ESSENTIAL STRATEGIES IN MEDI-CAL PAYMENT REFORM

Richard Popper, Director, Medicaid & Duals Strategy
August 3, 2017
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AGENDA

• Federal Payment Reform - MACRA
• Medi-Cal Payment Reform
• Essential Strategies
• Questions
FEDERAL REFORM

Affordable Quality Health Care

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

Reform Paradigm Shifts

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

- Enacted April 2015
- Bipartisan 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
4 CATEGORIES OF VALUE-BASED PAYMENT (VBP)

Starting Point

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)

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
3. Integrated Finance & Delivery System

Advancing Provider Alignment Creates Data and Operational Complexities

**PREDOMINANT PAYMENT REFORM MODELS**

**FFS + Quality Measures**
- Medical Home Incentives
- Care Management Fees
- Value-Based Payment Modifier (VBM)
- Pay-for-Performance/Incentives

**Risk-Bearing**
- Shared-Savings with PCMH / ACOs
- Accountable Care Organizations
- Bundled Payments
- Episode-Based Payment (e.g., OCM)
- Full/Partial Capitation + Performance

**Category 2**
- MACRA
- Quality Payment Program (QPP)
  - Merit-Based Incentive Payment System (MIPS)
    - (2017 Perform, 2019 Payment)

**Category 3**
- Advanced APM (A-APM)

**Category 4**
## FINAL RULE – 2017 TRANSITION YEAR

<table>
<thead>
<tr>
<th>Options</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| **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 |

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>
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</table>

*Measured for feedback only in 2017

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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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**EVOLUTION OF STATE MEDICAID PERFORMANCE CONTRACTING**

### Old Structure
Medicaid ties plan bonus or withhold to certain HEDIS scores

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<th>Performance</th>
<th>Outcome</th>
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<td>Well-Child Visits in the First 15 Months of Life</td>
<td>66.22%</td>
<td>+1.45%</td>
</tr>
<tr>
<td>Six or More Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>79.55%</td>
<td>-0.82%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</td>
<td>75.11%</td>
<td>-0.65%</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>54.74%</td>
<td>+0.72%</td>
</tr>
</tbody>
</table>

**Plans**
- Pay providers FFS or capitation while monitoring and cajoling.....
- Providers and members on preventive services & treatments

### Value-Based Structure
Medicaid sets % of provider payments tied to value/performance

**Plans negotiated alternative payment arrangements with providers, tied to HEDIS or outcomes**

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**Providers Incentivized**
NUMEROUS STATE VALUE / PERFORMANCE PAYMENT INITIATIVES

- 70% of states doing value, performance and/or bundled payments in Medicaid, with near term targets for majority of payments under VBP

- Most plans use manual process to issue and reconcile provider performance or value payments

<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Voluntary MCO arrangements to date. New PRIME program compels public hospitals have APM contract w/MCO. Goal: 60% of Medi-Cal mburs</td>
<td>2020</td>
</tr>
<tr>
<td>DC</td>
<td>35% of total dollar amount spent on health care services linked to Alternative Payment Models</td>
<td>2019</td>
</tr>
<tr>
<td>Georgia</td>
<td>MCOs distribute to providers Value Based Purchasing incentive payments which the plan receives from state Medicaid agency</td>
<td>In place</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Converting or merging MCOs with ACOs</td>
<td>2017</td>
</tr>
<tr>
<td>Michigan</td>
<td>Plans must increase total percentage of health care services reimbursed under value-based contracts</td>
<td>In place</td>
</tr>
<tr>
<td>New York</td>
<td>80-90% of MCO-PPS provider payments thru VBPs of either PMPM shared savings or bundles based on outcome scores</td>
<td>2019</td>
</tr>
<tr>
<td>Ohio</td>
<td>80-90% of members in VBP arrangements of episodic/bundled payment &amp; pop health/Patient Centered Medical Homes</td>
<td>2020</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Quality Performance Program thru P4P must target improvements in quality or access to care using 10 HEDIS measures</td>
<td>2017</td>
</tr>
<tr>
<td>Oregon</td>
<td>Coordinated Care Organizations must implement alternative payments, and adopt Medicare bundles to transform of care delivery</td>
<td>2017</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>80 percent of provider payments must be in alternative payment arrangements, with 65 percent made under a total cost of care model</td>
<td>2020</td>
</tr>
<tr>
<td>Texas</td>
<td>Texas requiring 22 Medicaid MCOs to administer alternative payment arrangement thresholds by mid-2018. Initial VBP threshold would be 25%, growing to 50% by 2021.</td>
<td>2018</td>
</tr>
<tr>
<td>Virginia</td>
<td>MCOs must develop alternative payment methods that tie to cost and quality incentives, including “pay for reporting”, upside &amp; downside</td>
<td>2017</td>
</tr>
</tbody>
</table>
California MCP’s ahead of MACRA in implementing Category 2, linking FFS with Quality:

Presence of P4P arrangements in Medi-Cal MCPs:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medi-Cal MCPs with P4P arrangements</th>
<th>2017 DHCS Medi-Cal auto-assign incentive measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well child visit with PCP 3-6 years</td>
<td>12</td>
<td>yes</td>
</tr>
<tr>
<td>Diabetes HbA1c testing</td>
<td>13</td>
<td>yes</td>
</tr>
<tr>
<td>Diabetes eye exam</td>
<td>11</td>
<td>no</td>
</tr>
<tr>
<td>Diabetes nephropathy</td>
<td>9</td>
<td>no</td>
</tr>
<tr>
<td>Diabetes LDL testing</td>
<td>6</td>
<td>no</td>
</tr>
<tr>
<td>Well child visit with PCP 3-6 years</td>
<td>12</td>
<td>yes</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>10</td>
<td>yes</td>
</tr>
<tr>
<td>Childhood immunizations</td>
<td>8</td>
<td>yes</td>
</tr>
</tbody>
</table>
**MEDI-CAL 2020 WAIVER: PRIME PROGRAM**

