April 19, 2017

TRUMPED-UP HEALTHCARE
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Agenda

• Trump and AHCA
• Federal Economic Reform
• Merit-Based Incentive Payment System
• Advanced APMs
• IT Industry Response
• Questions
The Politics

• 2018 Mid-Term Election Season → Earlier positioning than usual
• Normal Trend → President’s party tends to lose positions in mid-terms

115th Congress (2017-2018)

The Politics

• Eyes turned to Senate over next 21 months
  – 3-seat net gain needed by Dems for 2019 majority
  – BUT, Dems defending 25 seats, Repubs defending only 8
  – GOP seats appear stable
  – Dems working hard to hold onto MO, MT, IN, ND

• House elections
  – Not much change expected
  – Dems rely on younger/minority voters → tend to sit out mid-terms
  – 3 Vacant seats to fill → Becerra (AG in CA), Price (Sec. of HHS), and Pompeo (CIA Director)
# 2017 Legislative/Regulatory Agenda

## Trump FY2018 Budget: 3/14

## First 100 Days: Exec. Orders, Supreme Court nomination, Joint Session 2/28

## Cabinet Nomination Senate Hearings

## ACA Repeal and Repair (Reconciliation) – Two Reconciliation bills: first, FY 2017; then FY 2018 Reconciliation

## Debt Ceiling (late summer/early fall)*

## CHIP Reauthorization (Expires Oct. 1, but state budgets begin 7/1/17)* - shorter extension could be included in reconciliation

## CR FY 2017 Government Funding (April 28)*

## PDUFA (and other UFA) Reauthorizations (Expire Oct. 1)*

## Medicare Extenders (Expire Oct. 1/Jan. 1)*

## Annual CMS Rulemakings (e.g., QPP, IPPS, PFS, OPPS, PFS) (April - September)

## Trump Administration FY 2018 Budget Outline

## Tax reform

## Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

* “Must Pass” legislation

Source: Alston & Bird
**Trumped-Up Healthcare**

- **Interested in regulatory relief**
  - Regulatory freeze, Regulatory Reform Task Forces
  - “2 for 1” Executive Orders
  - Congressional Review Act → Planned Parenthood funding

- **Agency unilateral reg. action / non-enforcement**
  - IRS → Not checking taxpayer acknowledgement of coverage on tax forms
  - HHS proposed rule → Stabilize exchange thru incentives for insurers
  - Potential → Narrowing of essential health benefits, limits/elimination of HRSA women’s preventive services, expanded Hobby Lobby exemption re: contraceptives

*Source: Alston & Bird*
Trumped-Up Healthcare

- **AHCA (HR 1628) → House Vote Cancelled**
  - Trump ultimatum Friday a.m. → “Pass or Obamacare lives on”
  - Dissent among moderates and far right conservatives
  - Manager’s amendments 3/23/2017 → attempt to win support

- **GOP Repeal → Agreed**; Replace? Repair?

- **Lack of Provider support → AHA, AMA, MGMA**

- **Move to other issues?** E.g., Tax reform, immigration

- **Speaker Ryan →** Sec. Price can help stabilize = expect policy / regulatory modifications
Trumped-Up Healthcare

• **President Donald Trump**
  - **For** → Affordable, accessible, and innovative care
  - **Against** → Government forced coverage, healthcare increases under Obamacare

• **Result: Payment Innovations Will Continue**
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is Bipartisan, Bicameral
  - Mandates traditional Medicare provider payment reform
  - However, less prescriptive from federal government
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Federal Economic Reform

MACRA – 2 Payment Paths
Alternative Payment Model or MIPS

Pay for Higher “Value”
Value = f(Quality + Efficiency)

Pay-for-Reporting

Voluntary Clinical Reporting

Claims Data

Affordable Quality Health Care

Reform Paradigm Shifts

- **Delivery** → Prevention, Health and Patient-Centeredness
- **Payment** → Redesign Compensated
- **Data** → Distribute and Move Information

HIMSS Alabama Chapter

Trumped-Up Healthcare
Administrative Policymakers

• **Secretary Tom Price, MD**
  – GOP Rep from GA since 2005 → Former chair of House Budget Committee
  – Orthopedic surgeon by education
  – Penned GOP “replace” plan and full Medicaid expansion repeal

• **CMS Administrator Seema Verma**
  – Owner/CEO of SVC, Inc. → IN health policy consulting firm
  – Helped design Medicaid expansion waivers in IN, IA, OH, KY
Industry Economic Trends

MACRA – MIPS
- 676,722 clinicians $199-$321 million in ± adjustments
- $500 million in “exceptional perform.”

