N/A
In the VM program, many practices are in the ‘neutral zone’ and have no penalty if within one standard deviation from the mean (yellow area).

Starting in 2019—provider scores from 0—100 (including payment adjustments) in each category will be made publicly available on Physician Compare.

### TODAY

<table>
<thead>
<tr>
<th>Weight</th>
<th>Score</th>
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<tbody>
<tr>
<td>Payment Adjustment:</td>
<td>Yes—incentive</td>
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### TOMORROW

<table>
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<th>Score</th>
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<tbody>
<tr>
<td>Payment Adjustment:</td>
<td>Yes—incentive</td>
</tr>
<tr>
<td>Quality Score</td>
<td>50%</td>
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<tr>
<td>Resource Use</td>
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<tr>
<td>Meaningful Use</td>
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<tr>
<td>Clinical Practice Improvement</td>
<td>15%</td>
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<tr>
<td>Overall Score</td>
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</tbody>
</table>

SAMPLE ONLY (Illustrative Purposes) — ABC Practice - Dr. Jones

Or
Stakeholder Impact
Impact Across the Continuum of Care

Many of the core tenants in the MACRA legislation which guide the framework for the Quality Payment Program impact many programs across the care continuum.
Summary & Next Steps
Summary

• Understand the implications for your organization given the MACRA framework
• Educate key stakeholders
• Assess current local market conditions
• Develop an action plan for addressing key concerns
• Start today: 1st performance period begins January 2017
Audience Questions
Upcoming Webinars

May 23
MACRA Session 2: Developing a Game Plan-Case Study/Tool Kit

June 1
Medicare Proposed Rule S-10

June 6
IPPS Proposed Rule

June 9 (hfma webinar)
MACRA and the Proposed Rules: More than Acronyms

June 13
MACRA Session 3: Alternative Payment Modeling Planning-Get to Qualified APM Thresholds
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