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## Speaker introductions

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- Todd is a senior manager in the EY Advisory Services practice and EY's Health Lead for compliance technologies. He is also one of EY's regulatory compliance operations subject matter resources.
- Todd has 17 years' experience in health care leadership, focused in governance and compliance management, compliance technology enablement, finance and accounting, program management, data analytics, claims systems and risk management. He has worked in public, commercial and academic markets.
- Todd is also engaged by senior management and audit committees to conduct compliance and risk assessments for their hospital, pharmacy, IT, internal audit, compliance and finance departments. Prior to joining EY, Todd served under agency with the Centers for Medicare & Medicaid Services (CMS) as the Leader for Region A of the Recovery Audit Contractor Program, covering 13 states and respective hospitals in the upper northeast of the United States.

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- Lisa is a senior manager in the EY Advisory Services practice. Lisa's experiences include operational process improvement, risk management and mitigation, and major platform transformations for both commercial and government programs in the public and private sectors. Projects include but are not limited to provider/network operational readiness, compliance function integrations from acquisitions, claims processing implementation, the design, development and testing of operations reporting, ICD-10 readiness, and 4010 to 5010 readiness.
- Lisa has her JD from the Massachusetts School of Law and her BA, Political Science, from The University of Rhode Island.

## Agenda

- Objectives
- Understanding MACRA (provider and payer)
- Why MACRA is important for compliance officers
- Who else is concerned
- Getting ready
- FAQs



## Objectives and what participants will learn

Participants will learn:

- An understanding of MACRA from both a provider and payer point of view
- Why it is important for compliance officers to understand MACRA
- What potential compliance considerations and impacts are involved as a result of providers looking to payers and health systems to support and collaborate to achieve MACRA objectives
- Considerations for the right infrastructure to support MACRA as payers put in processes to monitor their CMS universes



## MACRA is challenging health systems, forcing new discussions

As the House and Senate look at the Affordable Care Act (ACA), we think that the Medicare Access and CHIP Reauthorization Act (MACRA) has the potential to be equally, if not far more, transformative to our health care system in terms of improving access to high-quality and lower-cost health care.

However, MACRA has been a sleeper issue. Many industry stakeholders are still trying to understand its implications. The complexity of this daunting reimbursement system has all physicians – especially those in small-and medium-sized practices – deeply concerned about their future with Medicare patients. In fact, this push by CMS forces payers and providers to align values and outcomes that, up until now, have been so difficult to achieve in the commercially insured population alone.

MACRA is already shifting dialogues with health care leaders:

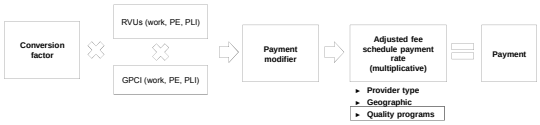
1. Will the government reduce payments with a new administration?
2. Are the criteria too restrictive?
3. Will the shared risk really improve care?

As it stands, MACRA will impact many Medicare stakeholders, not just providers, but also the nearly 50 million beneficiaries, the caregivers who serve them, the medical device manufacturers, the pharmaceutical companies and the health insurers.

## Overview

*Looking back at the start of all the need for change in the payment models*

- The sustainable growth rate (SGR) was enacted in 1997 by CMS to control Medicare spending by physicians; however, SGR did little to subdue cost and actually drove the growth in service volume and cost that plagues our health care system today. Quality of care and value is not implicitly included.
- MACRA is the first major change to the method of Medicare Part B physician payment in nearly two decades. It aims to rein in health care spending and redirect the health care dollar to ***better-quality care*** through the ***Quality Payment Program (QPP)***.




- Provider type
- Geographic
- Quality programs

**Physician quality reporting** | **Meaningful use** | **Value-based payment modifier**

RVU means relative value units.
GPCI means geographic practice cost indexes.
PE means practice expense.
PLI means professional liability insurance.



## Overview

*MACRA/Quality Payment Program*

**What is the QPP?**

- The QPP involves the replacement of the traditional fee-for-service model for providers.

**MACRA repeals and replaces the SGR formula** for determining Medicare payments for providers' services by creating two models: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Last year's performance data will impact reimbursement for 2019.

