Regulatory Disruption of The Health Care Industry—MACRA

December 15, 2016

Housekeeping Issues

- All participants are muted
  - To ask a question or make a comment, please submit via the chat feature and we will address as many as possible after the presentations.
- Audio and Visual is through www.readytalk.com
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- Today's slides will be available for download on the eHI Resource page at: **https://www.ehidc.org/resources/eventsummaries**

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Agenda

- Welcome Remarks
  - Claudia Ellison, Director of Programs, eHI
- Today's Speakers
  - Charles Kennedy, MD MBA
    CMO Clinical Integration
    Aetna
  - Kori Krueger, MD, MBA
    Medical Director Institute for Quality Innovation and Patient Safety
    Marshfield Clinic
- Questions & Answers from Audience

eHEALTH INITIATIVE

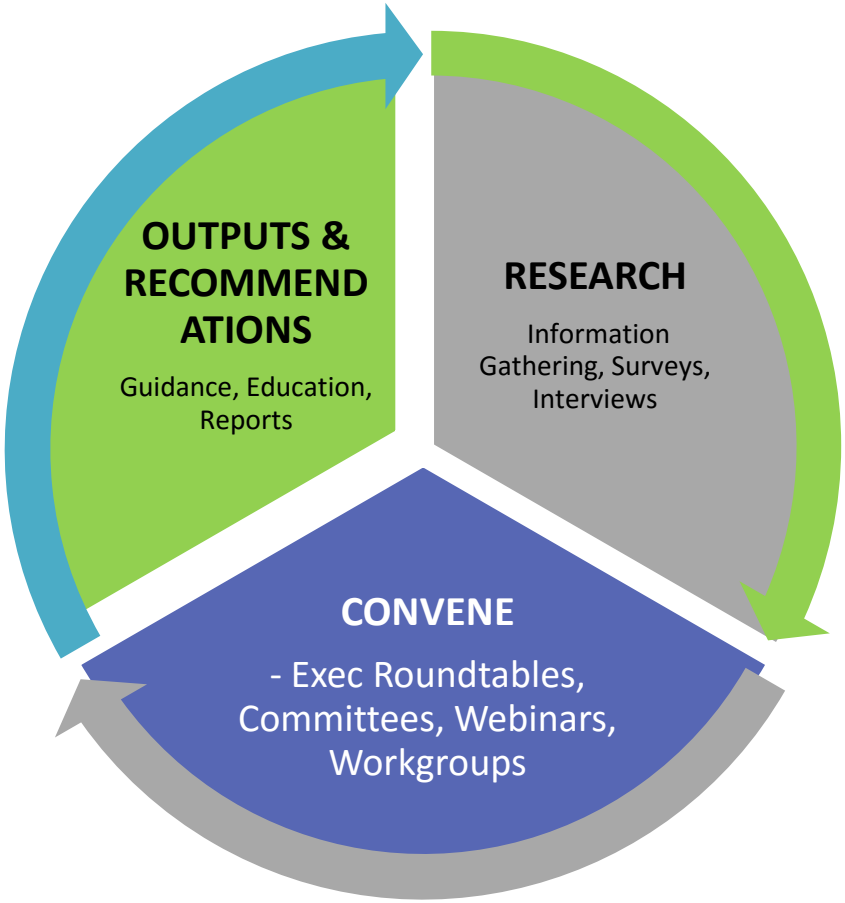
Thank You

eHEALTH INITIATIVE

Overview of eHealth Initiative

- Since 2001, eHealth Initiative (c6) and the Foundation for eHealth Initiative (c3) have conducted research, education and advocacy to demonstrate the value of technology and innovation in health.
- Serve as the industry leader convening executives from multi-stakeholder groups to identify best practices to transform care through use of health IT
- The missions of the two organizations are the same: to drive improvement in the quality, safety, and efficiency of healthcare through information and technology.
- Our work is centered around the *2020 Roadmap*. The primary objective of the *2020 Roadmap* is to craft a multi-stakeholder solution to enable coordinated efforts by public and private sector organizations to transform care delivery through data exchange and health IT.

