MACRA: MIPS / APMs
What are Episodes of Care

ASE (American Society of Echocardiography)
June 3rd 2016

Prometheus
Bridges to Excellence

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Who is HCI3?

Health Care Incentives Improvement Institute

- Not-for-profit organization - based in Newtown, CT
- Focused on payment and benefit programs to improve incentives for providers and plan members
- Developed Bridges To Excellence and PROMETHEUS Payment and we are implementing these programs in pilot sites across the country
- Development and testing of our programs was funded and supported from charitable foundations:
  - Robert Wood Johnson Foundation
  - Commonwealth Fund
  - NY State Health Foundation
  - Colorado Health Foundation
- Defined and worked on the CMS EOC grouper project – worked with volunteer clinical experts assembled in Clinical Working Groups

Agenda

- Overview of MACRA:
  - MIPS / APMs
- What are Episodes of Care
- What are Advanced APMs
- Timeline and other initiatives

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1: 30%

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: 85%

Medicare fee-for-service payments are **tied to quality or value** (categories 2-4) by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

Terminology

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

- Replaces SGR by paying clinicians for value and quality of care

Single Program: "Quality Payment Program": *Path to Value*

The Program has two paths:

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs): risk-bearing contracts

MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

Physician Quality Reporting Program **(PQRS)**	Value-Based Payment Modifier	Medicare EHR Incentive Program

MACRA streamlines those programs into **MIPS**:

Merit-Based Incentive Payment System **(MIPS)**

MIPS Performance Categories

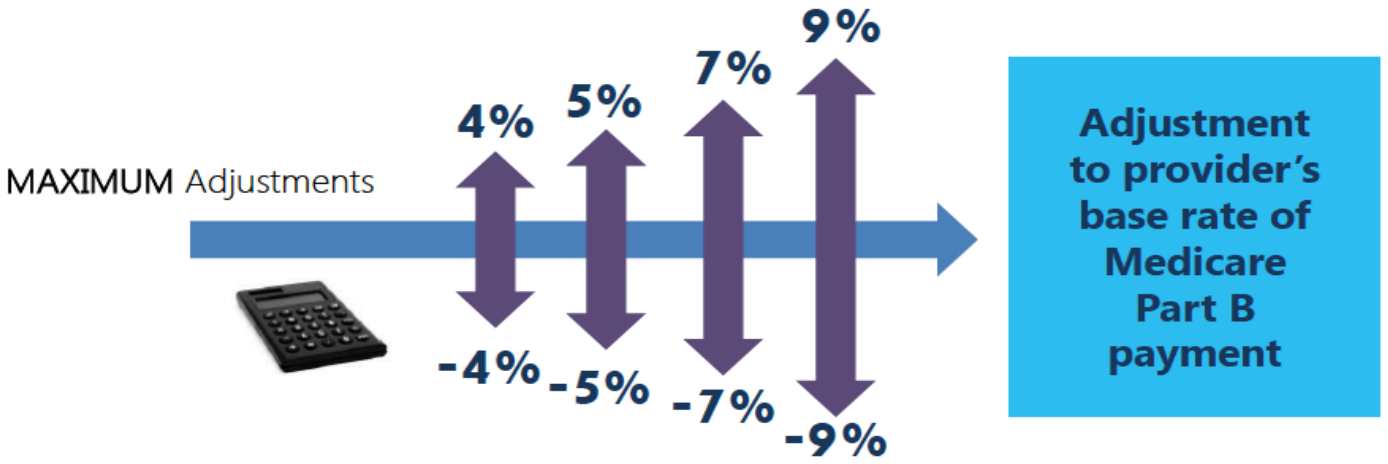
A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Advancing care information	25%	• Base score of 50 percentage points achieved by reporting at least one use case for each available measure • Performance score of up to 80 percentage points • Public Health Reporting bonus point • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	• Similar to quality

How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

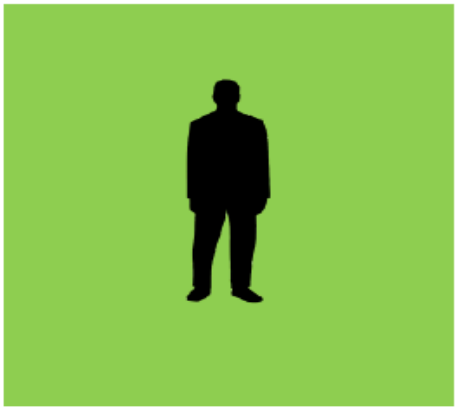


Are there any exceptions to MIPS adjustments?