**What clinicians are affected by the QPP?**

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Groups with such clinicians[1]

**What big changes will occur?**

The QPP replaces a patchwork system of Medicare reporting programs to:

- Require **higher levels of alignment** from clinical professionals at the point of care because greater value is placed on **quality measurement, coordination of care, population health and proper usage/management of resources**
- **Combine existing quality reporting programs** into one new system – physicians must be equally as good at meaningful use, clinical resource use via value-based modifiers (VBMs) and the Physician Quality Reporting System (PQRS) in their organization

[1] In 2021, the secretary of Health and Human Services can broaden the eligible clinicians group to include others.



## Overview

*MACRA/Quality Payment Program*

**Why is the QPP a big deal?**

- Large amount of investment needed (e.g., new performance reporting requirements, IT/data requirements, clinical practice improvement initiatives)
- Risk of further payment adjustments in 2019 and beyond
- Greater value placed on coordination of care, population health and proper usage/management of resources
- Need for clinicians to understand the impact that the QPP will have on their bottom line

**Why start QPP readiness now?**

- MIPS and APMs will go into effect in 2019 through 2024 and beyond; however, 2017 data will be used to determine 2019 payment adjustments.

**Summary: The QPP begins in 2019 and streamlines multiple Medicare quality programs (e.g., MU, VBM, PQRS) into two new payment paths. CMS will evaluate FY 2017 performance data to determine reimbursement in 2019.**

**Note: ~90% to 95% of clinicians will be part of MIPS.**

## Overview
*MACRA/Quality Payment Program*

- The QPP is an actionable step toward achieving a patient-centered health care system that delivers better care, smarter spending, and healthier people and communities by paying for value rather than just volume.
- CMS's final rule recognized the importance of small, independent practices and the need to design a QPP that allows them to succeed.
- 93% of Medicare Part B charges will be subject to the incentive framework.
- The resource use category was (or will be) simplified and weighted 0% of the final score for PY 2017.

**" Important: make sure you qualify."**
Many organizations think they qualify by virtue of being an accountable care organization (ACO), but do not – validating qualification is imperative.

**Goal of final rule:**
"Make the transition to MACRA as simple and flexible as possible."[1]

**Andy Slavitt**
Former Acting CMS Administrator

Note:
[1] Final MACRA rule expands exemptions, flexibility," *Modern Healthcare website*, modernhealthcare.com/article/20161014/NEWS/161019942, accessed 28 October 2016.



## APMs and MIPS
*MACRA/QPP payment models for Medicare Part B payments*

**1 Merit-based Incentive Payment System (MIPS)**

**Modified fee-for-service model**

- Provides more flexibility and choice of measures, while retaining fee-for-service payment option
- Consolidates three existing quality reporting programs (sunset in 2018) and adds a new program – clinical practice improvement

**Physician quality reporting program** | **Value-based payment modifier** | **Medicare EHR incentive program** | **New** **Clinical practice improvement**

**MIPS**

The QPP establishes a composite performance score (0–100) to determine positive or negative payment adjustments:

- Quality (PQRS): **60%**
- Resource use (VBM):* **0%**
- Advancing care information (MU): **25%**
- Clinical practice improvement: **15%**

*** Counted starting in 2018 based on Medicare claims data – no reporting necessary**

**Exemption from MIPS**

- First year of billing Part B participation
- Threshold: Medicare claims **< $30k and patients < 100**
- Advanced APM participants
- Physicians currently in Track 2 of the Medicare Shared Savings Program (MSSP)
- Providers who qualify for payment under APMs with associated bonuses exempt from MIPS
- Rural Health Clinics and Federally Qualified Health Centers

**2 Advanced Alternative Payment Models (APMs)**

**New payment models**

- APMs must meet the following requirements:
  - Include CMS Innovation Center models, Shared Savings Program tracks or specific federal demonstration programs
  - Require participants to use certified electronic health record (EHR) technology
  - Base payments for services on quality measures comparable to MIPS
  - Take on financial risk or fall within a medical home model expanded under Innovation Center authority

Make sure you qualify!