Roadmap to Transforming Care



eHealth - Convening Executives to Research & Identify Best Practices

Regulatory Disruption of The Health Care Industry—MACRA

Charles Kennedy, MD MBA
CMO Clinical Integration
Aetna

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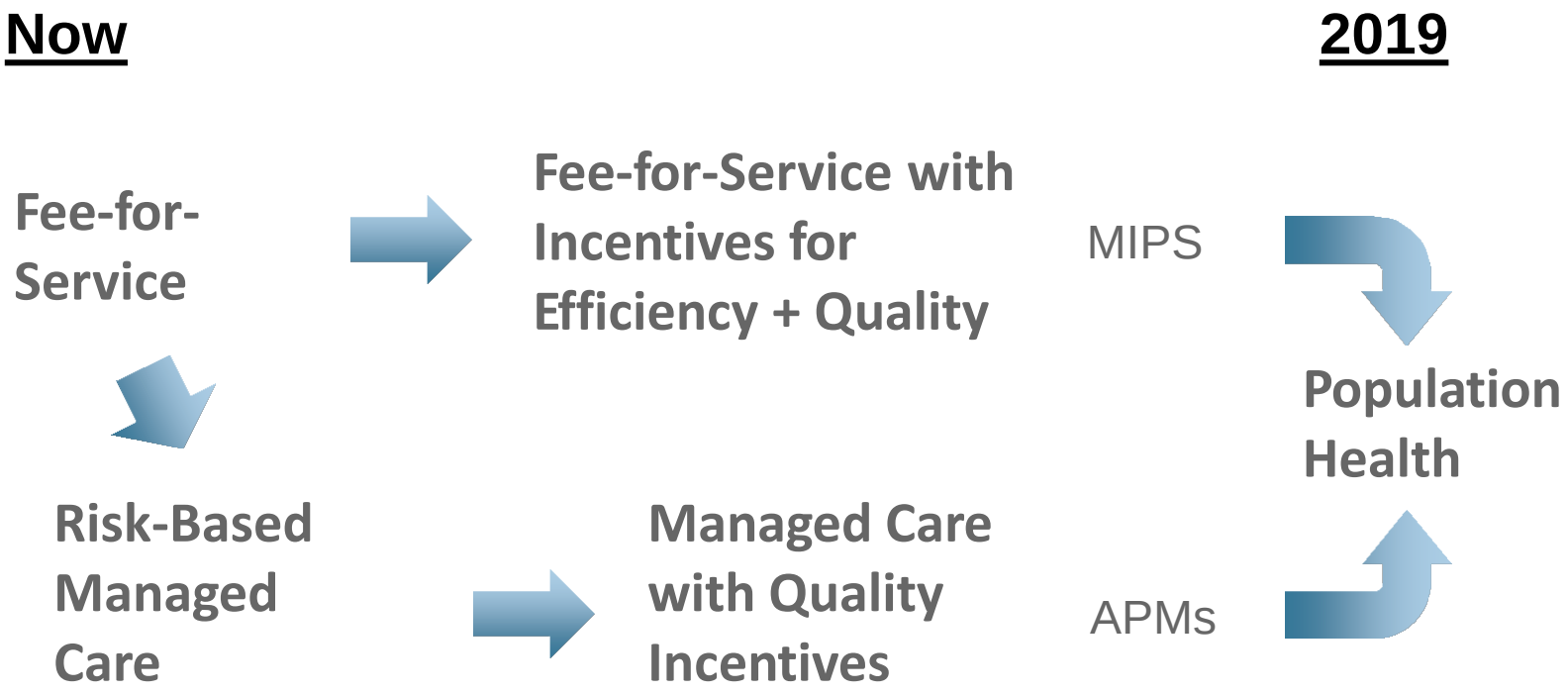
MACRA Will Link Clinical Effectiveness and Efficiency to Financial Reward



