Under the MACRAscope
Episodes of Care

IL and WI ACC Chapter
November 5, 2016
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1

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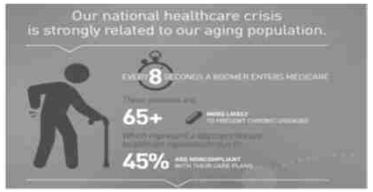
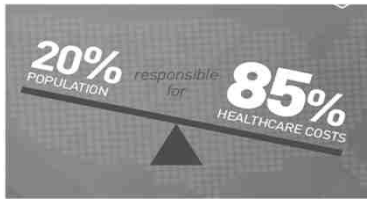
- Co-chair: ACC CV Administrator Work Group
- Member: Cardiovascular Management Council
- Member: Health Affairs Committee
- Member: BOT Work Group on Medical and Professional Liability Insurance
- Member: CQC AUC Implementation & Evaluation
- Member: CQC FOCUS Committee
- Member: Partners in Quality Committee
- Member: Task Force on MACRA
- Ownership Interest/Partnership/Principal: Cardiovascular Management of Illinois
- Consultant Fees/Honoraria: Medaxiom
- Organizational (Non-Commercial): Cardiology Advocacy Alliance
- Organizational (Non-Commercial): Medaxiom Advisory Board

How did we go from SGR to MACRA (what is MACRA?)

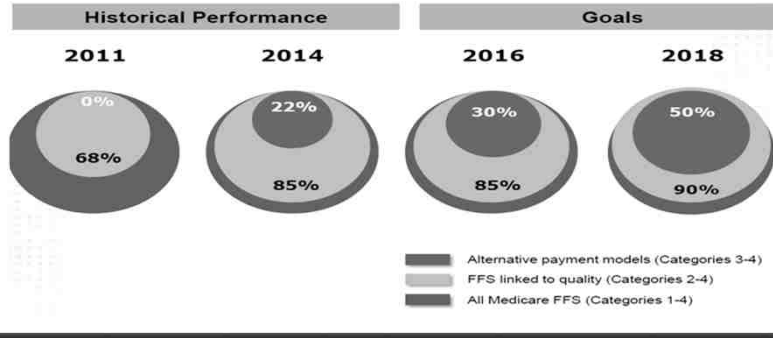
3

What is the problem…..





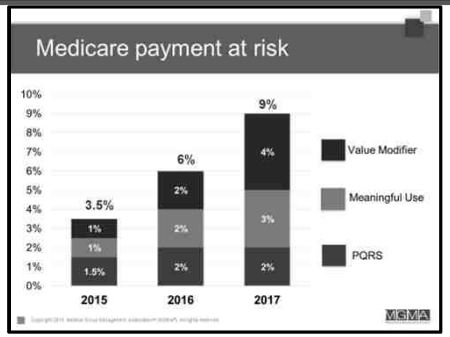
Where are we…..how do we get there



The march to value……..

The train has left the station, and it ain't coming back

MD Revenue at risk 2017 & 2018



Source: MGMA

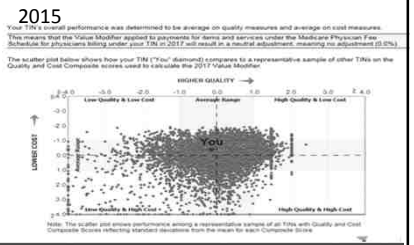
Value Agenda: Physician

- Meaningful Use
- PQRS
- Value Modifier
  - QRUR
  - S-QRUR
  - Physician Compare
- Hello MACRA
  - MIPs – Quality 60%, Cost 0%, ACI 25%, CPIA 15%

As the world turns…..

2014

2015



The Basics of MACRA

- **M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct
- Eliminate SGR
- Effective 1/1/19
- Infrastructure for MACRA: PQRS, VM, MU
- MACRA
  - APM: base year will be 2017
    - The new final rule has some changes in "qualifying APM's"
  - MIPS: base year will be 2017

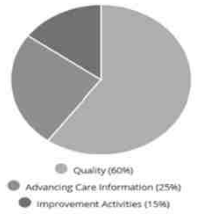
Practices will have choices under MACRA

Fee-for-Service under a "Merit-based Incentive Payment System" (MIPS)	• Statutory updates • Consolidated reporting • Reduced penalty risk
Alternative Payment Models	• Higher updates • Exempt from MIPS • Preferred treatment for medical homes • Specialty models encouraged