**Examples of advanced APMs**

- Medicare Shared Savings Program Tracks 2 and 3
- Next-generation ACOs
- Comprehensive Primary Care Plus (CPC+)
- Comprehensive End-Stage Renal Disease Care Model

**APM eligibility requirements**

- Use of quality measures comparable to measures under MIPS; substantial EHR use – at least 50%–75% of qualifying participants; acceptance of financial risk

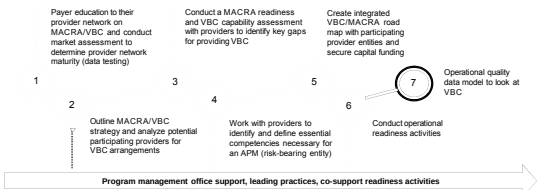
| | Claim threshold | Patient threshold |
|---|---|---|
| Qualifying participant (QP) status | 25% | 20% |
| **Partial QP status** | **20%** | **10%** |



## Due to MACRA, now is the time for payers to create or enhance VBC offerings

**By 2019, providers will seek to partner and align commercial payers to support and offer "other payer advanced APMs" in order to maximize incentives for transitioning to value-based care (VBC) payment models.**

- Between 2017 through 2019, providers will look to payers and health systems to support and collaborate to achieve MACRA's objectives. During this time, many providers will assess which payers are best to partner with for advanced APMs.
- Payers can offer clinical decision-support tools, access to data, better integrated care teams and additional CM/DM services and share knowledge from past experience predicting risk to show value-add services and maintain/grow market position.



## Value-based care contracting models

*Approaches for health systems and payers*

| | Conservative approach | Moderate/aggressive approach |
|---|---|---|
| Health systems | ▸ Conduct a value-based payment readiness assessment<br>▸ Perform assessment of current qualitative and quantitative metrics used to evaluate performance or providers<br>▸ Assess and create an improvement plan for provider network adequacy<br>▸ Assess any consumer education or engagement programs and impact on behavior | ▸ Conduct a gap analysis and comparative analysis between health system's current or risk-based arrangements and other systems' models<br>▸ Integrate data (consider a data warehouse) with largest provider(s) to allow for an analytics platform to assist with pop. health management<br>▸ Assess and implement new physician alignment models where a portion of compensation is contingent on metrics/quality<br>▸ Implement new consumer or provider health engagement models targeted at changing/influencing behavior<br>▸ Consider a collaboration with a large pharma company to conduct post-market effectiveness research |
| Payers | ▸ Conduct an assessment of current qualitative and quantitative metrics used to evaluate plans, systems and providers<br>▸ Assess the accessibility and interoperability of data repositories, analytics platforms and reports/dashboards<br>▸ Assess and create an improvement plan for provider network adequacy and patient access to care<br>▸ Assess, source/select and implement consumer health engagement programs that intend to alter behavior, rather than merely educate the consumer | ▸ Conduct a gap analysis and comparative analysis between payer's current value-based, risk-based or quality metrics-driven payment programs or value-based payment models<br>▸ Integrate data (consider a data warehouse) with largest provider(s) to allow for an analytics platform to assist with tracking population health<br>▸ Consider a collaboration with a large pharma company to conduct post-market effectiveness research (integrate data to see if real-world efficacy aligns with clinical trial efficacy) |



## VBC impacts payer's relationships

*with providers, suppliers, CMS, IPAs, PBMs, specialty pharmacies and others*

**Key components of value-based contracting:**

- Provider management and contracting
- Operational and IT capabilities for e2e member experience, analytics and insight
- Member outreach and servicing
- Governance structure and program oversight
- Clinical and disease management impact
- Member steerage and behavioral impact
- Provider performance and quality
- Population and community health needs and issues
- Provider and hospital network contracting/composition
- Market scan and competitor analysis



## Payer and provider collaboration

*Compliance officer considerations*

- What effect does MACRA have on payer and provider cooperation?
- What is the impact of risk sharing between payers and providers?
- VBC models and key risks for consideration

## Payer and provider cooperation
*Compliance officer considerations*

Various measurement criteria are similar for health plans and providers, especially in regards to the clinical quality metrics.
As health plans review their provider contracts, they can review provider performance and facilitate data sharing with each other as part of a value-based care contract.

- This will drive hospital quality risk departments to be more attuned to case management reviews, denials, etc. This can drive improved infrastructure to include ***compliance dashboards*** for analytics and workflow.
- Smaller provider groups or independent providers may not have a ***capital budget or bandwidth in their risk management teams*** to allow for enhancements of their EHRs. However, payers can leverage what providers send in data (unstructured and structured) to help providers meet MACRA requirements.
- Per MACRA, health plans should also be able to help providers educate their patients on the costs of care and the treatment options. In summary, ***the drive for collaboration*** between payers and providers will be critical. Compliance can help support monitoring.