MACRA Will Significantly Alter Physician Payment Models

MACRA replaces Fee for Service payments using the Medicare Provider Fee Schedule (PFS) in traditional Medicare with new payment methodologies centered on accountability for outcomes measured via population health and payment variability

Advanced Alternative Payment Models (APMs)

- From 2019-2024, **lump sum payments** equal to 5% of all reimbursement for services rendered under the Medicare PFS
- Beginning in 2026, annual payment updates of **0.75%** to the Medicare PFS
- CMS has indicated which ACOs and models under the Center for Medicaid and Medicare Innovation will likely be considered Advanced APMs (See Slide 18)

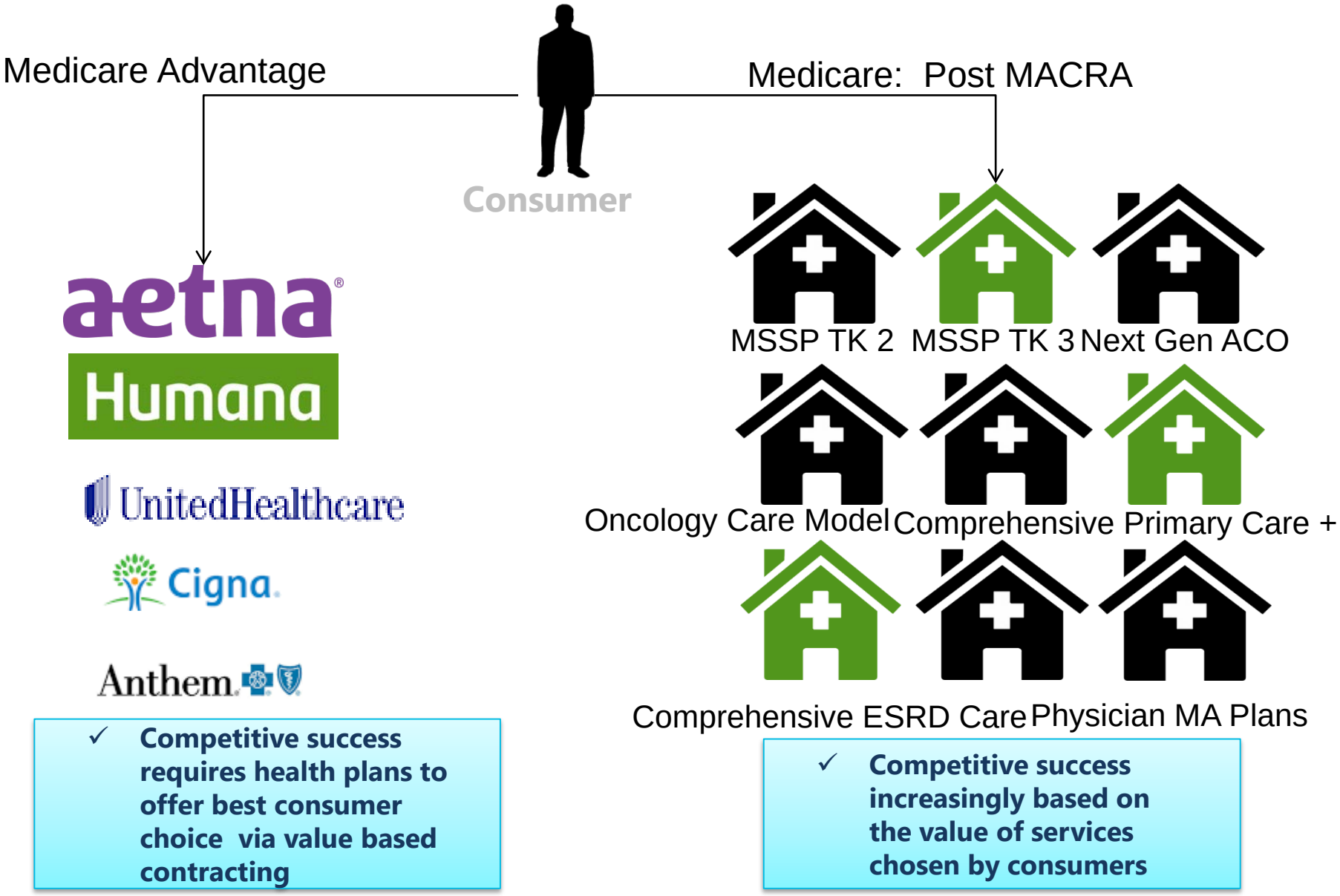
~120K of Eligible Providers by 2018
~$400 million in payment adjustments

