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Strategic Consulting at the Intersection of Health Care Policy, Politics and Business

MACRA & Implications for Telemedicine

June 20, 2016

Presentation Overview

- Introductions
- Deep Dive Into MACRA
- Implications for Telemedicine
- Questions

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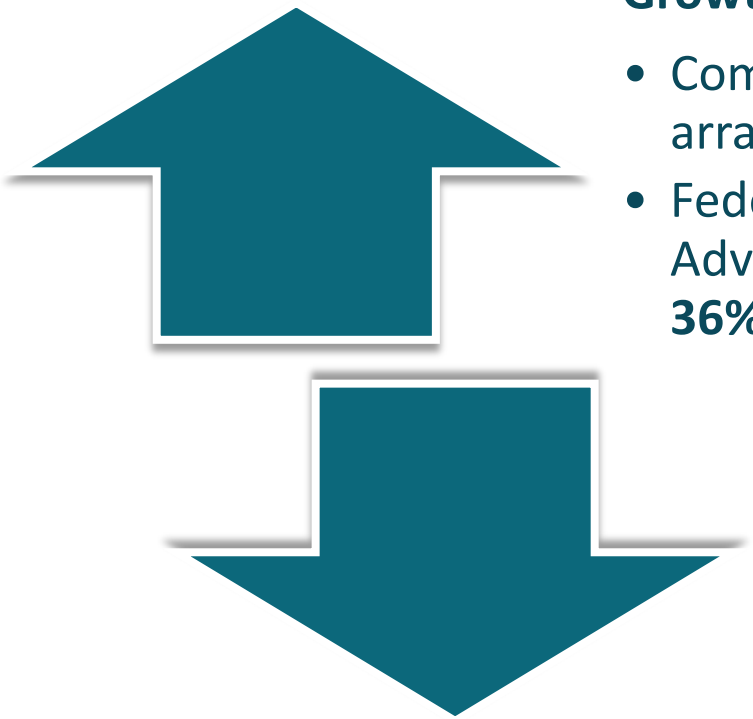
Growth in Value-Based Care Over Next Two Years



Growth in Value-Based Revenue

- Commercial ACOs and capitation arrangements are expected to **double**.
- Federal ACO programs and Medicare Advantage are expected to grow **20-36%.**

Decline in Fee-for-Service

- Multispecialty medical groups and Integrated-Delivery Systems expect **FFS payments to decline 24%.**

Source: AMGA September 2015 Survey

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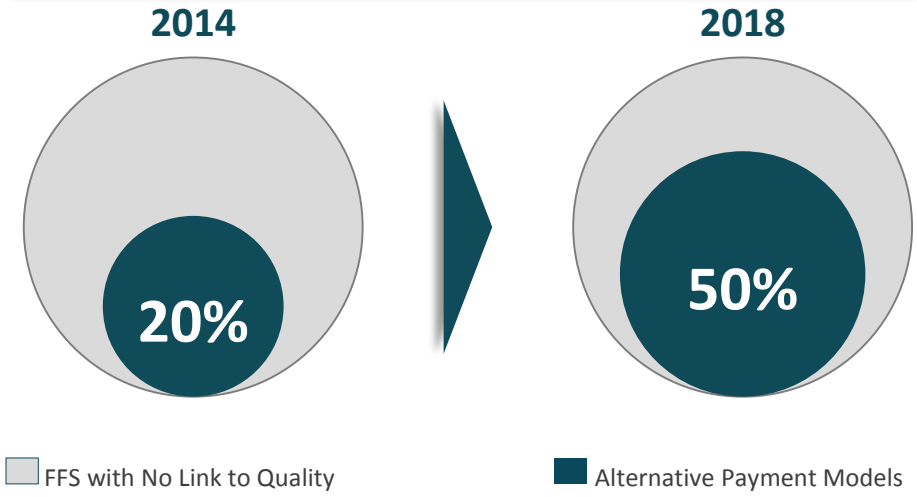
Value-Based Care Models are Growing

The shift to value-based care is being led by both public and private payers

- HHS recently announced concrete targets for value-based care.
  - 30% of Medicare payments tied to alternative payment models (APMs) by 2016; 50% by 2018
  - 85% of Medicare payments tied to quality or value by 2016; 90% by 2018.
- Resulting in significant pressure on providers to adapt with new care models.