## Potential impacts of risk sharing
*Compliance officer considerations*

1. MACRA is about managing risk, which is where compliance and quality work closely together to help look at patient populations and manage financial risk through the reimbursement process.
2. Health plans are preparing to see how they can be able to support providers on their network. Potential risks of provider data:
   - Completeness – missing key information
   - Accuracy – reporting from EHR systems could be inaccurate if not tested periodically
   - Quality – able to get data from the key systems
3. Payer risks can be mitigated through defined data protocols validated periodically similar to CMS universe protocols data validation.



## Other key risks and potential mitigating activities
*Compliance officer considerations*

| Function | APM req. | Risks/issues | Potential mitigation |
|---|---|---|---|
| IT | Data integration and sophisticated analytics capabilities | ▸ Data sharing and access – EHRs/HIEs<br>▸ Data integrity<br>▸ Insufficient data warehouse and analytics platforms or modeling tools | ▸ Data management plan<br>▸ Data quality assessment and data quality management plan<br>▸ Data warehouse investment<br>▸ Integration of payer, provider data |
| Ops | Integrated clinical operations aligned with consistent incentives | ▸ End-to-end patient experience and services<br>▸ Disparate financial and clinical operations and decision-making<br>▸ Increased marketing scrutiny<br>▸ UM/RM shifted to providers | ▸ Patient flow diagrams and redesign for end-to-end patient care exp.<br>▸ Marketing compliance plan<br>▸ Organizational redesign; task forces |
| Finance | Sophisticated budgeting, planning and forecasting; understanding risk contracting | ▸ Cannibalization of revenue<br>▸ Reduce costs without hurting quality<br>▸ Cost/accrual accounting<br>▸ Ability to pay losses<br>▸ Dividing shared savings/losses and incentive payments<br>▸ Hospitals, specialists, PGPs<br>▸ Funding up-front sunk costs | ▸ Integrate financial and clinical decision-making functions<br>▸ Request to CMS to withhold savings<br>▸ Analytics platform and modeling |

## Other key risks and potential mitigating activities
*Compliance officer considerations*

| Function | APM req. | Risks/issues | Potential mitigation |
|---|---|---|---|
| Clinical | Physician alignment on care management and measurement | ▸ Physician autonomy<br>▸ Size and cost of formulary<br>▸ Decentralized supply chain<br>▸ Patient preference<br>▸ High-risk patients | ▸ Long-term acute care contracts for high-cost patients<br>▸ Care protocols; centralized formulary<br>▸ Product portfolio managers; restricting sales access<br>▸ Supply chain management |
| People | Staff alignment on care management and measurement | ▸ Medical staff buy-in and contracting<br>▸ Control over physician and staff (alignment)<br>▸ Measurement of individual vs. group performance and costs<br>▸ Variations in practice/treatment | ▸ Change management plan<br>▸ Physician champion/leader<br>▸ Build physician performance metrics into annual contracts |
| Patients | Ability to track patient across full continuum of care | ▸ Size of patient population<br>▸ Patient satisfaction<br>▸ Patient attrition<br>▸ Patient attribution<br>▸ Consumer health engagement | ▸ Track/measure patient loyalty and leakage<br>▸ Formalize patient attribution method and periodic adjustments in contracts<br>▸ Recruit more patients |



## Who else is concerned?
*Accountable care organizations (ACOs)*

*"ACOs are extremely concerned about the direction the CMS is going not only in the proposed MACRA rules but also with the conflicts created by its other value-based payment programs such as bundled payment, and when you add that to how much it costs to run an ACO, there's a significant number of ACOs ready to leave the [Medicare Shared Savings Program, MSSP] program."*

*Clif Gaus, President and CEO of NAACOS, said in a public statement.*



## Why are ACOs concerned?
*Needing to help serve their community, and there is a shortage*

- ACOs participating in the Medicare Shared Savings Program (MSSP) will be allowed to:
  1. Participate in an advanced APM
  2. Obtain 5% payment boost
  3. Other providers can participate in bundled payment models instead
- ***The impact***[1] – ACOs will need to show their coordination of care, such as with social service agencies. All focused to improve population health management. ***Examples include*** employing community health programs targeting chronic disease management, health care coordination and patient education.
- ***The risk***[1]***:***
  - With a desire to support community health systems, less than 25% have enough staff members available to meet behavioral health needs of their patient population. This is where cost management will be key.
  - Most ACO leaders see funding as a barrier to connecting their providers with social service programs. They feel they are in a catch-22.