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
- Beginning in 2026, annual payment updates of **0.25%** 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

~600Kof Eligible Providers by 2018
~$700 million in payment adjustments

MACRA Narrows Differences Between MA and Medicare



- ✓ **Competitive success requires health plans to offer best consumer choice via value based contracting**

- ✓ **Competitive success increasingly based on the value of services chosen by consumers**

Providers Need Help With MACRA

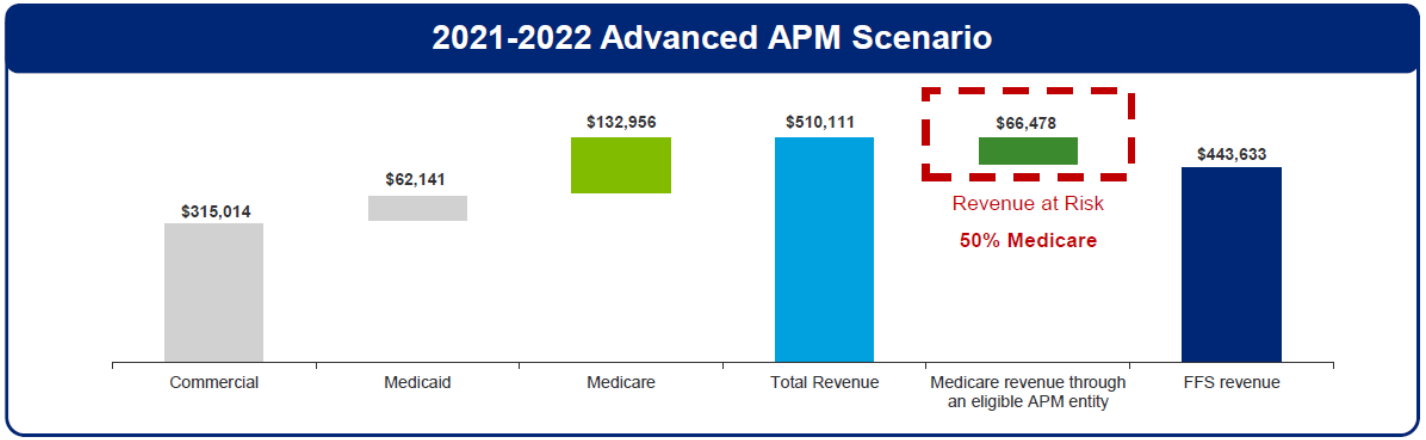
Only 2% of Providers say they have sufficient knowledge of MACRA*