MACRA – Advanced APMs
- 70,000-120,000 clinicians in 2019
- $333-$571 million APM incentives

CMS Policy
- Mandatory Bundles → Ortho and Cardio

Aetna
- Merck – Januvia and Janumet rebates for T2DM
- Driven by treatment outcomes

Cigna
- Sanofi and Amgen – Praluent and Repatha – Cholesterol PCSK9 inhibitors ~ $14K/year
- Discounts linked to LDL reduction benchmarks

2017 High Target Drugs
- Hep C and Oncology therapies

BCBS Plans VBP
- 350 Programs in 49 States for > 24 million members
- > 155,000 PCPs, and > 60,000 SCPs
- 37 Plans
  - 237 ACOs in 41 states and DC ~ 93,000 MDs
  - 63 PCMH initiatives in 48 states, DC and Puerto Rico

UnitedHealth Group
- Category 2 P4P rewards → 1,900 PCPs
- $148 million in bonuses

Medicare Advantage
- Seeking data on 4 categories of VBP
- VBID model 2017 → 5 years in 7 states; 2018 → 5 years in 3 states

Managed Medicaid
- 5 state approaches
  - MCOs use state developed VBP model
  - % of payments must be VBP
  - Evolving VBP over years
  - Multi-payer VBP alignment
  - State approved VBP pilots

Private APM Adoption & Growth

- **2016 Public and Private National Health Plan Survey**
- **Participants** → > 128 million Americans, ~ 44% of Market
  - Commercial → 26 health plans, 90 million lives, 44% of market
  - Medicare Advantage → 23 health plans, 10 million lives, 58% of MA market
  - Managed Medicaid → 28 health plans and 2 states, 28 million lives, 39% of Medicaid

![Pie charts comparing Legacy Payments, FFS linked to Quality, and APMs (Categories 3 & 4) for 2015 and 2016.](chart.png)

- **2015**
  - Legacy Payments (Category 1): 23%
  - FFS linked to Quality (Category 2): 15%
  - APMs (Category 3 & 4): 62%

- **2016**
  - Legacy Payments (Category 1): 22%
  - FFS linked to Quality (Category 2): 51%
  - APMs (Category 3 & 4): 27%

- **2016**
  - Legacy Payments (Category 1): 22%
  - FFS linked to Quality (Category 2): 51%
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Medicare Access & CHIP Reauthorization Act

• Bipartisan, Bicameral Medicare Cost Containment law
• Mandates 2 Medicare VBP Provider Payment Paths:
  – Merit-based Incentive Payment System (MIPS) – Payment differentially based on measures of Quality & Value
  – Advanced Alternative Payment Models (APMs) – Risk-based contracting with Providers for defined services
• Performance begins 2017 for statutory effective date Jan. 2019
MACRA 2018 Proposed Rule

- OMB received proposed rule last week
- Industry hoping for transition year repeat in 2018
- Final rule expected in Fall → No time to prepare / position
- Note: Mandatory cardiac / ortho bundles delayed, not abandoned
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MACRA By the Numbers

- **95** – Pages long
- **31** – “Reasonable Cost Reimbursement”
- **18** – Risk
- **27** – EHR or Technology to Manage, **Measure** and Report
- **8** – Meaningful Use
- **38** – Quality **Measures**
- **19** – Resource Use or Efficiency
- **171** – “Measures” or “Measurement”
- **103** – **Data**
# Categories of Value-Based Payment