There are **3 groups** of physicians and practitioners who will NOT be subject to MIPS:

FIRST year of Medicare participation

Participants in eligible Alternative Payment Models who qualify for the bonus payment



Below low volume threshold

Note: MIPS **does not** apply to hospitals or facilities

Alternative Payment Models (APMs)

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

According to MACRA law, APMs include:

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by Federal Law

- MACRA **does not change how any particular APM rewards value**.
- APM participants who are not "QPs" will receive **favorable scoring under MIPS**.
- Only **some** of these APMs will be **eligible** APMs.

What is an eligible APM?

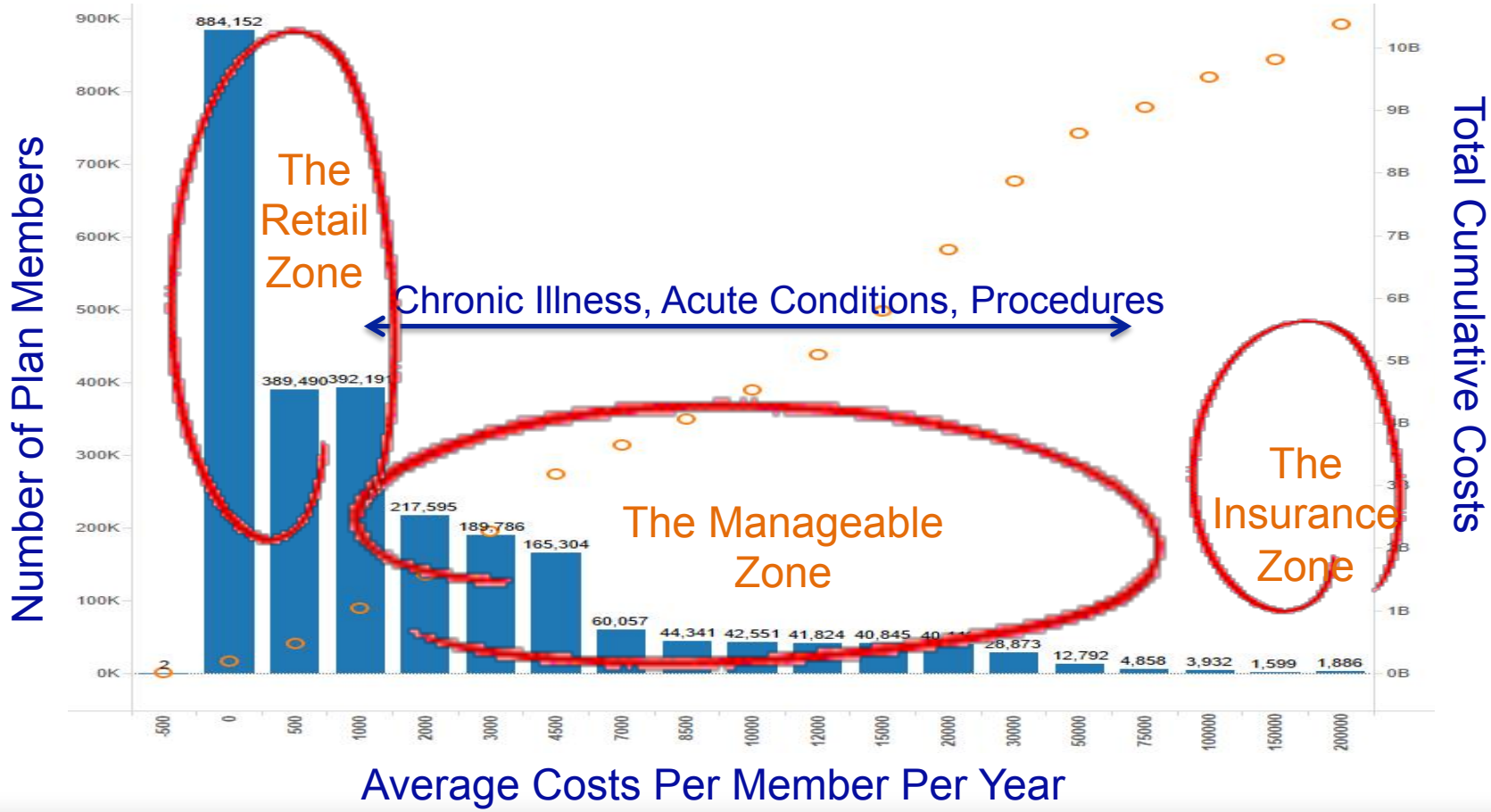
Eligible APMs are the **most advanced** APMs that meet the following criteria according to the MACRA law:

- ✓ **Base payment on quality** measures comparable to those in MIPS
- ✓ Require use of certified **EHR** technology
- ✓ Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