Marquee Payers are Placing Bets

CMS	50% *of Medicare payments by* 2018
UnitedHealthcare	$65 billion *in payments tied to VBC models by* 2018
aetna, HCSC	75% *of membership in VBC models by* 2020
Humana	75% *of MA membership in VBC models by* 2017

Medicare Access and CHIP Re-Authorization Act (MACRA)

MACRA – Implementation Timeline

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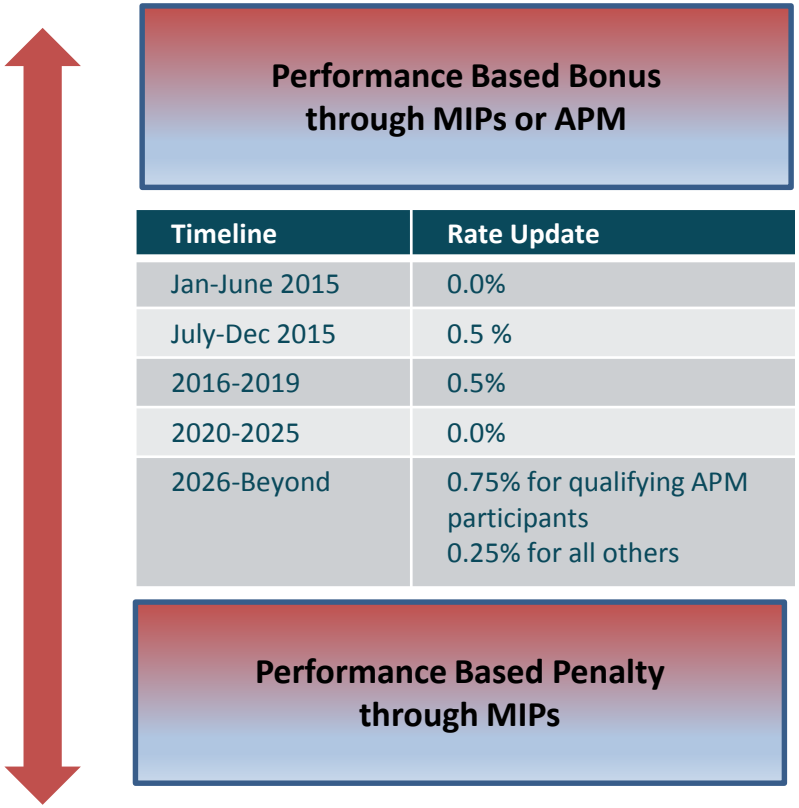
Bonus Payments: Two Tracks



Timeline	Rate Update
Jan-June 2015	0.0%
July-Dec 2015	0.5 %
2016-2019	0.5%
2020-2025	0.0%
2026-Beyond	0.75% for qualifying APM participants 0.25% for all others

- Opportunity to earn bonus payments in two tracks
  - **Merit-Based Incentive Program (MIPS)** (approx. 680,000 to 747,000)
  - **Alternative Payment Model (APM)** (30,000 to 90,000)
- Risk of penalty for MIPS eligible providers who do not meet performance thresholds

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Merit-based Incentive Payment System (MIPS) Basics

- **What**: A "voluntary" program linking Medicare payment to performance. Providers will be judged (and paid) based on –
  - **Performance in four categories** –
    - Quality
    - Resource Use
    - Clinical Practice Improvement Activities
    - Meaningful Use of Certified EHR Technology
- **Who**: Phased approach capturing additional Medicare professionals over time.
  - **2019-2020**: MDs, DOs, PAs, NPs, CNSs, CRNAs
  - **2021-Beyond**: Other eligible professionals as outlined by HHS Secretary
- **When**: Starts January 1, 2019

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Providers Excluded from MIPS

- **Newly Enrolled Clinicians**
- **Full and Partial Qualifying APM Participants**
- **Low-volume providers:** Clinicians who have Medicare billing charges less than or equal to $10,000 K; **AND** Provides care for 100 or fewer Part B-enrolled Medicare beneficiaries

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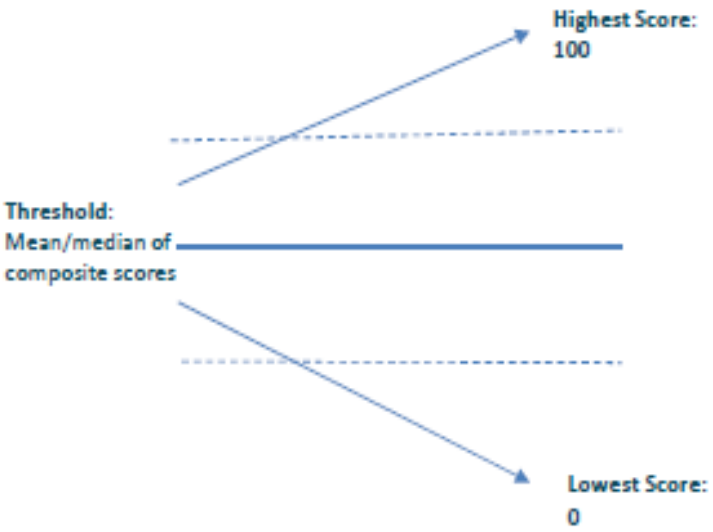
Financial Structures of MIPS