MIPS Composite Score

MU requirements: 25 points
- Performance score
- Base Score
- 5 measures
  - Earn full points
  - There were 11
  - The others are optional

Clinical Practice Improvement (15 points)
- 90 activities
- Pick 4 medium or 2 high



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se:

Quality/PQRS: 60 points
- 6 quality measures
- 1 sub-specialty measure set
- Web interface rules different

Resource Use: 0 points
- MSPB
- Total cost of care
- **Episodes of care**
  - Only 10 vs 40
  - Only ones in s-QRUR
- 30% by 2021

Changes

- 2017 will be a transition year
- Quality is King
- Cost is collected but not scored …..yet
- APM
  - Looking at an ACO Track 1+
  - Details not out yet
  - Looking at Private payer & Medicaid
- Excluded providers: $30K or 100 patients

Latest on MACRA

- Pick your Pace: PYP
  - Announced 9/8 – more details today
  - For reporting year 2017 ONLY
    - 1 measure from each of the 3
    - No negative adjustment
    - If you do NOTHING = 4%
  - Option 2: Participate for a partial year
    - 90 days
    - More than 1 measure from the 3 categories
    - Could get a positive adjustment

PYP: continued

- Option 3: Participate for the full year
  - You could be eligible for a "modest" positive payment adjustment
- Option 4: Join a Qualified ACO
  - MSSP Track 1, 2 or 3 – YEA!!!
  - 5% bonus IF qualifying provider

QRUR and s-QRUR have been released
The final MACRA rule was just released
The final Episode rule will be released in early Dec.

Pick your pace:

ACO Alert

- Qualifying APM
  - MSSP Track 2&3
  - NextGen
  - Pioneer
  - CPCI+
  - Oncology
  - Maybe MSSP track 1+
  - ??CMS mandated bundles
- APM – Doesn't qualify '17
  - Medicare Shared Savings Track 1
  - BPCI

18

How do we report

- Individual
  - Electronic health record
  - Registry
  - QCDR: qualified clinical data registry
  - Medicare claims process.
- Group
  - CMS web interface
  - Electronic health record
  - Registry
  - QCDR: qualified clinical data registry.

Web interface MUST apply by 6/30

19

Quality: 60%

Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.

Groups using the web interface: Report 15 quality measures for a full year.

Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

20

Advancing Care Information: Required

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

ACI: Bonus

For bonus credit, you can:

- Report Public Health and Clinical Data Registry Reporting measures
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

OR

You may not need to submit advancing care information if these measures do not apply to you.

Clinical Practice Improvement: CPI

Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.

Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

23

Rated as High and Medium

Population Management	Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program)for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors).	High
Population Management	Participation in CMMI models such as Million Hearts Campaign.	Medium
Population Management	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).	Medium
Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms.	Medium

24

Cost

- 0% for year one
- Three cost measures
  - Total cost per beneficiary
  - MSPB
  - 10 episodes of care ONLY those in s-QRUR
    - Only CABG and Valve surgery in final list

25

Attribution & Risk

- Attribution is critical
  - QRUR 2 step attribution method
  - Adding Chronic care codes
  - Adding SNF codes
- Part A and Part B costs for 1 year
- Risk scores are critical

MSPB

- Inpatient only
- Attribution
  - Plurality of claims (as measured by allowable charges)
- Cost 3 days pre and 30 days post

APMs

- APM is a generic term describing a payment model in which providers take responsibility for cost and quality performance and receive payments to support the services designed to achieve high value
- According to MACRA, APMs include:
  - Medicare Shared Savings Program ACOs – Track 2 & 3 ONLY
  - CPCI +
  - Pioneer & Next Gen
  - Onc model
  - ??? New CMS Mandated cardiac bundles

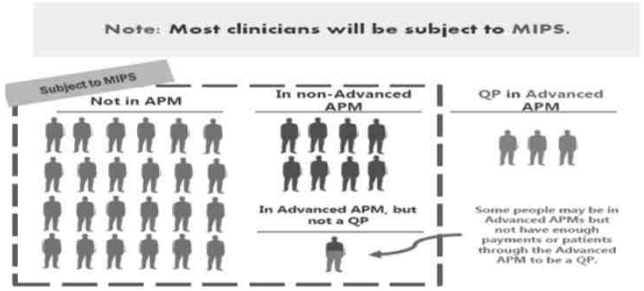
There are really 3 "Buckets"

- APMs—and eligible APMs in particular—offer greater **potential risks and rewards** than MIPS.
- **In addition** to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.