## Category 1
- FFS No Link to Quality & Value

## Category 2
- FFS Linked to Quality & Value

## Category 3
- Alternative Payment Built on FFS Architecture

## Category 4
- Population-Based Payment (PBP)

### You Are Here
- 1. Pay for Infrastructure & Operations
- 2. Pay-for-Reporting
- 3. Pay-for-Performance
- 4. Performance Rewards and Penalties
- 1. Alternative Payment Models (APMs) with Upside Gainsharing
- 2. APM with Upside Sharing & Downside Risk
- 1. Condition-Specific Population-Based Payment
- 2. Comprehensive Population-Based Payment

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Predominant Payment Reform Models

- Medical Home Incentives
- Care Management Fees
- Value-Based Payment Modifier (VBPM)
- Pay-for-Performance/Incentives
- Shared-Savings with PCMH / ACOs
- Accountable Care Organizations
- Bundled Payments
- Episodes of Care Groupers
- Full/Partial Capitation + Performance

Category 2

Category 3

Category 4
MACRA

- Medical Home Incentives
- Care Management Fees
- Value-Based Payment Modifier (VBM)
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Merit-Based Incentive Payment System (MIPS)
(2017 Perform, 2019 Payment)

Category 2

Advanced APM (A-APM)

Category 3

Category 4

Quality Payment Program (QPP)
2017 Transition Year

1. **MIPS – Penalty Avoidance**
   - Submit by Mar. 31, 2018
   - 90 days of data between Jan. 1 and Oct. 2, 2017
   - 1 Quality Measure,
   - 1 Clinical Practice Improvement Activity, or
   - 5 required Advancing Care Information measures

2. **MIPS – Delayed Start**
   - Submit by Mar. 31, 2018
   - 90 days of data between Jan. 1 and Oct. 2, 2017
   - > 1 Quality Measure,
   - > 1 improvement activity, and/or
   - > 5 required Advancing Care Information measures

3. **MIPS – Ready to Go**
   - Submit by Mar. 31, 2018
   - “Full Year” of data
   - 6 Quality Measures (1 outcome) – MIPS APM Groups report 15;
   - 4 improvement activities; or 2 for small, rural, HPSA or non-patient facing
   - Required or up to 9 of advancing care information measures

4. **Advanced Alternative Payment Model**
   - Significant portion of Medicare patients or payments
   - Qualified Participant (QP) determination “snapshot” and inclusive
   - Driven by patient or pay thresholds

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CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Released to Office of Federal Register, October 14, 2016
## MIPS Composite Performance Score

<table>
<thead>
<tr>
<th>Performance Year / Application Year</th>
<th>Quality Measures</th>
<th>Resource Use or Cost</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Replaces CMS Physician Quality Reporting System (PQRS)</td>
<td>Replaces ACA Value-based Payment Modifier</td>
<td>New category of measurement; Medical Homes and NCQA PCSR receive full credit; 93 activities available</td>
<td>Replaces CMS EHR Incentive Programs f/k/a Meaningful Use;</td>
</tr>
<tr>
<td><strong>Reporting Methods</strong></td>
<td>Claims, CSV, Web Interface (for group reporting), EHR, Qualified Clinical Data Registry (QCDR)</td>
<td>Claims</td>
<td>Attestation, QCDR, Qualified Registry, EHR Vendor</td>
<td>Attestation, QCDR, Qualified Registry, EHR Vendor, Web Interface (groups only)</td>
</tr>
<tr>
<td><strong>2017 / 2019</strong></td>
<td>60%</td>
<td>0%*</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>2018 / 2020</strong></td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>2019 / 2021</strong></td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
</tr>
</tbody>
</table>

*Measured for feedback only in 2017"
MIPS – CPS Payment Adjustments

- **Positive / Negative adjustments are CMS budget neutral**
- Scoring → “Points” earned under each category, 0-100 points
- Eligible Clinicians (ECs) → perform all or none of categories
- **ECs performing none** → Composite Performance Score (CPS) of zero and subject to maximum negative adjustment

