Beyond MIPS Reporting – Planning for Long-Term Success Under MACRA

Penny Osmon Bahr and Kassie Remo

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- More than 5,400 employees
- Offices coast to coast
- Serve more than 7,500 health care clients

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Speaker Introductions

- **Penny Osmon Bahr**
  Penny is a health care principal at CLA with more than 20 years of industry experience and has worked across the continuum with independent physicians practices, accountable care organizations, health systems and health plans. She is an executive level health care operations specialist that works to develop business strategy, navigate regulatory impact and execute improvement across the health care ecosystem.
- **Kassie Remo**
  Kassie is a health care director at CLA with over 20 years of experience leading and consulting in health care operations and system implementations. She advises clients in operations initiatives necessary to achieve value-based payment. Kassie has been an operations leader within a highly capitated, integrated health care system and has led client projects to transition operations during system implementations.

Learning Objectives

- At the end of this session, you will be able to:
  - Compare currently available alternative payment models
  - Explain why clinical variation will quickly become a cost control issue
  - Describe key elements of practice transformation and how to prioritize them within your organization

What a Difference a Year Makes

2017 Mixed Messages

- CMMI accused of "overstepping" its authority *
- Cancellation of bundled payments program for certain cardiology services
- Scaled back CJR bundled payments from 67 mandatory geographies to 33 voluntary
- CMMI RFI on new payment model ideas
- Secretary Tom Price's resignation

2018 Accelerated Pace

- New bundled payment model
- New participants in MSSP and Next Gen ACO Models
- 168 new participants in CPC+
- Bipartisan Budget Act of 2018 (CHRONIC Care Act of 2018)
- New Secretary of HHS
- New Director of CMMI
- 2017 CMMI RFI comments released w/new DPC RFI
- CMS releases "Rural Health Strategy"

**** Source: 2016 letter to CMS from 178 congressional law makers***

2018 A New Era:
Alex Azar Secretary of HHS

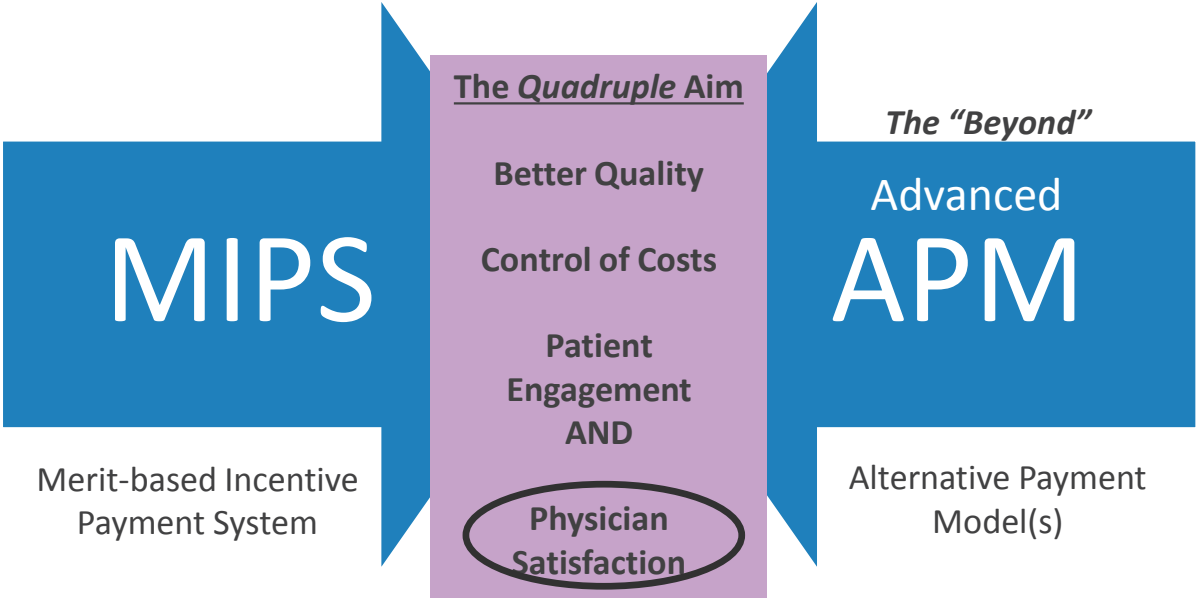
- HHS Priorities:
  - Sky rocketing drug prices
  - Health care affordability and availability
  - **Shifting Medicare to paying for health outcomes (i.e. Value-based transformation)**
  - Tackling the opioid epidemic

- Value-Based Transformation Priorities:
  - Interoperability and accessibility of health information
  - Increasing transparency – providers and payers
  - Medicare & Medicaid need to drive the value-based transformation
  - Addressing governmental regulatory burdens

"…value-based payment….far from reaching its potential…..Results….to be honest (are) underwhelming…"
Azar's comments to Federation of American Hospitals 3/5/18

MACRA Quality Payment Program (QPP) Paths

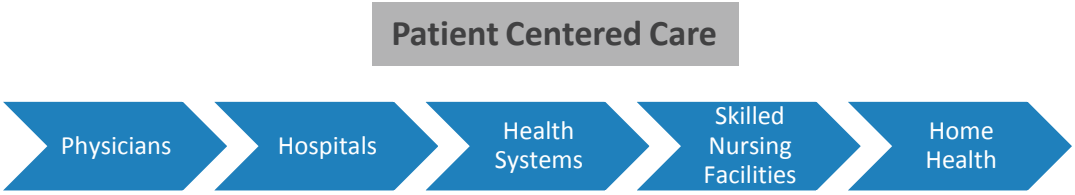
Medicare Participating Physicians



Complex, yet flexible reporting requirements

Requires technical infrastructure and appetite for risk

MACRA Influences the Care Continuum



Sample Variables

- ✓ Risk based contracts
- ✓ Network design
- ✓ Patient stickiness
- ✓ Geography

A Deeper Dive into Advanced Alternative Payment Models

Defining an Advanced APM under MACRA

To be an Advanced APM, an APM must meet the following three criteria:

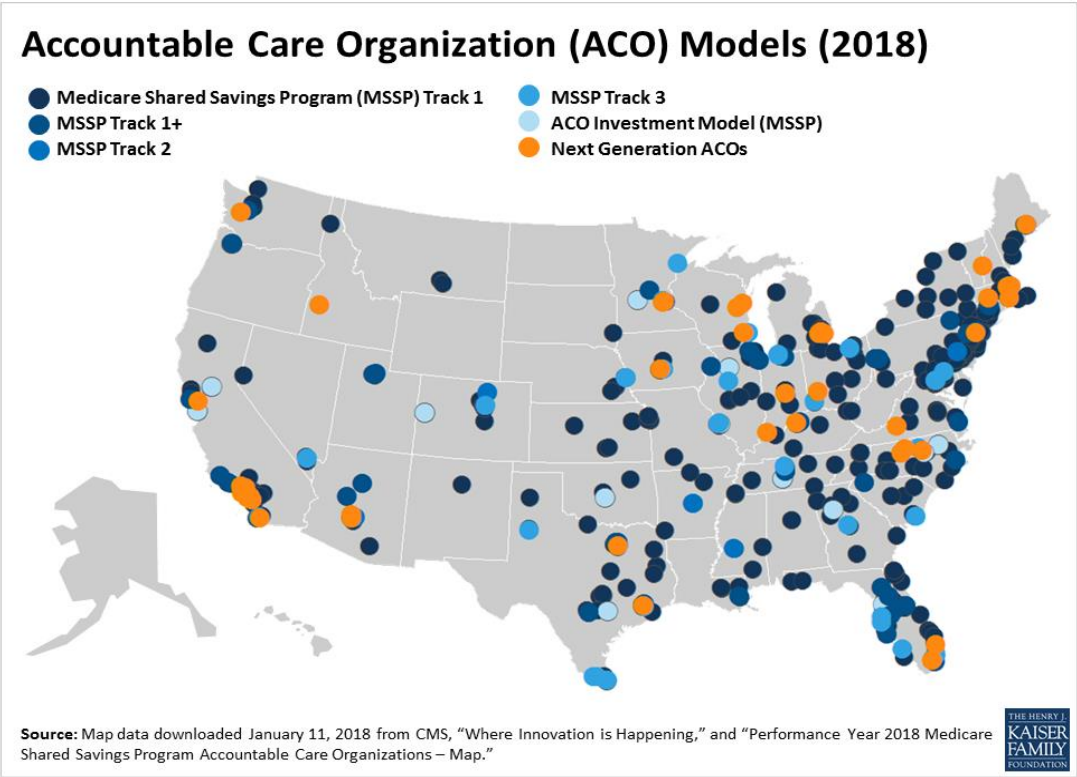
1. Require participants to use certified electronic health record technology (CEHRT);
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Current MACRA Advanced APMs

- AIM Model Track 1*
- CJR Track 1
- ESRD Care Model (LDO)
- ESRD Care Model (Non-LDO, two-sided risk)
- CPC +
- Medicare ACO Track 1*
- Medicare DPP*
- Medicare/Medicaid Shared Savings Model Track 2and 3
- MSSP Track 2 and 3
- Next Gen ACO
- Oncology Care Model (two-sided risk)
- Vermont All-Payer ACO*

**** 2018 implementation***

Distribution of ACOs Across the Country



"Accountable Care Organization (ACO) Models (2018)," The Henry J. Kaiser Family Foundation, accessed 6/13/2018, https://www.kff.org/faqs-medicare-accountable-care-organization-aco-models/attachment/aco-map-woutline_1-11-18/

CMS Accountable Care Models

Approximately 33% of Medicare FFS Beneficiaries Receive Care from an ACO

ACOs Authorized Under Section 3021 of ACA*	No. of	At Risk for Losses	Qualifies as Advanced APM
All MSSP ACOs	**561**	**Varies**	**Varies**
MSSP ACO Track 1	460	No	No
MSSP ACO Track 1+	55	Yes	Yes
MSSP ACO Track 2	8	Yes	Yes
MSSP ACO Track 3	38	Yes	Yes
ACO Investment Model **	**45**	**Yes**	No
NexGen ACO	**51**	**Yes**	**Yes**
Comprehensive ESRD Care Model ***	**37**	**Yes**	**Yes**
Total Active ACOs	**694**	**Varies**	**Varies**