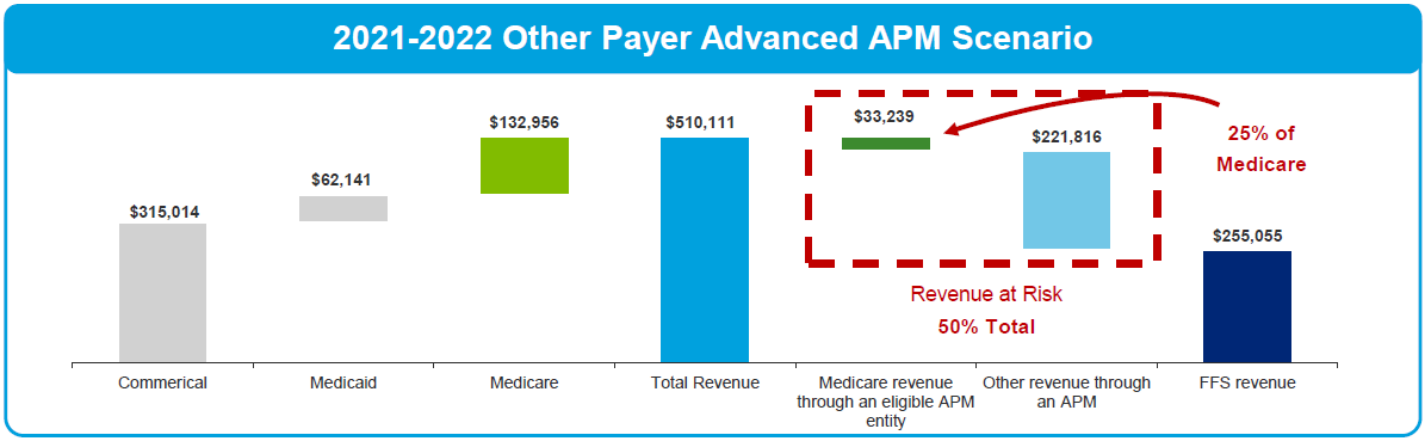
Providers express broad areas of need for the transition to value based care**

Area of Potential Need	% of respondents expressing a need
Change Management	68%
Data Integrity & Interoperability	62%
Clinical Workflow & Productivity	58%
Competing I.T. Priorities	54%
Physician alignment	48%
Cost of technology tools	46%
Effectively trained staff	46%
Patient engagement	45%
Risk Based Contracting skills	28%
Losses in Revenue	27%
Policy & Security	27%
Board & Mgmt team leadership	8%

Source:*Deloitte survey; **Medicity survey sponsored survey

MACRA Has Specific Incentives for Private Payer Collaboration in the Transition to Value Based Care





Source: MGMA Cost Survey: 2014 Report Based on 2013 Data, Primary Care Physician - Mean.

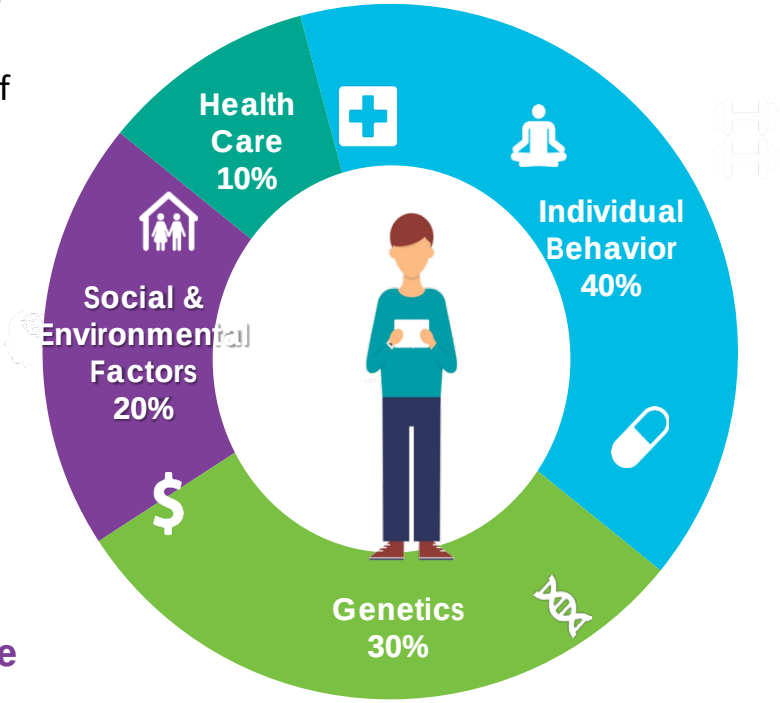
MA & Commercial contracts from private payers may help providers qualify as Advanced Alternative Payment Models thereby achieving higher risk & re-imbursement opportunities

Business Development Focus: Value Measurement & Maximization is Key to "Winning in MACRA"

The concept of value must be measured and maximized at the individual consumer / patient level