- Providers meeting or exceeding threshold receive + or neutral update
- From 2019-2024, providers in the top ¼ may receive an additional bonus payment
- Capped at $500 M annually, and no more than 10% per provider
- Providers in the bottom ¼ receive penalties:
  - 2019 – 4%
  - 2020 – 5%
  - 2021 – 7%
  - 2022 and on – 9%

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Illustrative MIPS Payment Scenarios

	2014	2015	2019	2020	2021	2022	2023	2024
Highest Performer	$100/visit	$101/visit	$117/visit	$131.50/visit	$146/visit	$160.50/visit	$175/visit	$189.50/visit
Meeting Expectations	$100/visit	$101/visit	$103/visit	$103.50/visit	$104/visit	$104.50/visit	$105/visit	$105.50/visit
Lowest Performer	$100/visit	$101/visit	$99/visit	$94.50/visit	$88/visit	$79.50/visit	$71/visit	$62.50/visit

Assumptions:

- Base fee of $100/visit
- Highest performer: Base fee + 0.5% update + initial bonus + additional bonus
- Meeting expectations: Base visit fee + 0.5% update
- Lowest performer: Base visit fee+ 0.5% update – statutory penalties

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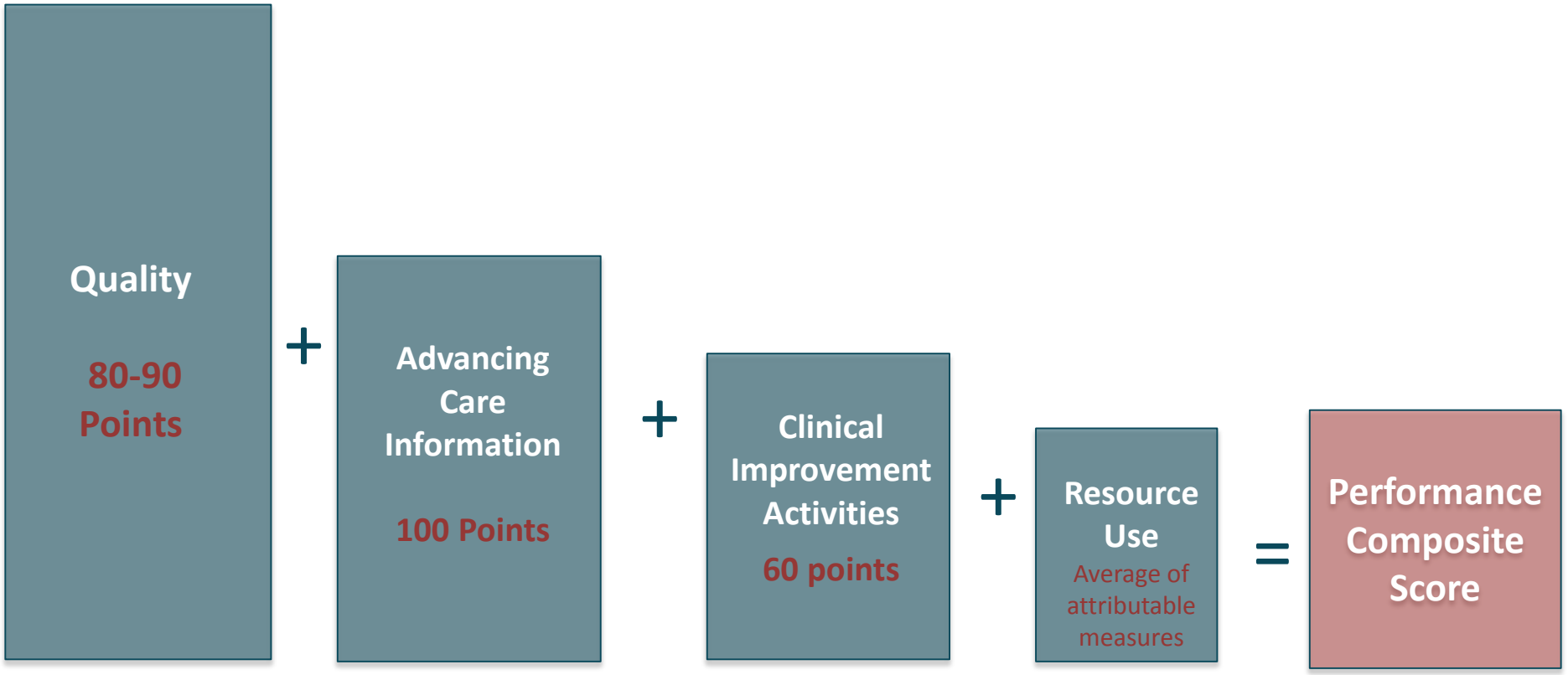
MIPS Performance Score Calculation