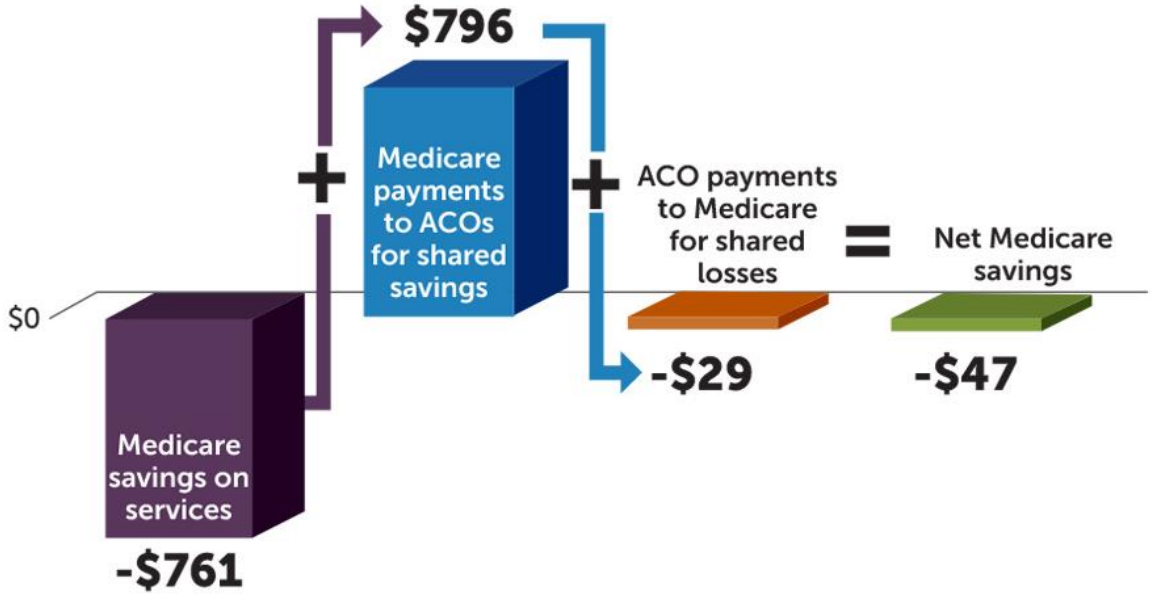
**** Source: CMS Innovation https://innovation.cms.gov/initiatives/index.html#views=models***

***** Generally at risk for prepayments made to ACO by CMS; beyond prepayments no risk.***

****** Large Dialysis Organizations (LDOs) w/200+ dialysis facilities at risk; non-LDOs w/<200 facilities have option.***

Medicare ACO Financial Results Relative to Benchmark*

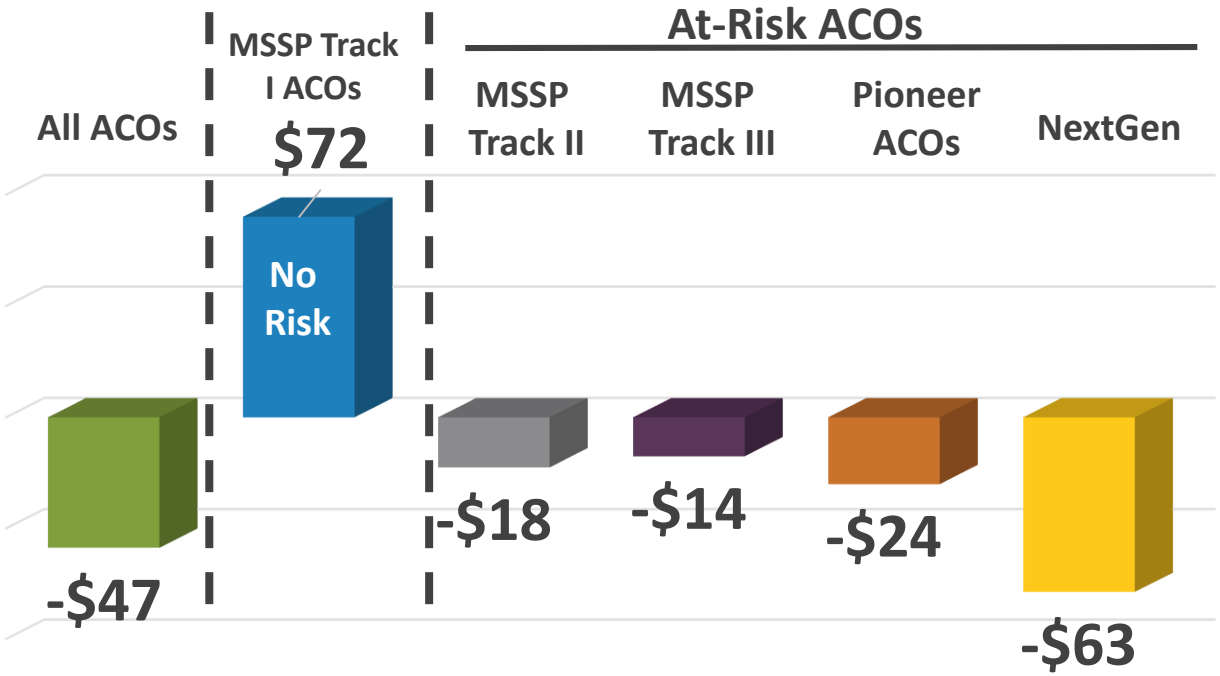
(Dollars in Millions)



Source: Kaiser Family Foundation analysis of 2016 results for MSSP and Next Generation ACOs public use files and unpublished CMS data