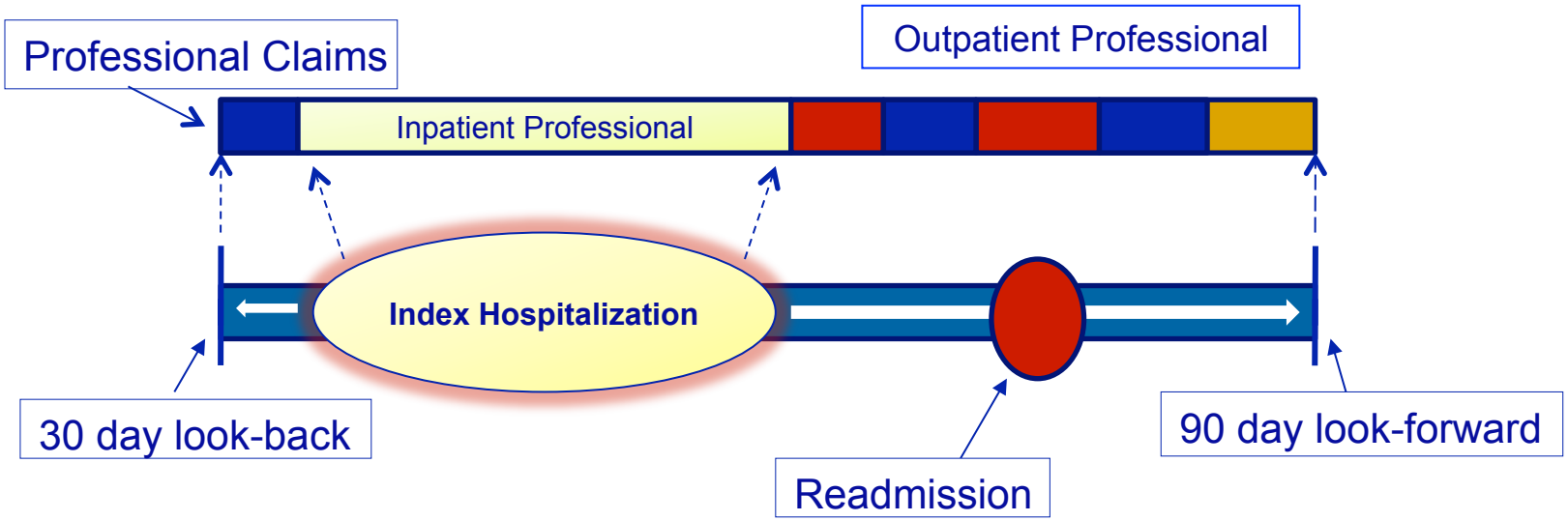
Those who participate in **the most advanced** APMs may be determined to be **qualifying APM participants ("QPs")**. As a result, QPs:

1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024
3. Receive a **higher fee schedule update** for 2026 and onward

Managing Total Costs of Care



What is an Episode-of-care?



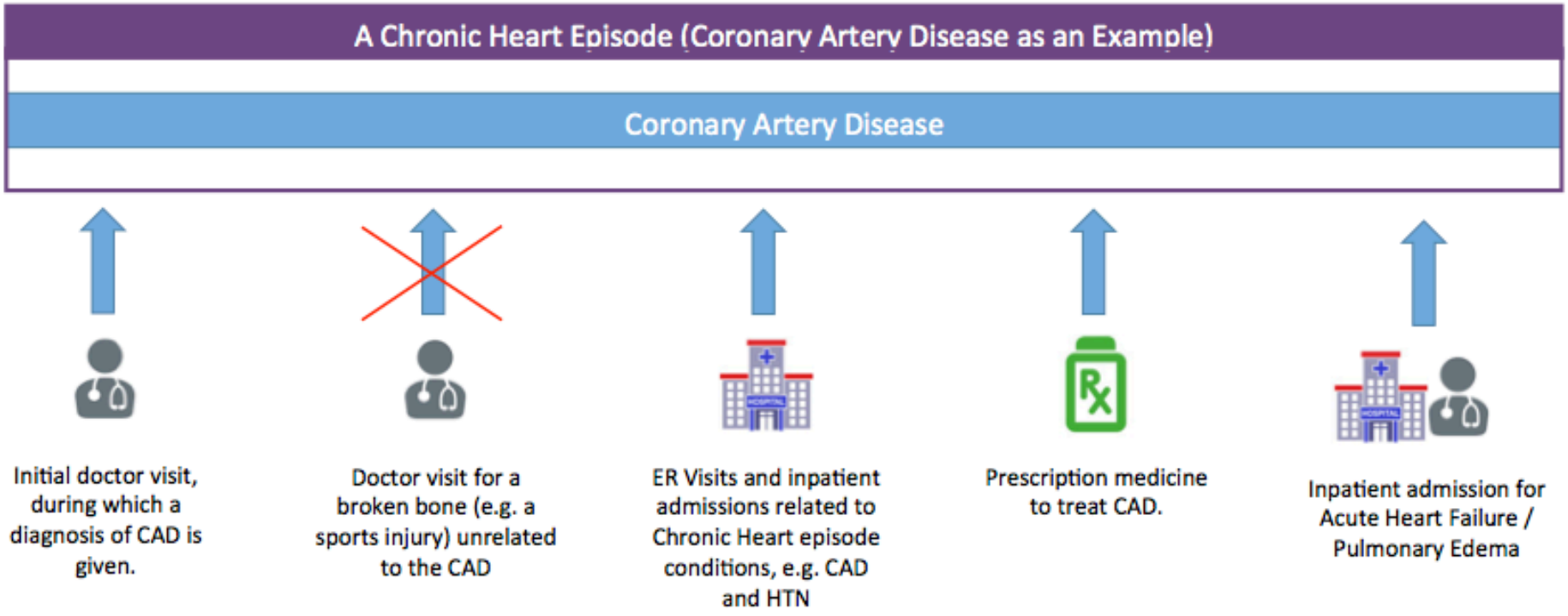
Key:

- Irrelevant
- Either typical or PACs
- Claims with potentially avoidable complications (PACs)
- Claims for typical care and services

Episodes look at all clinically related services for a discrete condition / procedure for the entire continuum of care: management, surgery, ancillary, lab, pharmacy services for a given time frame (one-year, start of symptoms to finish)

Claims Assignments

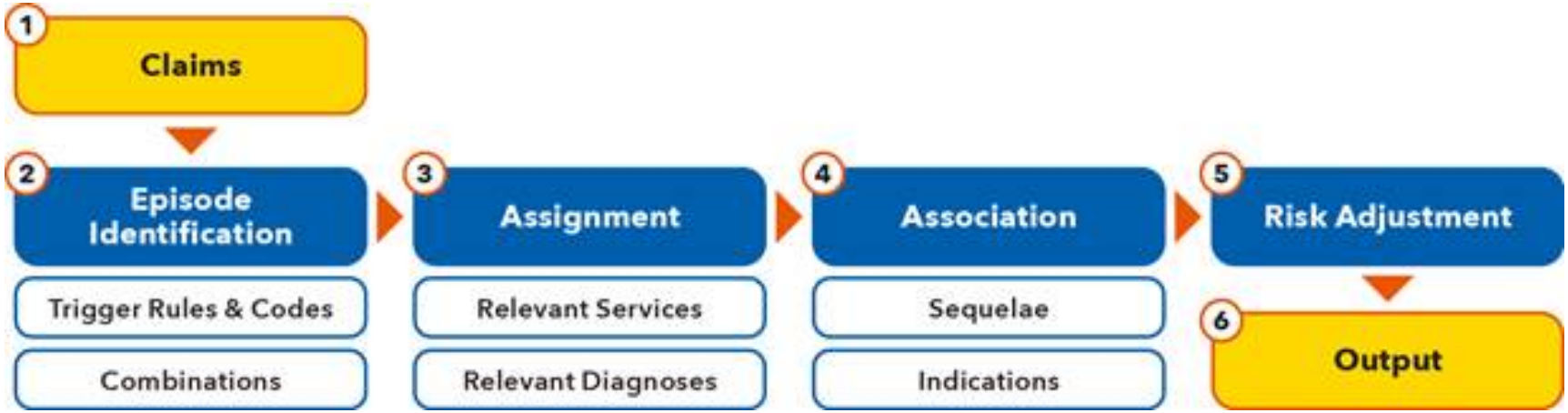
Clinical Logic



Components of Episodes

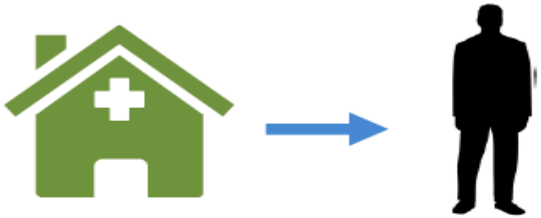
- Trigger codes – procedure and/or diagnosis codes that clearly identify the presence of a condition, treatment, illness or injury, e.g., CABG procedure code (ICD9/ ICD-10 proc / CPT code), CHF diagnosis code
- Trigger Rules – help define the existence of an episode
- Time window – helps define the start and end of an episode
- Subtypes – most episodes have sub-types to distinguish a category of a condition, treatment, illness or injury
  - For example CABG alone vs. CABG w Valve Replacement
  - CABG in the setting of AMI
- Relevant Diagnosis
  - Complication – avoidable complications for the episode
    - Directly due to the condition / treatment such as wound infection after surgery
    - Patient safety issues such as drug-drug interactions, deep vein thrombosis
  - Typical – signs and symptoms such as chest pain, shortness of breath
- Relevant Procedure Codes
    - CPT, HCPCS, ICD procedure codes

How episodes are constructed



- Episodes are triggered
- Claims are assigned to open episodes
- Episodes may get associated to each other for a more comprehensive picture
- Costs for the claims are aggregated to calculate episode costs
- Risk adjustment creates expected costs for patients based on their risk profile

How do I become a Qualifying APM Participant (QP)?