<table>
<thead>
<tr>
<th>Final Score Points</th>
<th>MIPS Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0 – 0.75</td>
<td>Negative 4 percent</td>
</tr>
<tr>
<td>0.76 – 2.9</td>
<td>Negative MIPS payment adjustment &gt; -4.0% and &lt; 0.0% on a linear sliding scale</td>
</tr>
<tr>
<td>3.0</td>
<td>0.0% adjustment</td>
</tr>
<tr>
<td>3.1 – 69.9</td>
<td>Positive MIPS payment adjustment &gt; 0.0% to 4.0% x a scaling factor to preserve budget neutrality, on a linear sliding scale</td>
</tr>
<tr>
<td>70.0 – 100</td>
<td>Positive MIPS payment adjustment of 4.0% AND additional MIPS bonus for “exceptional performance” of 0.5 percent to 10.0% on a linear sliding scale x scaling facture</td>
</tr>
</tbody>
</table>

CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Table 31, Released to Office of Federal Register, October 14, 2016
CMS Resources

Help!
Agenda

• Trump and AHCA
• Federal Economic Reform
• Merit-Based Incentive Payment System
  • **Advanced APMs**
• IT Industry Response
• Questions
CMS APM vs. A-APM

CMS Alternative Payment Model (APM)

CMS Advanced Alternative Payment Model (A-APM)

There is a difference!
2-Part Qualifier For A-APMs

1. Nominal Risk Standard
2. Volume Threshold
Financial Rewards

- **Advanced APM**
  - APM-specific Rewards
  - Lump sum incentive of 5% of Medicare payments
  - Qualified Participants (QPs) not subject to MIPS

- **Non-advanced APM or MIPS APM**
  - APM-specific Rewards
  - MIPS Opt-In – Collective Scoring
    - Clinicians Scored Individually
    - Scores averaged across APM
    - Average score applied to all APM clinicians subject to MIPS
  - MIPS Opt-Out – No Scoring

- **Not in APM**
  - MIPS Rewards (or penalties)
Advanced Alternative Payment Models

- **A-APMs specifically included in Performance Year (PY) 2017**
  - Medicare Shared-Savings Programs (MSSP) – Tracks 2 and 3
  - Next Generation ACO Model
  - Comprehensive ESRD Care (CEC)
  - Comprehensive Primary Care Plus (CPC+) → "Advanced Medical Home Model"
  - Oncology Care Model (OCM) – 2-sided risk starts in 2018

- **A-APMs for PY2018**
  - MSSP Track 1+ → New model; details to come
  - Medicare Episode Based Payment Model → Proposed only


CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Released to Office of Federal Register, October 14, 2016
Advanced Alternative Payment Models

• **A-APMs included in PY2019**
  - Approved commercial contracts with sufficient risk
  - Medicare Advantage

• **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** →
  11-member MACRA established advisory committee, reviews/recommends APM models to HHS

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CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Final Rule, Released to Office of Federal Register, October 14, 2016
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- **IT Industry Response**

- Questions
Gartner Hype Cycle

- Peak of Inflated Expectations
- Plateau of Productivity
- Slope of Enlightenment
- Trough of Disillusionment

Bleeding Edge

Leading Edge

TIME

VISIBILITY
Providers Health IT

Source: Gartner (July 2016)
U.S. Healthcare Payers

Source: Gartner (July 2016)
Hype Cycle – Medicine & Care Delivery

- Care Management Population Health Platforms, Analytics
- FHIR
- Telemedicine and Virtual Care Platforms
- Gen 3 Electronic Health Records
- Integrated Business/Clinical EDWs
- Smart Machines — Healthcare Sages Genomics Precision Medicine
- 3D Bioprinting
- Nanomedicine

2015 - 2020
CIO, CMIO, CNIO and CDO Implications

- **IT Shift** → Transaction-based automation to service delivery and prioritizing real-time actions (business, clinical, consumer)
  - Requires bimodal IT thinking
    - 2 separate, coherent modes of IT delivery
    - 1 focusing on stability and 1 on agility
  - Requires data mastery & analytics re: behaviors, processes, performance
    - Logical data warehouse
    - Consider adding a CDO

- **Agile development acumen** → Part of IT services (not just for vendors)
  - Large health delivery orgs
  - Self-develop extension and IT innovations with strategic platforms & domain knowledge clouds
  - Increased security risk across expanding public/private clouds & infrastructures
Thank you!

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