Understand the Individual

- Consumer centric strategies requires deep understanding of the consumer and how they measure value
- Consumers demand high value for their dollar in almost every industry and should do the same in retail health



Evolve the Community

- Complete population based analytics at the community level to identify opportunities to improve social and environmental factors toward better health
- Leverage Public Health methodologies to drive improved performance
- Convene and align social, environmental, public safety entities toward a healthier, safer community

Align With Providers of Care

- Contracting--Value Based Contracts need to align and support MACRA based requirements
- Providers will need value based metrics to support value based contracts

Marshfield Clinic Health System Approach to MACRA

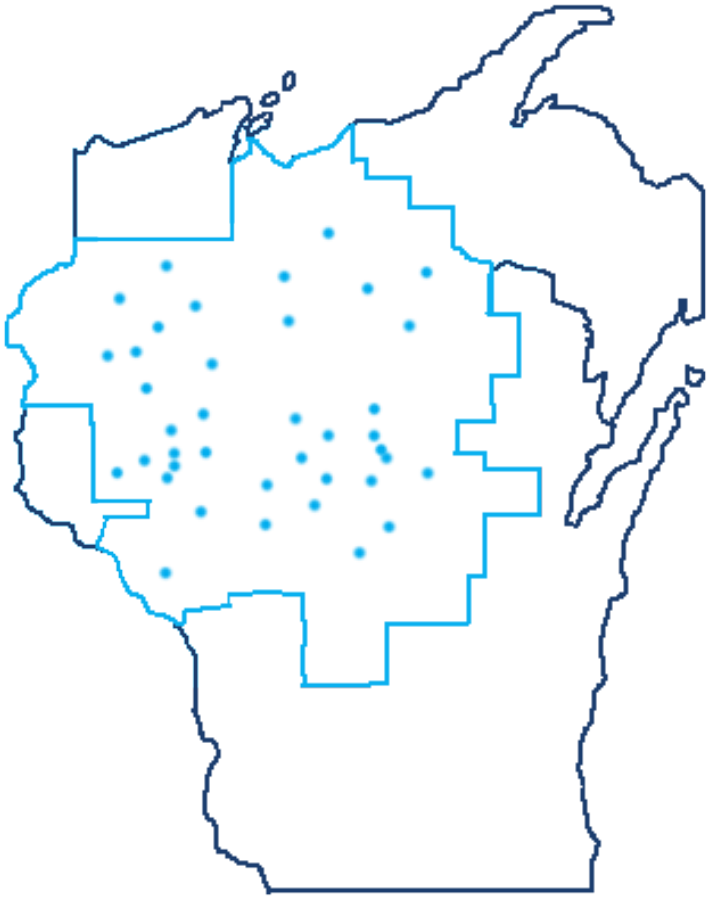
Kori Krueger, MD, MBA Medical Director Marshfield Clinic
Institute for Quality Innovation and Patient Safety

Marshfield Clinic
HEALTH SYSTEM

Objectives

- Provide a brief overview of the Medicare Access and CHIP Reauthorization Act (MACRA)
- Discuss how and integrated health system is preparing for MACRA
- Understand the gap analysis necessary to plan for MACRA
- Future planning

Marshfield Clinic Health System



- Formed 1916
- Physician led – 501(c)3
- 750 physicians in 86 specialties
- 6,450 employees
- 56 regional sites
- 375,000 unique patients/year
- 3.7 million patient encounters/year
- >$2 billion in annual revenue
- Security Health Plan 228,000 member HMO
- MCIS, Inc.
- Division of Laboratory Medicine
- Research and Education Foundation
- Family Health Center – FQHC (76,000 patients, 443,000 encounters/ year)
- Integrated Dental Clinics in underserved areas
- An Academic Campus of UW School of Medicine and Public Health

2017 2018 2019 2020 2021 2022 2023 2024 2025 2026

- measurement years, 0.5% payment update

- Adv APM 5% bonus for qualifying part B services
- Exceptional performer bonus for MIPS
- 0% payment update