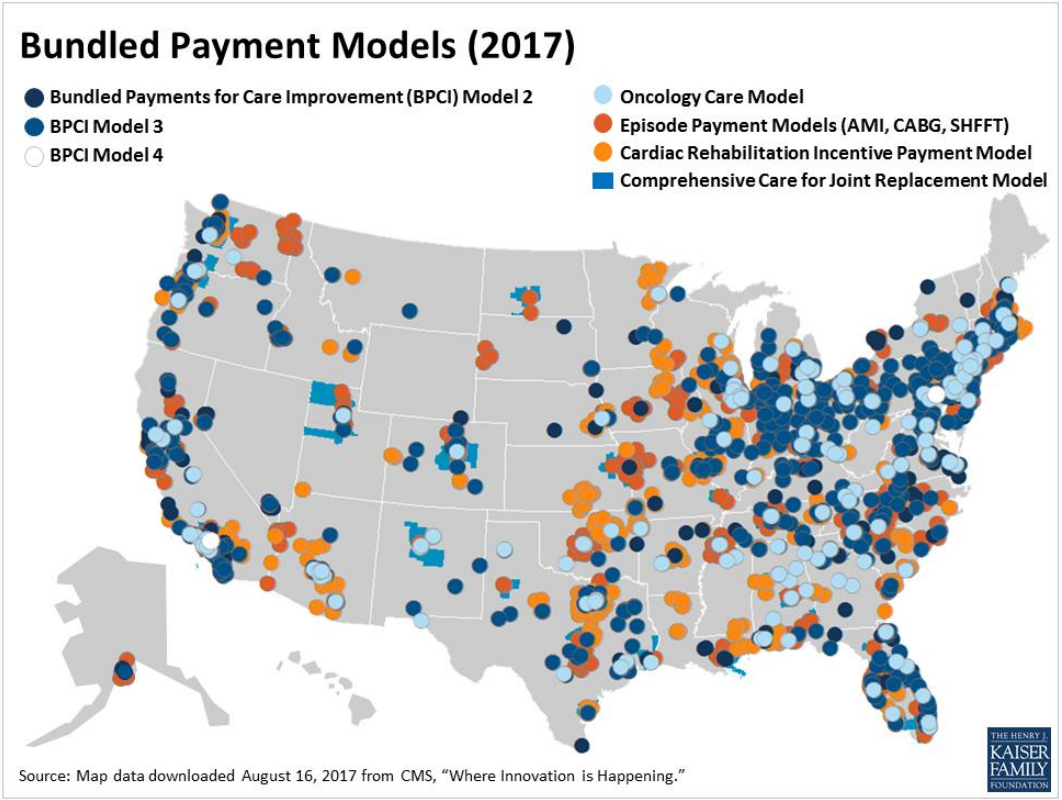
Is Bearing Risk the Answer to Driving Results?*

(Dollars in Millions)



** Source: Kaiser Family Foundation analysis of 2016 results for MSSP and Next Generation ACOs public use files and unpublished CMS data*

Bundled Payment Models: A Snapshot of Activity



"Bundled Payment Models (2017), The Henry J. Kaiser Family Foundation, accessed 6/13/2018, https://www.kff.org/faqs-medicare-bundled-payment-models/attachment/bp-map/

Bundled Payments

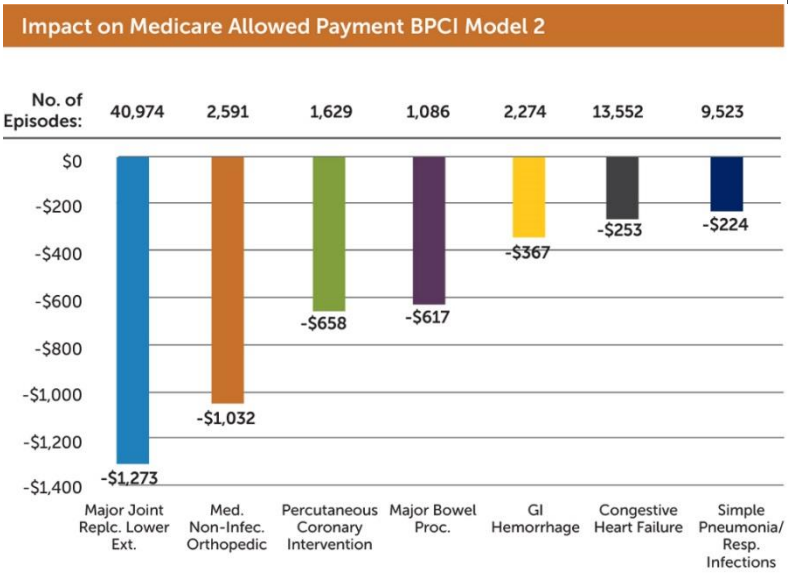
Bundled Payments for Care Improvement (BPCI)

Major initiative in testing bundled payments comes under BPCI, four models to date, another model on the way.

- *Model 1:* Acute care hospital inpatient stay, with retroactive payment (ended in 2016)
- *Model 2:* Acute inpatient, physician, and post-acute services, with retrospective payment
- *Model 3:* Post-acute care only, with retrospective payment
- *Model 4:* Acute care hospital inpatient services, prospective payment
- *BPCI Advanced* (begins Oct. 2018)

Is BPCI Driving Improvement?

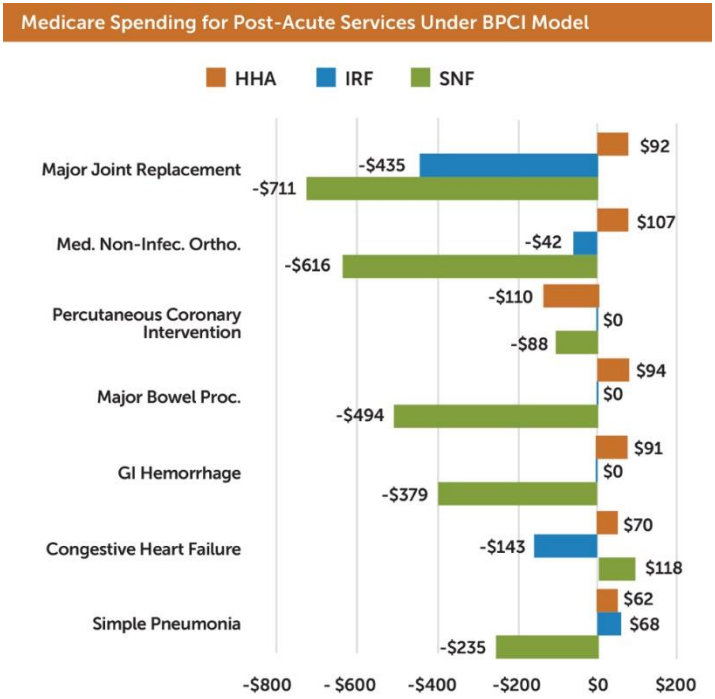
- The graphic at right depicts the reduction in Medicare allowable payment for various clinical episodes under Model 2.
- Out of 23 different clinical episodes analyzed in BPCI Model 2, Major Joint Replacement posted the largest reduction in allowed Medicare payment at $1,273.
- Even with this reduction, the results of the study did not reflect any clear patterns in the total allowed Medicare payment amount across all clinical episodes.
- The clinical episodes depicted in the graphic at right represent those episodes that reflected the largest reductions.



*** Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation Report Prepared for CMS, Prepared by The Lewin Group, dated October 2017.**

BPCI Model 2:
Changing Utilization Patterns

- One pattern noted in the study, was BPCI participants attempted to reduce episode payments by shifting post-acute services from an institutional setting (i.e. SNF or IRF) to home health.
- The graphic at right depicts this shift in service utilization for the 7 clinical episodes that reflected the highest reductions in Medicare spending.
- Of the 23 clinical episodes analyzed, 19, or 83% reflected an increase in home health spending.
- Of the 19 reflecting increased home health spending, 12, or 63%, reflected decreases in SNF spending, with IRF utilization decreasing about 66%.



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation Report Prepared for CMS, Prepared by The Lewin Group, dated October 2017.

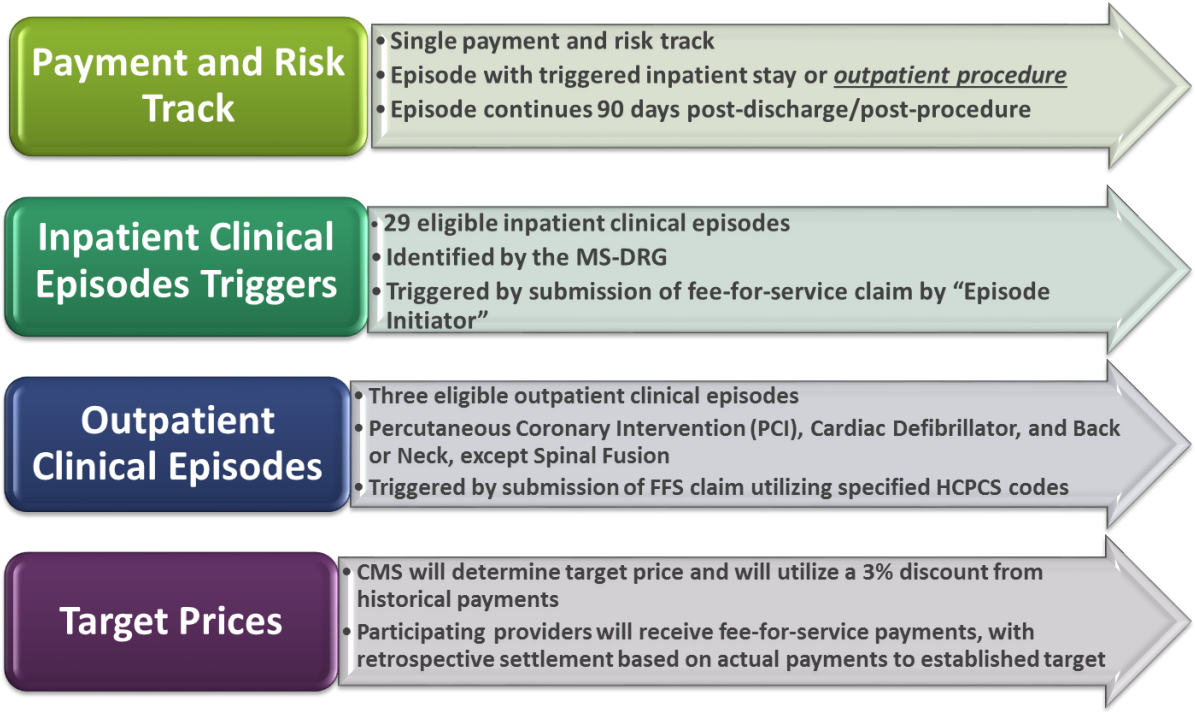
Advancing Bundles:
Bundled Payments for Care Improvement Advanced

- Announced by CMS on 1/09/18
- Application deadline: 3/12/18
- First performance period: 10/1/18 – 12/31/23
- Designed by CMS by considering:
  - Evaluation results from other CMMI models, BPCI models
  - Industry experience with bundled payments
  - Key provider stakeholder input
- Eligible Participants:
  - Non-Convener: Acute Care Hospitals (ACH) or Physician Group Practices (PGP) (only)
  - Convener: ACHs, PGPs, and other

"……BPCI Advanced builds upon earlier success of bundled payment models and is an important step in the move away from fee-for-service and towards paying for value……."

Seema Verma, CMS Administrator

BPCI Advanced: 4 Characteristics



“The All Payer Combination Option”
Advanced APM Arrives in 2019

What is an All Payer Combination Option?

- Other Payer Advanced APMs are non-Medicare Fee For Service (FFS) payment arrangements with other payers such as Medicaid, Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans), payers with payment arrangements in CMS Multi-Payer Models, and other commercial and private payer arrangements that meet the criteria to be an Other Payer Advanced APM.