*Unless you are in an APM or an exception applies

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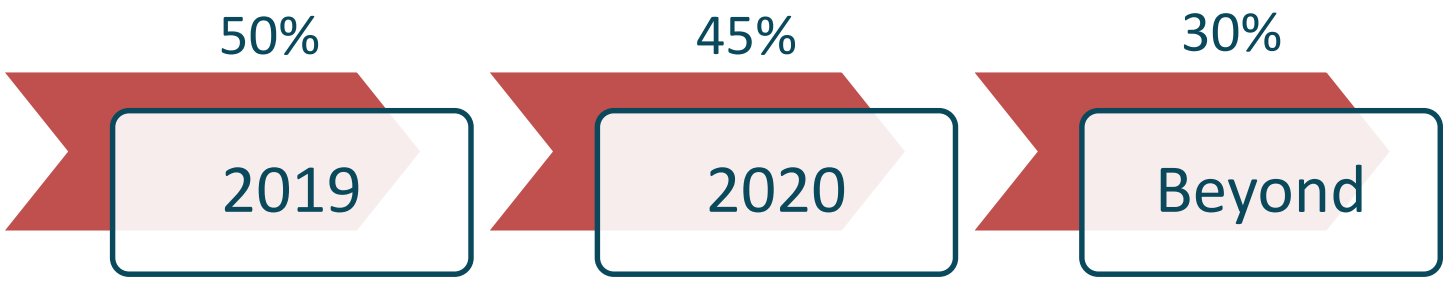
Spotlight: Quality Component



- Core set of requirements for individual clinicians may be adjusted depending on –
  - Whether clinician is part of an APM
  - Whether clinician is reporting as an individual or part of a group
  - Mechanism through which data is being submitted
  - Whether clinician is patient-facing or non-patient facing (e.g., radiologists, pathologists)

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Spotlight: Quality Component

Clinicians choose six measures to report annually

- Must pick one “cross-cutting measure”
- Must pick one outcome measure
- 200 measures, 80% tailored to specialists
- Bonus point for reporting electronically

Clinicians must choose 2-3 population measures

- Acute and chronic composite measures of the AHRQ Prevention Quality Indicators, as well as the all-cause hospital readmissions measure from the Value Modifier program
- Calculated from claims data

*Unless you are in an APM or an exception applies

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Specific Measures Outlined in Proposed Rule

TABLE A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017 *(Existing Measures Finalized in CMS-1631-FC).* The 2016 PQRS Measures Specifications Supporting Documents can be found at the following link: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/measurescodes.html.

Note: Existing measures with proposed substantive changes are noted with measures are noted with a plus symbol (+), core measures as agreed upon noted with the symbol (§), high priority measures are noted with an exclam measures that are appropriate use measures are noted with a double excla Number" column.

MIPS ID Number	NQF/ PQRS
* § !	0059/0
§	0081/0

TABLE C: Proposed Individual Quality Cross-Cutting Measures for the MIPS to Be Available to Meet the Reporting Criteria Via Claims, Registry, and EHR Beginning in 2017

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data Submission Method	Measure Type	Measure Title and Description[x]	Measure Steward
!	0326 /047	N/A	Communication and Care Coordination	Claims, Registry	Process	**Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	National Committee for Quality Assurance/ American Medical Association-Physician Consortium for Performance Improvement

TABLE E: 2017 Proposed MIPS Specialty Measure Sets

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description[x]	Measure Steward
1. Allergy/Immunology/Rheumatology							
	0041/	147v5	Claims, Web	Process	Community	Preventive Care and Screening: Influenza Immunization aged 6 months and older seen for a and March 31 who received an OR who reported previous receipt ation	American Medical Association -Physician Consortium for Performanc e Improveme nt
						Status for Older Adults 5 years of age and older who have ococcal vaccine	National Committee for Quality Assurance
						Jiroveci Pneumonia (PCP) aged 6 weeks and older with a ho were prescribed Pneumocystis P) prophylaxis	National Committee for Quality Assurance
						A): Tuberculosis Screening aged 18 years and older with a arthritis (RA) who have erculosis (TB) screening performed within 6 months prior to receiving	American College of Rheumatol ogy

CAHPS Measures Summary

- Getting Timely Care, Appointments, and Information;
- How well Providers Communicate;
- Patient's Rating of Provider;
- Access to Specialists;
- Health Promotion and Education;
- Shared Decision-Making;
- Health Status and Functional Status;
- Courteous and Helpful Office Staff;
- Care Coordination;
- Between Visit Communication;
- Helping You to Take Medication as Directed; and
- Stewardship of Patient Resources.