Note:
[1] Based on findings from the Robert Wood Johnson Foundation and Premier Research Institute

## Getting ready
*Infrastructure*

**Payer and provider infrastructure:**

Referring back to the article in the HFMA, payers and providers entering and renegotiating value-based contracts will likely need robust infrastructure and dashboards to track the three Ps (patient, procedures, performance). This will relate to the following:

1. *Patient* treatments
2. *Patient* outcomes
3. *Provider* follow-up and medical/treatment adherence

**Life sciences and path to influence care and cost of care:**

To support improved patient experiences, care and cost management, life sciences companions should consider focusing on the outcomes most important to the patient, from interactions with the pharmacy, to medical devices.

**Research and clinical trial organizations:**

Academic, private and commercial institutions should work closely with their stakeholders to determine a definition of value that they can attribute to the drug therapy or device.

***Example:*** Speed to trial on less-invasive treatments and protocols



## Other potential technology implications
*Leveraging technology solutions will be critical*

1. **IT vendor as intermediary**
Third-party health IT vendors can act as intermediaries on behalf of MIPS-eligible physicians to submit data quality, improvement activities and advancing care information performance categories. Practices need to know where they stand. Be ready to do your own analytics.

2. **APM meaningful use requirements**
Beginning in 2018, physicians must use electronic health record technology that is certified for 2015 instead of 2014; 75% of providers had the 2014 edition as of July.

3. **Practice improvement activities**
In 2017, bonus points were awarded for providers completing "improvement activities" through their EHRs and for reporting to public health and clinical data registries (e.g., telehealth).

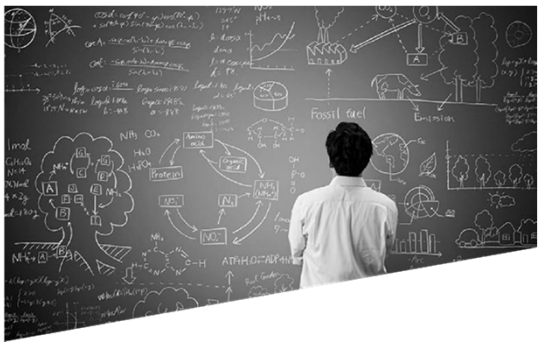
4. **Reoccurrence in IT investment**
The certification rule is tough for small IT vendors to meet – and there are downstream implications for providers invested in those systems which may result in a resurgence in IT investment.

5. **Reduction in measures for reporting**
The final rule reduced the number of measures from 18 with meaningful use to 5 for MACRA. All of MACRA's measures are predicated on interoperability, which is often outside the control of physicians. Check where you stand today and make sure your vendor has a road map.

6. **Physician attestation**
Physicians must attest to not blocking exchange of data – the first step (e.g., potential demand for vendor attestation) toward increasing accountability for information blocking.



## Conclusions



## Conclusions on getting ready for MACRA

- For non-provider groups, establish a MACRA steering committee
- Conduct a risk assessment of the current process to capture information to support your MACRA decisions
- Actively involve stakeholders within your organization so that the considered processes and systems addressing MACRA are compliant
- Align to the risk management process required for MACRA
- Document and keep decision-making rationale for changing processes with providers
- Just because you are not a provider does not mean that MACRA can not impact you



## In closing

- ✓ Gained an understanding of MACRA from both a provider and payer point of view
- ✓ Why it is important for compliance officers to understand MACRA
- ✓ What potential compliance considerations and are involved as a result of providers looking to payers and health systems to support and collaborate to achieve MACRA objectives
- ✓ Considerations for the right infrastructure to support MACRA as payers put in processes to monitor their CMS universes



## Questions and answers

- Q&A
- Contacts:
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  - ✓ Lisa Alfieri, JD, lisa.alfieri@ey.com
- Send us an email with your questions and comments

## Thanks for your participation





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