- 0.25% payment update MIPS
- 0.75% payment update Adv APM

CMS Moderated 2017 Requirements

- Removed requirement for utilization component in 2017
- Allowed systems to “pick their pace”
  - No action - 4% penalty
  - Test report at least one metric – 0% penalty/bonus
  - Partial Participation for at least 90 days – May earn small positive adjustment
  - Full participation for at least 90 days – May earn moderate positive adjustment

2017 MIPS Scoring

- 60% overall score based on quality
- 25% overall score based on Advancing Care Information (ACI)
- 15% overall score based on Clinical Practice Improvement (CPI)
- 0% overall score based on utilization

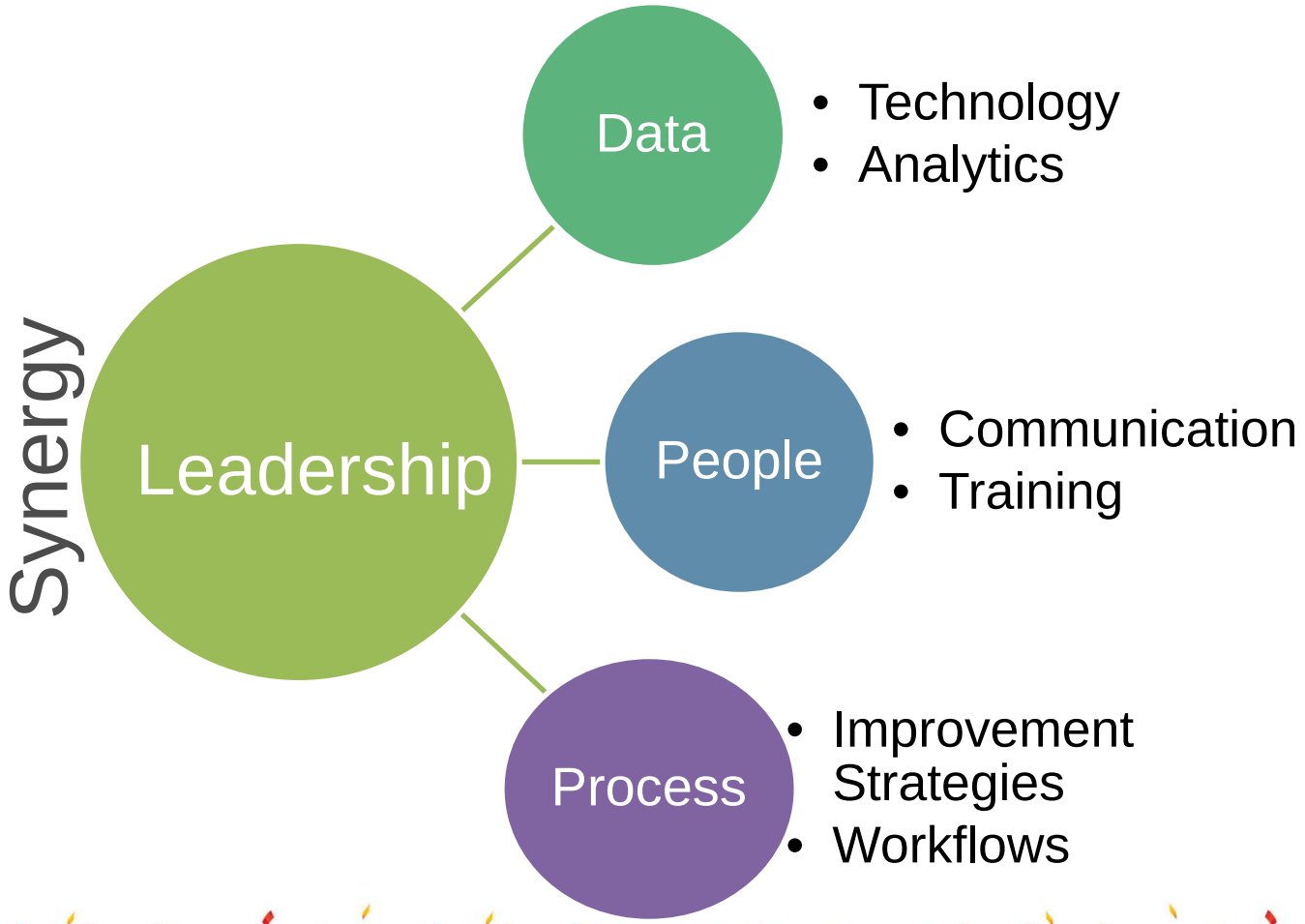
Ramp up to 2021 MIPS Scoring

- 30% overall score based on quality
- 25% overall score based on Advancing Care Information (ACI)
- 15% overall score based on Clinical Practice Improvement (CPI)
- 30% overall score based on utilization

MIPS Exemptions

- 100 or less Medicare Part B attributed members
- $30,000 or less in allowed claims for the calendar year
- Provider new to Medicare (1st year practice taking Medicare members)

Making It Count



MCHS – Our Analysis

- Baseline
  - Track One MSSP ACO >30,000 attributed members
  - Not in CPC+ eligible area and > 50 providers in ACO
  - Not part of other initiative deemed Adv APM eligible

- Conclusion:
  - Not eligible for Adv APM under MACRA
  - Do meet thresholds
  - Will be in MIPS for 2017 measurement year

MIPS for MCHS – Quality (60%)

- Do quality reporting through GPRO for MSSP
- Top decile performance nationally for multiple measures
- Identify metrics with opportunities for improvement
- Perform gap analysis
- Develop action plan
- Goal: top decile performance in ACO reporting

Quality Use Case

- Heart Failure Beta Blocker Therapy Metric
  - Current vs. goal performance
  - Action Plan – collective effort
    - Heart failure care management program
    - Engage primary care
    - Engage cardiology
    - Supply patient lists
    - Feedback mechanism
    - Audits

MIPS for MCHS – ACI (25%)

- Understand current performance under MU modified stage 2 and upcoming stage 3