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Spotlight: Advancing Care Information

One year reporting period aligned with other MIPS components

Report customizable set of measures on EHR use

Accounts for 25% of performance score

(unless in an APM or exception applies)

Made up of base score plus performance score

Worth 100 pts

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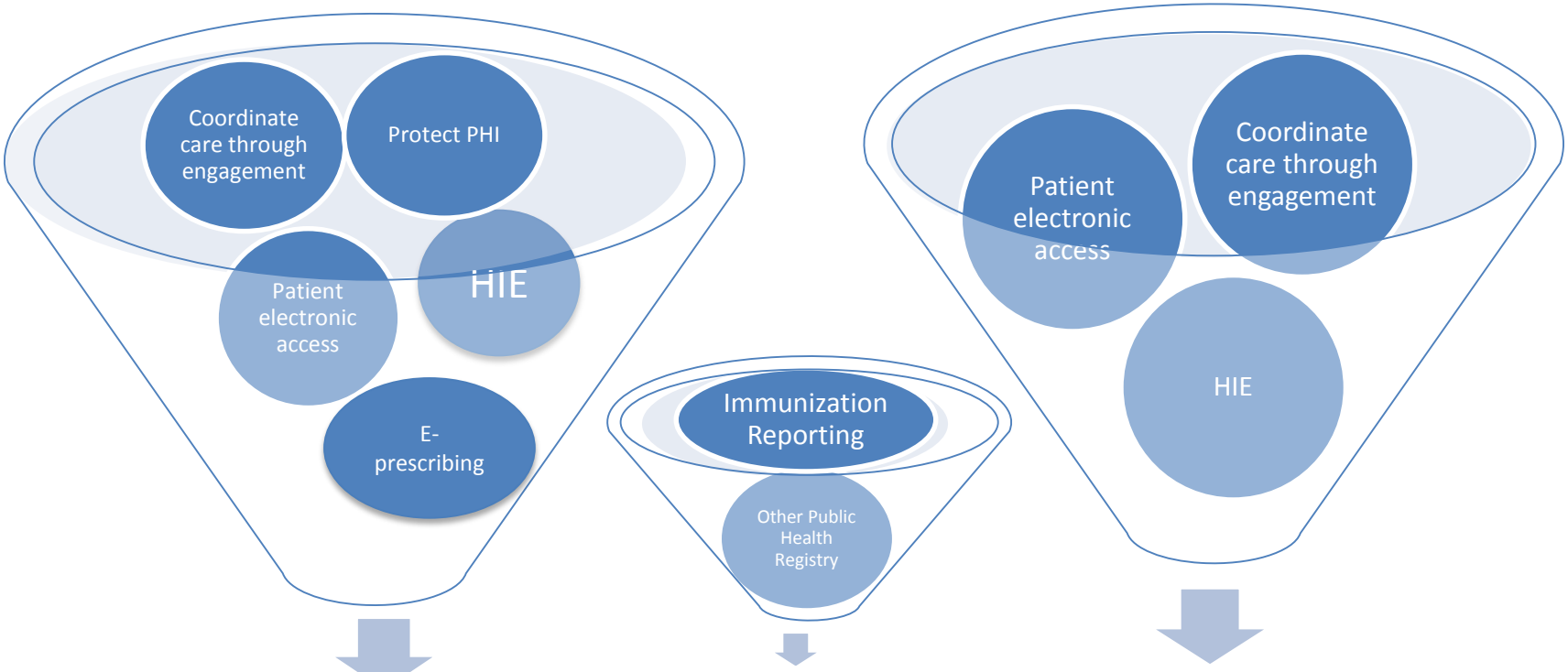
Spotlight: Advancing Care Information



Base Score

50 Points

Bonus Point

One point

Performance Score

Up to 80 Points

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Proposed Base Score Measures, Advancing Care Info

Objective	Measure
Protect Patient Health Information	• Security Risk Analysis
Electronic Prescribing	• ePrescribing
Patient Electronic Access	• Patient Access • Patient-Specific Education
Coordination of Care Through Patient Engagement	• View, Download, or Transmit • Secure Messaging • Patient-Generated Health Data
Health Information Exchange	• Patient Care Record Exchange • Request/Accept Patient Care Record • Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting	• Immunization Registry Reporting • (Optional) Syndromic Surveillance Reporting • (Optional) Electronic Case Reporting • (Optional) Public Health Registry Reporting • (Optional Clinical Data Registry Reporting

Alternate Base Score Measures, Advancing Care Info

Objectives	Measures
Clinical Decision Support	• Clinical decision support intervention • Drug interaction and drug-allergy checks
Computerized Provider Order Entry	• Medication orders • Laboratory orders • Diagnostic imaging orders

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Exclusions: Advancing Care Information

Exclusions available for the following types of providers:

- **Hospital-based MIPS Eligible Clinicians**
- **MIPS Eligible Clinicians Facing Significant Hardship**
- **NPs, PAs, CNSs, and CRNAs**
  Category will be given weight of zero if clinician does not submit any data for any measures

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Spotlight: Clinical Practice Improvement Activities

Full credit will be given to providers with 60 points; exceptions for certain groups

Full credit if provider participates in Patient-Centered Medical Home; half credit for participating in APM

Proposed rule suggests 90 activities, and will be updated annually.