Examples of CMS Multi-Payer Models include the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model

An Other Payer Advanced APM, must meet the following three criteria:

- **Require use of certified EHR technology (CEHRT).** The other payer payment arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity Group to use CEHRT to document and communicate clinical care information.
- **Base payments for covered professional services on quality measures that are comparable to those used in the MIPS quality performance category.** The payment arrangement must base payment on quality measures that are evidence-based, reliable, and valid, at least one of which must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.
- **Require participants to bear a certain amount of financial risk.** A payment arrangement meets the financial risk if actual expenditures exceed expected aggregate expenditures, or is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Social Security Act.

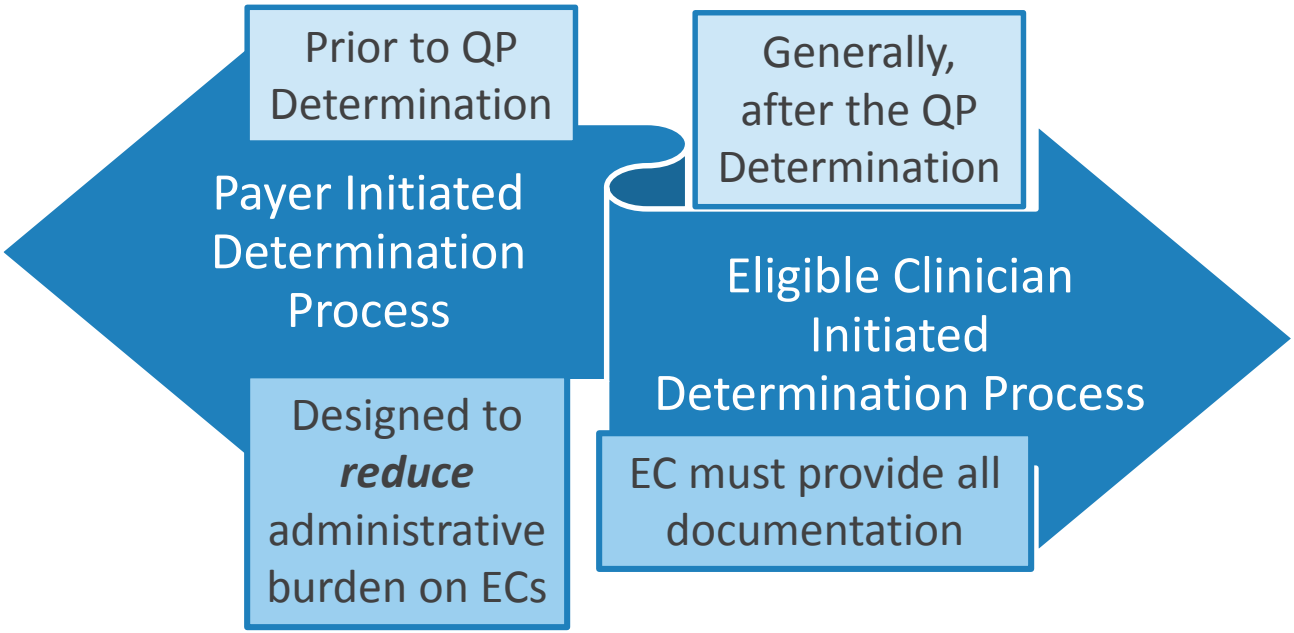
What's the Generally Applicable Nominal Amount Standard for Other Payer Advanced APMs?

Expenditure based Nominal Amount Standard	Revenue based Nominal Amount Standard**
Nominal amount of risk must be: • Marginal Risk of at least 30 percent; • Minimum loss rate of no more than 4 percent; and • Total Risk of at least 3 percent of the expected expenditures the APM Entity is responsible for under the APM	Nominal amount of risk must be: • Marginal Risk of at least 30 percent; • Minimum loss rate of no more than 4 percent; and • Total Risk of at least 8 percent of combined revenues from the payer to providers and other entities under the payment arrangement

**Note that total combined revenues from a payer include any financial risk payments or supplemental service payments including but not limited to payments comparable to care management fee payments, shared savings payments, or other types of performance-based incentive payments typically used in APMs and Advanced APMs with Medicare.

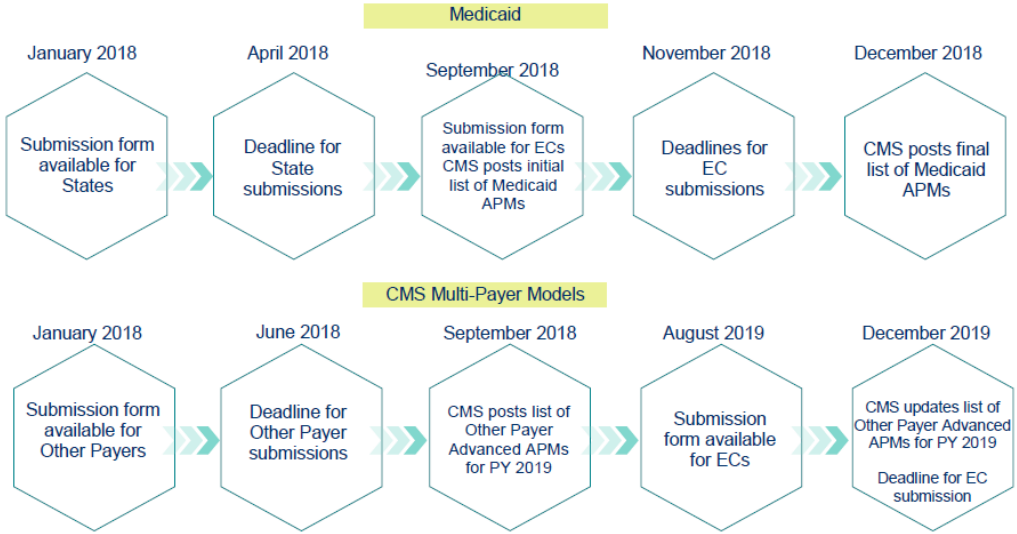
The revenue-based standard will apply only to models in which risk for APM Entities is expressly defined in terms of revenue and is an alternative option to the expenditure-based nominal amount standard.