Advanced APM → QP

You must have a **certain %** of your patients or payments through an **Advanced APM**.

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

PROPOSED RULE

Advanced APM Criterion 3: Example

The following is an example of a risk arrangement that would **meet the Advanced APM financial risk criterion**:

How are expected costs calculated
Benchmarks vs. risk adjustment

What does two sided shared savings arrangement mean?
- Upside only
- What is downside risk

An APM consists of a **two-sided** shared savings arrangement:

- ✓ If the APM Entity's actual expenditures exceed expected expenditures (the "benchmark"), then the APM Entity **must pay CMS 60% of the amount that expenditures that exceed the benchmark**.
- ✓ The APM Entity **does not have to make any payments** if actual expenditures exceed the benchmark by **less than 2%** of the benchmark amount.
- ✓ There is a **stop-loss provision** so that the APM Entity could pay up to but no more than a **total amount equal to 10%** of the benchmark.

Patient Provider Attribution

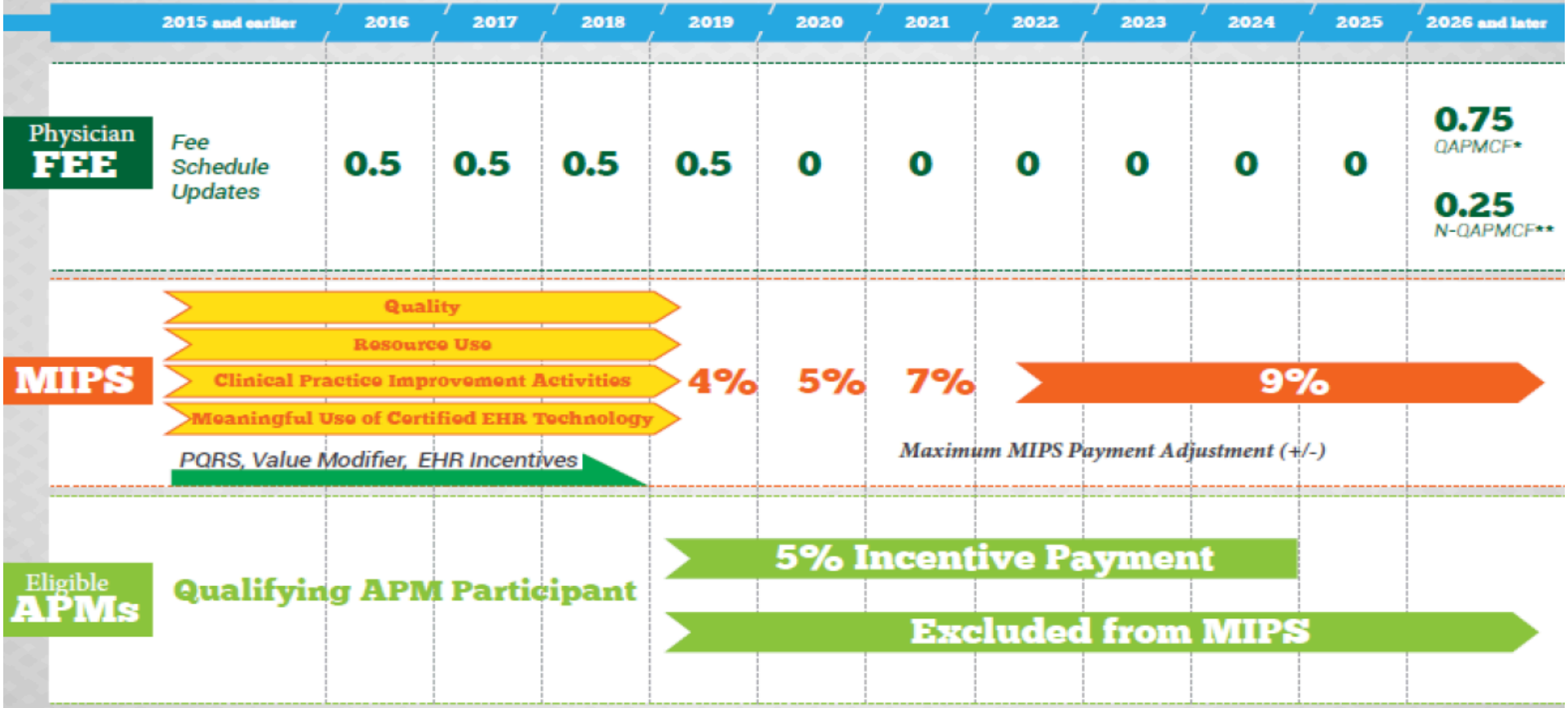
- Various options proposed for accountability purposes
  - Leverage the VM method – single winning provider based on the score of the facility TIN
  - For MIPS:
    - Acute condition episodes - use group / individual clinicians - use Plurality of E&M claims > 30% rule
    - Surgeon for procedural episodes
  - For Advanced APMs – give performance score calculated to the APM entity to each QP
- Proposal to add codes to claims to identify
  - Principal Provider
  - Secondary Provider