Scores are based on the weight of the activity: High, Medium

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Spotlight: Clinical Practice Improvement

- 15% of total score
- Activity must be performed for at least 90 days during performance period.
- Providers report yes/no to indicate whether they met the requirement; CMS indicates that it "cannot measure variable performance within a single CPIA."
- General standard is that most providers must report a combination of activities that adds to 60 points.
- The following groups of providers only have to report any two activities:
    - MIPS small groups (15 or fewer)
    - MIPS eligible clinicians and groups located in rural areas
    - MIPS eligible clinicians and groups in geographic HPSAs
    - Non-patient facing MIPS eligible clinicians/groups

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Categories for Clinical Practice Improvement Activities

STATUTORY CATEGORIES	CMS-ADDED CATEGORIES	FUTURE CATEGORIES
• Expanded practice access • Population management • Care coordination • Beneficiary engagement • Patient safety and practice assessment • Participation in APM	• Achieving health equity • Emergency preparedness and response • Integration of primary care and behavioral health	• Promoting health equity and continuity • Social and community involvement

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Spotlight: Clinical Practice Improvement Activities

Examples

High

(20 pts/each)

- Expanded evening & weekend hours
- Collection of patient experience and satisfaction data
- Consultation of PDMP prior to opioid prescription

Medium

(10 pts/each)

- Group visits for chronic conditions
- Steps to help health status of communities
- Episodic care management
- Manage medications
- Timely communication of test results

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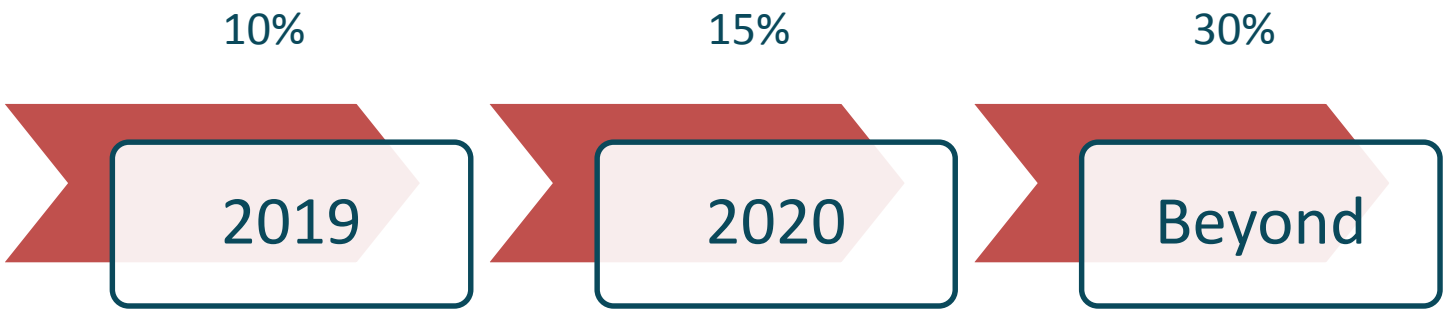
Spotlight: Resource Use



- Score will be calculated using claims; no data submission needed.
- 40 episode-specific measures (vary by specialty)
  - Adjusted for geographic payment rate adjustments and beneficiary risk factors, as well as a specialty adjustment
  - All measures weighted equally and no minimum number of measures
- Part D costs are not included in resource use calculation.

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Alternative Payment Model (APM) Bonus Payment Basics

- **What:** Advanced 5% bonus payment track for certain providers participating in qualifying alternative payment models.

- **Who:** Providers with a significant amount of payments derived from services provided through an APM. **CMS estimates that 31 K – 90 K providers will receive bonuses in 2019.**

- **When**: Starting on January 1, 2019; running through 2024. Measurement starts January 1, 2017.

- **Why:** Physicians who meet the requirements of the APM track are exempt from MIPS. They get bonuses from APM participation.

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Revenue Targets for APM Participants

	Qualifying Participant	Partially Qualifying Participant
2019-2020	25% of Medicare payments	20% of Medicare payments
2021-2022	50% of Medicare payments; **OR**	40% of Medicare payments; **OR**
	50% of all payments, including 25% of Medicare payments	40% of all payments, with 20% of Medicare payments
2023-Beyond	75% of Medicare payments; **OR**	50% of Medicare payments; **OR**
	75% of all payments, including 25% of Medicare payments	50% of all payments, including 20% of Medicare payments

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TRACK 2: Advanced Alternative Payment Models

- Clinicians must receive a certain amount of revenue from an advanced APM to qualify to be in the APM track (i.e. exempt from MIPS and still get bonus payments).