How Do I Pursue this Model?



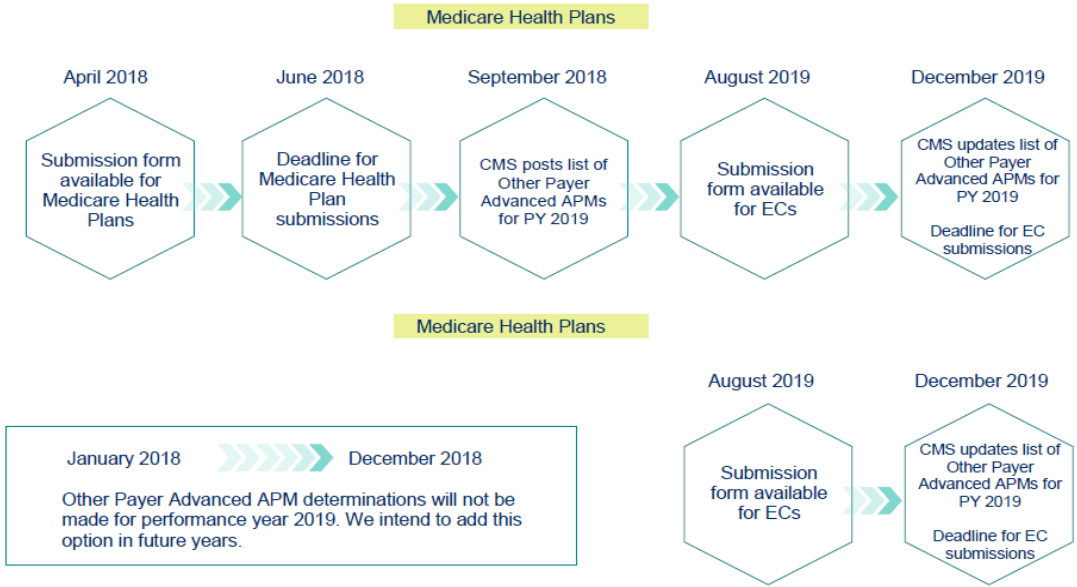
All Payer Model Timelines

Figure 1: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations



https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/All-Payer-Combination-Option-and-Other-Payer-Advanced-APMs-FAQs.pdf

All Payer Model Timelines



https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/All-Payer-Combination-Option-and-Other-Payer-Advanced-APMs-FAQs.pdf

What to Expect?
Physician Technical Advisory Committee & Direct Provider Contracting

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Focused on development of physician-focused payment models (PFPMs)

10 Criteria of PFPMs

- *Value over volume*
- *Flexibility*
- *Quality and cost*
- *Payment methodology*
- *Scope*
- *Ability to be evaluated*
- *Integration and care coordination*
- *Patient choice*
- *Patient safety*
- *Health information technology*

PFPM Fast Facts

- 25 proposed models since January 1, 2017
  - 3 since April 1, 2018
  - Models across the continuum

The Proposal Submission Process

A non-binding letter of intent is required at least 30 days prior to the submission of a full proposal. Must follow the template and use HHS submission system.

APMs Under Current Consideration by PTAC – A Sample

Hospital at Home Models:

- Hospital at Home Plus (HAH+) *(Icahn School of Medicine at Mount Sinai)*
- Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home *(Marshfield Clinic & Personalized Recovery Care)*

Primary Care Models:

- Advanced Primary Care: A Foundational APM *(American Academy of Family Physicians)*
- Comprehensive Care Physician Payment Model *(University of Chicago Medicine)*
- An Innovative Model for Primary Care Office Payment *(Jean Antonucci, MD)*

APMs Under Current Consideration by PTAC – A Sample

Oncology Models:

- Oncology Bundled Payment using CNA guided care *(Hackensack Meridian Health and Cota Inc.)*
- MASON - Making Accountable Sustainable Oncology Networks *(Innovative Oncology Business Solutions, Inc.)*

Palliative Care Models:

- The Advanced Care Model Service Delivery and Advanced Alternative Payment Model *(The Coalition to Transform Advance Care)*
- Patient and Caregiver Support for Serious Illness *(American Academy of Hospice and Palliative Medicine)*

APMs Under Current Consideration by PTAC – A Sample

Specialty Models:

- Project Sonar *(the Illinois Gastroenterology Group and SonarMD, LLC)*
- Prospective Payment Model for Screening, Surveillance, and Diagnostic Colonoscopy *(Digestive Health Network, Inc.)*
- ACS-Brandeis Advanced APM *(The American College of Surgeons)*
- COPD and Asthma Monitoring Project *(Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. (PMA)*

New Direction RFI and Direct Provider Contracting (DPC)

- "New Direction" RFI released by CMMI on September 20, 2017
  - Purpose of RFI… "new direction to promote patient-centered care and test market-driven reforms that ***empower beneficiaries as consumers***, ***provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes***."
  - Over 1000 responses received and CMMI has spent 5 months reviewing them

April 23, 2018: CMMI Announcement

1. The "new direction" RFI responses become publicly available; and
2. A *new RFI is released focusing on "Direct Provider Contracting" (DPC)*

> *"The Innovation Center is a central focus of the Administration's efforts to accelerate the move from a healthcare system that pays for volume to one that pays for value and encourages provider innovation…"*