Proposed Rule
Advanced APMs

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- ✓ **Shared Savings Program** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

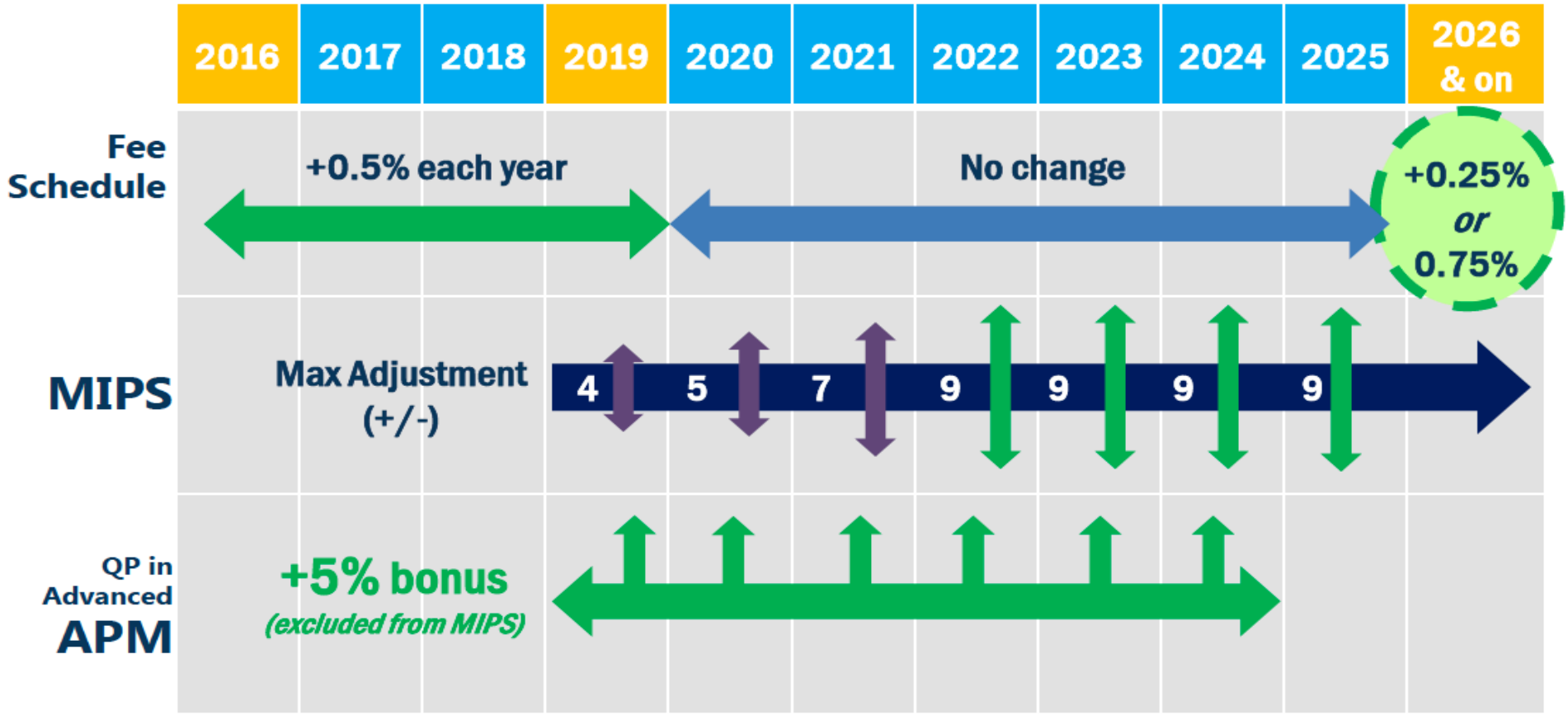
Timeline



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

Putting it all together:



What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

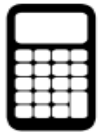
Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP.