- Advanced APMs must:
    - Require quality measure reporting
    - Utilize certified EHR technology; and
    - Bear more than "nominal" risk or be a medical home model expanded under section 1115A

- More than "nominal" risk is defined as: 1) marginal risk must be at least 30% of losses in excess of expected expenditures; 2) minimum loss ratio must be no greater than 4% of expected expenditures; 3) total potential risk must be at least 4% of expected expenditures.

- CMS will update the list of qualifying APMs annually.

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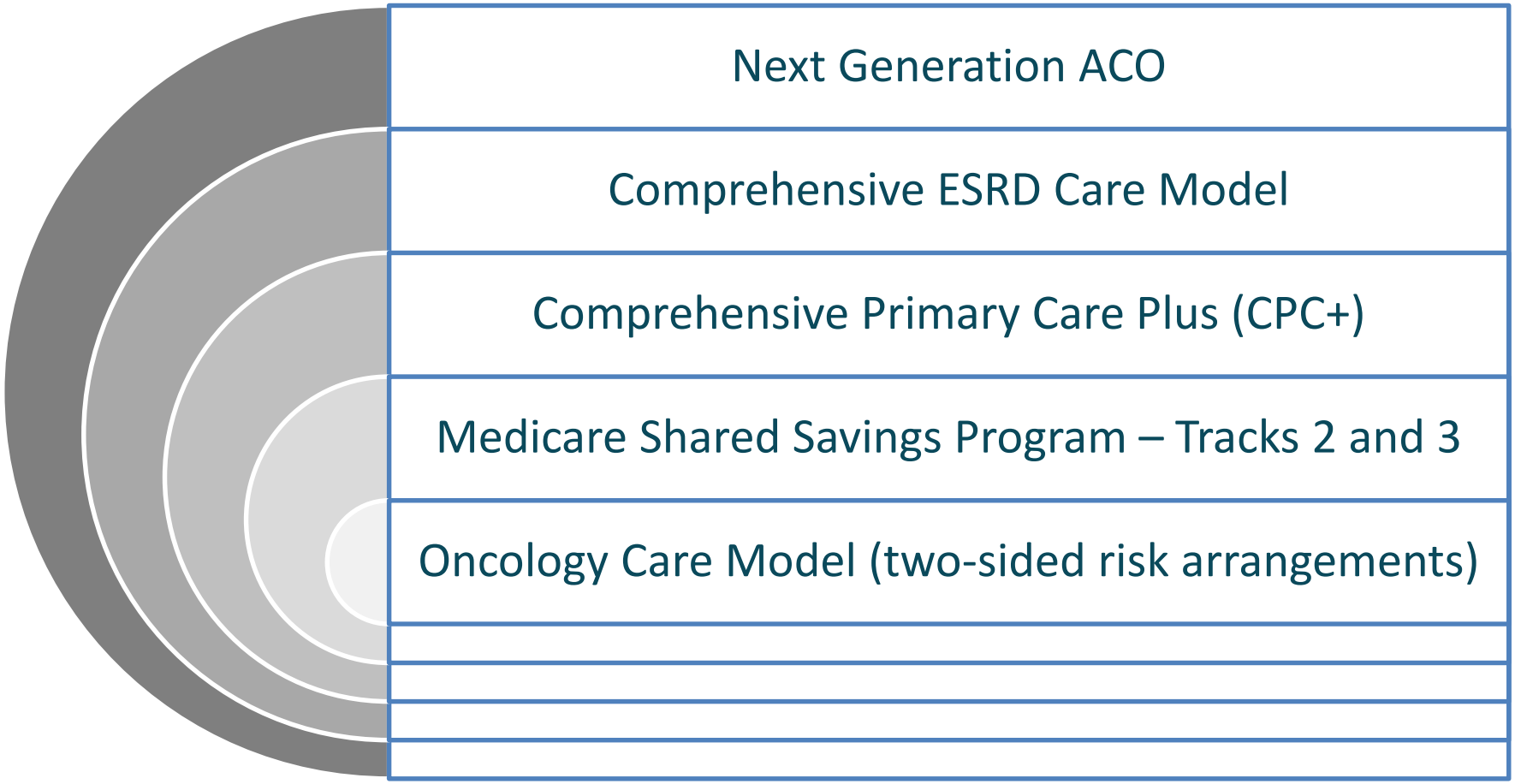
Proposed Advanced APM Models



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Spotlight CPC+

- **WHAT**: National, multi-payer advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation.