> *"HHS has made shifting our health care system to one that pays for value one of our top four department priorities*," said HHS Secretary Alex Azar. "*Using bold, innovative models in Medicare and Medicaid is a key piece of this effort. We value stakeholder input on the new direction for the Innovation Center, and look forward to engaging on especially promising, groundbreaking ideas such as direct provider contracting*." – April 23, 2018

Key Tenants of DPC

Beneficiary consent and engagement

Enhanced access

Prospective payment for main source of care

Reduce clinician burden, especially billing

Two sided risk

Reliable revenue stream

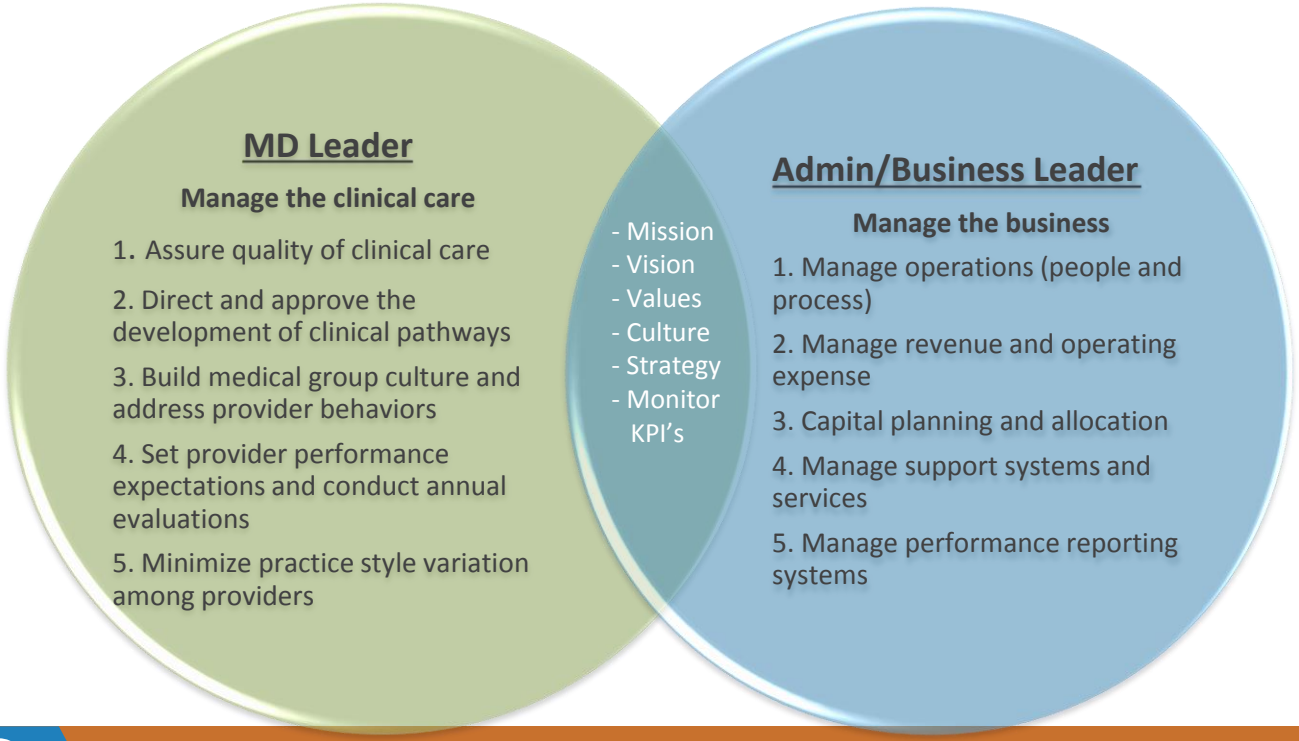
Key Steps In Practice Transformation for Value Based Care

Organizational Transformation Key Elements

- Leadership
- Culture and physician engagement
- Governance
- Data and technology
- Physician/operations alignment
- Financial risk

Leadership

Dyad Management Model



Data & Technology

- Standardize quality metrics across contracts
  - To increase focus among physicians on achievable set of metrics
  - To limit additional data collection required
  - To ease contract analysis
- Use certified EHR technology (CEHRT)
- Employ technology with interoperability to support care transitions
- Participate in Health Information Exchange (HIE)
- Telehealth
- Engage patients – portals, wearables

Financial Risk

- Anticipate cash flow implications of delayed shared savings bonuses, retrospective payments
- Plan for capital investments necessary to succeed with value-based payment
- Develop cost accounting necessary for detailed analysis of costs of care
- Expand view of costs across the continuum of care (use approach similar to payers)
- Understand how spending is influenced at acute and post-acute sites, how readmissions affect payment across the care continuum, and how the management of chronic conditions impacts payments.

Organizational Transformation Key Practices

- Site of service
- Access
- Chronic care management
- Performance measurement
- Care standardization
- Transparency
- Shared decision making
- Behavioral health integration
- Community intervention/partnership
- Lifestyle interventions
- Palliative care
- De-institutionalization

Considerations for CPC+

- Site of service
- Access
- Chronic care management
- Performance measurement
- Care standardization
- Transparency
- Shared decision making
- Behavioral health integration
- Community intervention/partnership
- Lifestyle interventions
- Palliative care
- De-institutionalization

Considerations for BPCI Advanced

- Site of service
- Access
- Chronic care management
- Performance measurement
- Care standardization
- Transparency
- Shared decision making
- Behavioral health integration
- Community intervention/partnership
- Lifestyle interventions
- Palliative care
- De-institutionalization

Considerations for Direct Provider Contracting

- Site of service
- Access
- Chronic care management
- Performance measurement
- Care standardization
- Transparency
- Shared decision making
- Behavioral health integration
- Community intervention/partnership
- Lifestyle interventions
- Palliative care
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Questions?

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