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program
  - Part of California’s approved “Medi-Cal 2020” section 1115 Medicaid Demonstration

- Goal: Move Medi-Cal MCP payments to public hospitals to value-based structures

- Waiver sets public hospital alternative payment targets, with non-compliance penalties

- Targets: Medi-Cal managed care beneficiaries assigned to hospitals where all or portion of care is under an APM:
  - 50% of beneficiaries by Jan 2018
  - 55% by Jan 2019
  - 60% by end of 2020

- 5% ($10 million) of PRIME pool at risk for penalty if APM targets unmet
PRIME cont’d

MCP/hospital contracts require hospitals to report on broad range of metrics to meet quality benchmark goals that improve patient outcomes.

4 tiers of alternative payment:

1) Partial (primary care only)
2) Partial-plus (primary care and some specialty care)
3) Global (primary, specialty, ancillary and/or hospital care)
4) Additional payment methodologies approved by DHCS/CMS

PRIME alternative payment model requires:

- Defined patient population for which hospital is accountable
- Set of quality accountability metrics aligned with MCPs quality accountability and clinical outcome metrics
- Can be adjusted for population socioeconomic and demographics
- Some contractual level of risk for cost of care, such as risk sharing, incentives or shared savings for reduced cost

Jan 2018: Hospital systems must enter APM contract with at least 1 area Medi-Cal MCP
FQHC ALTERNATIVE PAYMENT PILOT

California SB 147, enacted 2015, authorizes 3-year APM pilot program for county and community-based FQHCs, to incentivize delivery system and practice transformation at FQHCs through flexibilities available under a capitated model.

Goal: move clinics away from the traditional volume-based FFS to APM to provide FQHCs flexibility to deliver care in the most effective manner, without restrictive traditional billing structure.

Examples of non-traditional services could include but are not limited to:
- Integrated primary and behavioral health visits on the same day
- Group visits
- Email visits
- Phone visits
- Community health worker contacts
- Case management
- Care coordination across systems

Jan 2018 DHCS pilot implementation target
CMS/DHCS HEALTH HOMES

ACA program to coordinate the full range of physical health services, behavioral health services, and community LTSS for members with chronic conditions. CMS requirements:
- Improve care coordination
- Strengthen community linkages and team care
- Improve outcomes for high risk/chronic condition beneficiaries
- Cost avoidance results in 2 years

DHCS requirements:
- Develop provider infrastructure
- Serve homeless
- Integrate physical and behavioral health
- Fiscally sustainable after 2 years

Payments flow from DHCS, to MCPs, to Health Home Providers

Possible APMs, based on CMS Health Home core quality measures:
- All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
AGENDA

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## PLAN FUNCTIONS NEEDED TO ADMINISTER APMS

<table>
<thead>
<tr>
<th>Tool</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims system</strong></td>
<td>Processes claims and applies base fee schedule, bonus fee schedule or penalty fee schedule</td>
</tr>
<tr>
<td><strong>Population health analytics</strong></td>
<td>Population health management to measure and report HEDIS® &amp; other quality standards, to measure provider performance &amp; identify member-level care gaps</td>
</tr>
<tr>
<td><strong>Bonus &amp; accumulator tool</strong></td>
<td>Solution can operate separate from claims system to fetch &amp; accumulate FFS claims (shots, screenings, visits, episodes of care) under rules engine to create scorecard; calculate bonus, adjustment, bundle or loss; creates bundles from FFS claims</td>
</tr>
<tr>
<td><strong>Pricing tool</strong></td>
<td>Identify eligible providers and lookup appropriate bonus or penalty payment rate</td>
</tr>
<tr>
<td><strong>AP system</strong></td>
<td>Applies bonus payment or charge loss to provider, based on produced score card or report card</td>
</tr>
</tbody>
</table>
PAYMENT INNOVATION PROCESS SOLUTION

Pricing Tool

FFS

Provider Grade

Pricing

Good = rate + $X
Poor = rate - $X

Any Claims Engine

Population Health Analyzer

Provider Report Card or Bundle

Bonus / Accumulator Tool

Medical Records

Supplemental

Claims

Providers

Eligibility

Members

Any Claims

Provider

Grade

Pricing Tool
### VALUE INCENTIVE PAYMENTS BEING IMPLEMENTED BY DST PAYMENT INNOVATION SOLUTION

<table>
<thead>
<tr>
<th>Category</th>
<th>Service/Activity</th>
<th>Incentive/Bundle</th>
<th>Example of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>Well Child</td>
<td>Bundle</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>Immunizations</td>
<td>Combo 3 Bundle</td>
<td>$200</td>
</tr>
<tr>
<td></td>
<td>HRA completion</td>
<td>Incentive</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td>Chlamydia screening</td>
<td>Incentive</td>
<td>$30</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>Diabetic Measures</td>
<td>Bundle: HbA1c, LDL screening, nephrology screening, eye exam</td>
<td>$250</td>
</tr>
<tr>
<td></td>
<td>Cancer screenings</td>
<td>Mammography and Cervical Cancer</td>
<td>$50 $50</td>
</tr>
<tr>
<td>PCMH</td>
<td>E&amp;M Codes</td>
<td>Enhanced fee schedule, Progressive continuity of care adjuster for retention</td>
<td>+25% of Medicaid fee schedule paid as quarterly bonus</td>
</tr>
</tbody>
</table>
THANK YOU

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RAPopper@DSTHealthSolutions.com
410 294 8215