  Qualifies as an Advanced APM under MACRA proposed rule**

- **WHEN**: Five years, starting in 2017.

- **WHERE**: Up to 20 regions, which will be selected after payers have submitted their applications. Preference given to:
  - **Original CPC regions**: Arkansas (statewide), Colorado (statewide), New Jersey (statewide), New York (Capital District-Hudson Valley region), Ohio (Cincinnati-Dayton region), Oklahoma (greater Tulsa region), and Oregon (statewide),
  - **States participating in Multi-Payer Advanced Primary Care Demonstration**: Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont.
  - **States receiving State Innovation Models (SIM) Initiative Model Test Awards**, where Medicaid is a participating payer

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Spotlight CPC+
Examples of CPC+ Practice Activities

- Functions are “corridors of action” for comprehensive primary care; requirements vary by track.
- Track 2 capabilities are inclusive of and build on Track 1 examples.

	Track One	Track Two
Access and Continuity	• 24/7 patient access • Assigned care teams	• E-visits • Expanded office hours
Care Management	• Risk stratify patient population • Short and long-term care management	• Care plans for high-risk chronic disease patients
Comprehensiveness and Coordination	• Identify high volume/cost specialists serving population • Follow-up on patient hospitalization	• Behavioral health integration • Psychosocial needs assessment and inventory resources and supports
Patient and Caregiver Engagement	• Convene a Patient and Family Advisory Council	• Support patients’ self-management of high-risk conditions
Planned Care and Population Health	• Analysis of payer reports to inform improvement strategy	• At least weekly care team review of all population health data

Spotlight CPC+Three Payment Streams

	Care Management Fee (PBPM)	Performance-Based Incentive Payment	Underlying Payment Structure
Track 1 – "Basic" Track	$15 average	$2.50 opportunity	Standard FFS
Track 2 – "Advanced" Track	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP) Two options: 1) FFS (60%) + CPCP (40%), OR 2) FFS (35%) + CPCP (65%)

Implications for Telemedicine

Likely Physician Group Consolidation

CMS-5517-P TLP 4/25/16 676

TABLE 64: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY PRACTICE SIZE*

Practice Size	Eligible Clinicians	Physician Fee Schedule Allowed Charges ($ Mil)	Percent Eligible Clinicians with Negative Adjust-ment	Eligible Clinicians with Negative Adjust-ment	Percent Eligible Clinicians with Positive Adjust-ment	Eligible Clinicians with Positive Adjust-ment	Eligible Clinicians with no Adjust-ment	Aggregate impact Negative Payment Adjust-ment ($ Mil)	Aggregate Impact Positive Adjustment ($ Mil)	Aggregate Positive Adjustment, excluding exceptional Performance Payment ($ Mil)	Aggregate Positive Adjustment, exceptional Performance Payment only ($ Mil)
Solo	102,788	$12,458	87.0%	89,383	12.9%	13,302	103	-$300	$105	$65	$40
2-9 eligible clinicians	123,695	$18,697	69.9%	86,519	29.8%	36,887	289	-$279	$295	$182	$113
10-24 eligible clinicians	81,207	$9,934	59.4%	48,213	40.3%	32,737	257	-$101	$164	$103	$61
25-99 eligible clinicians	147,976	$12,868	44.9%	66,515	54.5%	80,588	873	-$95	$230	$147	$84
100 or more eligible clinicians	305,676	$18,648	18.3%	56,045	81.3%	248,626	1,005	-$57	$539	$336	$203
Overall	**761,342**	**$72,606**	**45.5%**	**346,675**	**54.1%**	**412,140**	**2,527**	**-$833**	**$1,333**	**$833**	**$500**

*2014 data used to estimate 2017 performance. Payments estimated using 2014 dollars.

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Implications for Telemedicine

Need to Focus on Whole Patient

- Improved information sharing
- Expanded practice access
- Patient engagement
- Broader provider partnerships

Expanded Practice Access

- 24/7 Access to Urgent and Emergent Care
- Highest point category under CPI
- Timing of telemedicine access closely aligns with ER visits

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Implications for Telemedicine

Resource Use Tracked Much More Closely

- Secretary can use frequency of use of items and services as a measure in resource utilization
- Resource use will be compared to similar patients and care episodes
- Telemedicine is an alternative to more resource intensive urgent care or ER
- Telemedicine can be used to check in with patients

Population Health Management

- Monitoring health conditions of individuals to provide timely health care interventions.

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Implications for Telemedicine

Other Clinical Improvement Activities

- Use of telehealth services for quality improvement
- Resource use will be compared to similar patients and care episodes
- Telemedicine is an alternative to more resource intensive urgent care or ER
- Telemedicine can be used to check in with patients

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Questions?

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