"All-Payer Combination Option"

IF the "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs":

Certified EHR use

Quality Measures



Financial Risk

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Encourage new **APM options** for Medicare physicians and practitioners.

Submission of model proposals

Technical Advisory Committee (11 appointed care delivery experts)

Review proposals, submit recommendations to HHS Secretary

Secretary comments on CMS website, CMS considers testing proposed model

PROPOSED RULE

Physician-focused Payment Model (PFPM)

Proposed definition: An Alternative Payment Model wherein Medicare is a payer, which includes physician group practices (PGPs) or individual physicians as APM Entities and targets the quality and costs of physician services.

Proposed criteria fall under 3 categories

- ✓ **Payment incentives for higher-value care**
- ✓ **Care delivery improvements**
- ✓ **Information availability and enhancements**

Any PFPM that is selected for testing by CMS and meets the criteria for an Advanced APM would be an Advanced APM.

EPISODE SELECTION CRITERIA

Empowering Consumers

Conditions & procedures with opportunities to engage patients and family caregivers' through the use of decision aids support for shared decision-making; goal setting and support for identifying high-value providers.

High Volume, High Cost

Conditions & procedures for which high cost is due to non-clinical factors such as inappropriate service utilization and poor care coordination that correlate with avoidable complications, hospital readmissions and poor patient outcomes.

Unexplained Variation

Conditions & procedures for which there is high variation in the care that patients receive, despite the existence evidenced based "best" practices.

Care Trajectory

Conditions & procedures for which there is a well-established care trajectory, which would facilitate defining the episode start, length and bundle of services to be included.

Availability of Quality Measures

Conditions & procedures with availability of performance measures that providers must meet in order to share savings which will eliminate the potential to incentivize reductions in appropriate levels of care.

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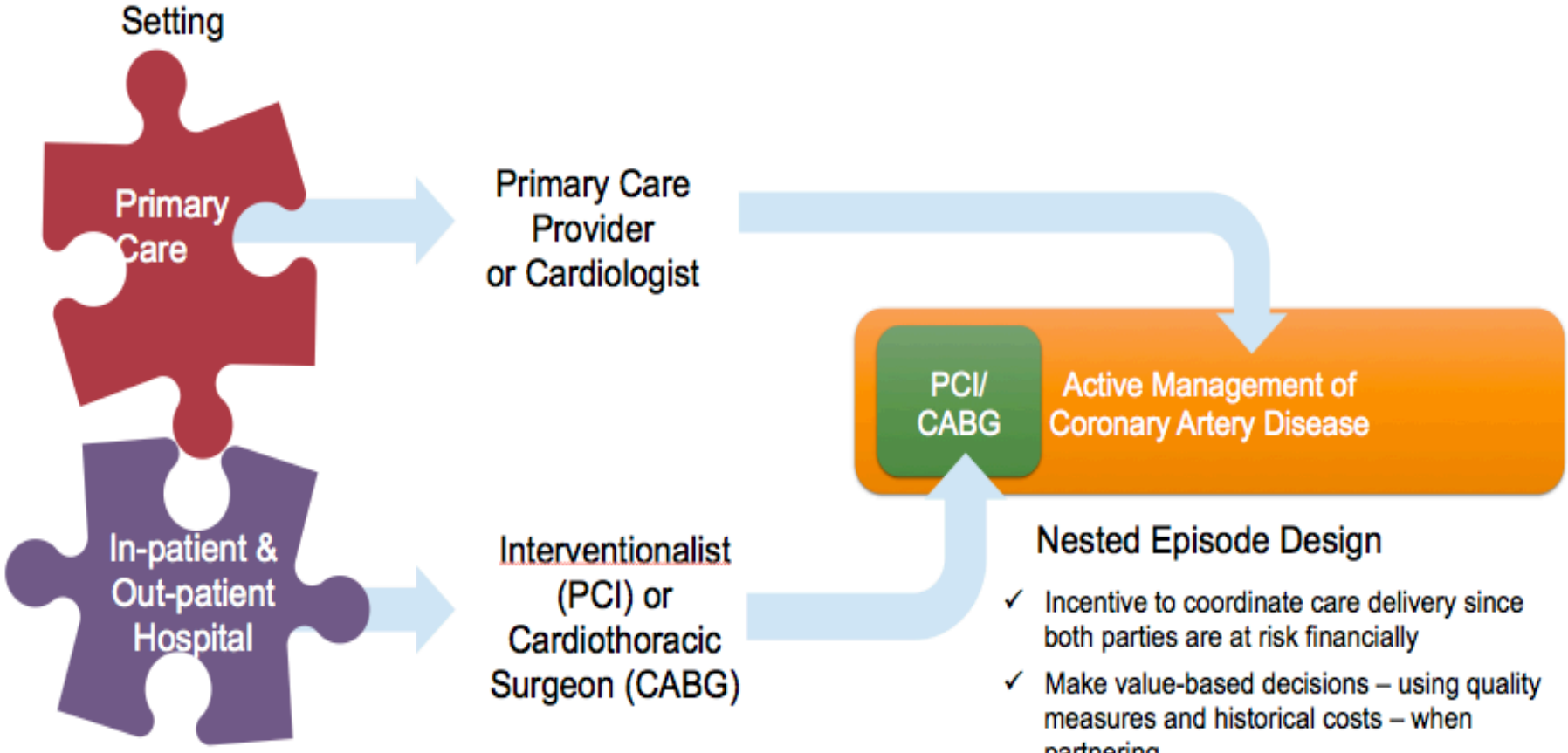
CARDIAC – PRICE & CARE