- Model perceived gaps and develop plans to address
- In case of MCHS, anticipate no significant gaps and expect full or near full points

MIPS for MCHS – CPI (15%)

- MCHS recognized at all primary care locations as NCQA level III PCMH
- MCHS also qualifies as APM under track 1 MSSP
- Anticipate full points in this area

*Hint: Inventory of nearly 100 activities available from CMS weighted in points from 10 to 20 for each project. Maximum of 40 points. Choose projects that align with needed quality improvement or meet strategic objectives for your organization.

MCHS Outlook for 2019 Payment

- Anticipate:
  - No penalties
  - Little likelihood of significant bonus given CMS pick your pace approach
  - Possibility of small bonus for full participation and traditional high performance in all 3 categories

Future Planning

- Possible advantage to Adv APM qualification
  - Dependent on program announcements in 2017 (ex: Track 1+ MSSP option)
  - Future changes to current programs
  - 2019 measurement year can “count” Medicare Advantage plan program participants as “risk”
  - Uncertain political climate makes future unclear

Future Planning

- Need to be attentive to utilization
  - Episodes of care
  - Understanding opportunities in ACO data set or other claims data sets
  - Remove unjustified variability in clinical care delivery
  - Goal: Reduce total per capita care costs with specific focus on episodes put forth by CMS or episode groupers

Strategy

- Move toward obtaining status of Adv APM
  - 5% annual bonus until 2024
  - 2026 and forward 0.75% annual positive adjustment
  - Risk vs. benefit MUST be modeled and understood
- If remain in MIPS
  - Performance initially decided based on quality but in 2018 utilization will become an increasing factor
  - Need to maintain ACI and CPI efforts
  - Bonus will be dependent upon engagement of other health systems
  - Plan for lower annual Medicare part B reimbursement increases 2026 and forward (0.25%)

Reality

MACRA readiness is a moving target that is in large part driven by the political changes in Washington and program changes at CMS.

Stay tuned…

Thank You

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