Why a Nested Cardiac Care Episode?



Nested Episode Design

- ✓ Incentive to coordinate care delivery since both parties are at risk financially
- ✓ Make value-based decisions – using quality measures and historical costs – when partnering

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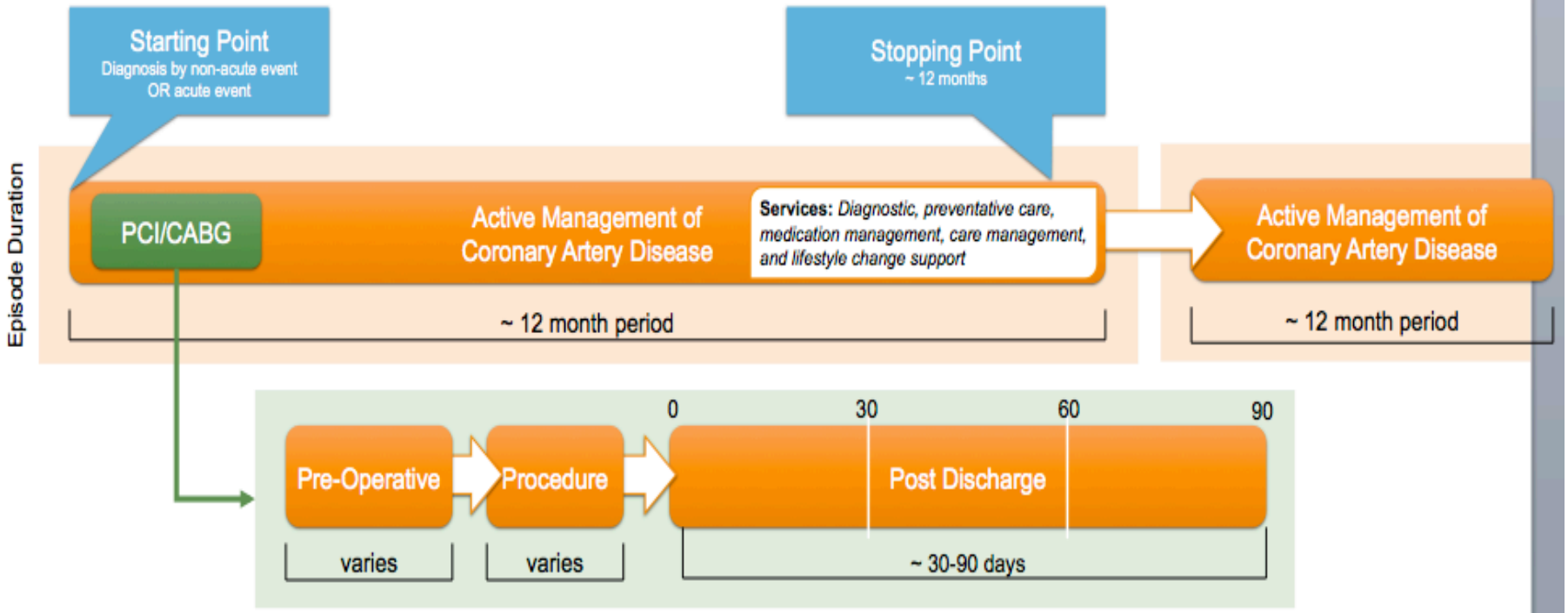
CARDIAC - TIMELINE

Episode Timeline for Cardiac Care

NOTIONAL – Still in Development



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What this means to you?

- CMS is pushing for participation in Advanced APMs
- Quality Measurement is fundamental
- Use of a certified EHR is vital
- Participation in APMs will provide a means to get 5% bonus payment upfront
- Advanced APMs are still being developed