MIPS only	APMs	eligible APMs
MIPS adjustments	APM-specific rewards + MIPS adjustments	eligible APM-specific rewards + 5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**

Qualifying ACO *AND* Qualifying Provider



Are You MACRA Ready?

- Organizational focus
- Physician led process
- Currently successful in
  - PQRS
  - MU
  - VM – QRUR and s-QRUR
- You have found your data
- You know your numbers
- Reducing variability in care delivery – MUST happen
- Understanding cost
- Understanding episodes of care
- Care coordination is an organizational priority
- Documentation is a focus – clinic & hosp.

2017 –No Adjustment

The Value Modifier calculated for your TIN is shown in the highlighted cell in Exhibit 1. The Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering (TINs with 10 or More Eligible Professionals)

	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+2.0 x AF	+4.0 x AF
Average Cost	-2.0%	**0.0%**	+2.0 x AF
High Cost	-4.0%	-2.0%	0.0%

Quality Measures

Exhibit 3-ECC. Effective Clinical Care Domain Quality Indicator Performance
Domain Score

Measure Identification Number(s)	Measure Name	Your TIN: Number of Eligible Cases	Your TIN: Performance Rate	Your TIN: Standardized Performance Score	Your TIN: Included in Domain Score?	All TINs in Peer Group: Benchmark (National Mean)	All TINs in Peer Group: Standard Deviation
1* (GPRO DM-2, CMS122v3)	Diabetes: Hemoglobin A1c Poor Control	3,171	**71.33%**	-1.88	Yes	**28.42%**	22.83
5 (CMS135v3)	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	833	**77.19%**	-0.37	Yes	**83.01%**	15.94
6	Coronary Artery Disease (CAD): Antiplatelet Therapy	10,750	**80.87%**	-0.51	Yes	**89.48%**	16.92
7 (CMS145v3)	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	1,477	**78.06%**	-0.38	Yes	**88.37%**	26.85
8 (GPRO HF-6, CMS144v3)	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	837	**76.70%**	-0.60	Yes	**86.35%**	16.04
117 (GPRO DM-7, CMS131v3)	Diabetes: Eye Exam	2,612	**60.76%**	-0.91	Yes	**85.70%**	27.29
116 (GPRO CAD-7)	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy -- Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	1,897	**70.95%**	-0.09	Yes	**72.74%**	19.16
242	Coronary Artery Disease (CAD): Symptom Management	169	**94.67%**	0.17	Yes	**91.47%**	18.93
326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	1,013	**73.45%**	0.06	Yes	**71.65%**	32.46
ACCPin 1	Hypertension (HTN): Blood Pressure (BP) Management	17,497	**86.75%**	—	No	—	—
ACCPin 2	Coronary Artery Disease (CAD): Blood Pressure Control	10,785	**87.98%**	—	No	—	—

Supplemental QRUR


Medicare Fee-For-Service
2014 Supplemental QRUR: Episodes of Care
Performance Period: 01/01/2014 - 12/31/2014

The 2014 Supplemental Quality and Resource Utilization Reports (QRURs) provide information to medical group practices and solo practices on their resource utilization for the management of episodes of care ("episodes") for only Medicare fee-for-service (FFS) patients. The 2014 Supplemental QRURs are for informational purposes practice efficiency. This report is limited to 26 major inpatient episode types and an additional 38 episode subtypes and procedural episodes and include the following:

Condition Episodes
1. Acute Myocardial Infarction (AMI) (All)
2. AMI without PCI (All)

Procedural Episodes
21. Aortic Aneurysm Procedure (All)
22. Abdominal Aortic Aneurysm Procedure

And so…..What can YOU do…

- Ensure coding is accurate
- Understand YOUR current quality thresholds
- Find your NCDR data --- review it
- Know your data – PQRS, MU, QRUR, and s-QRUR
- Establish data analytics and information sharing
- Reduce variation in care across the System
- Create the infrastructure and expertise to coordinate care transitions and manage post-acute services

Episodes of care - historical

- 1990's Bundled payments CABG
  - Successful in reducing cost, improved quality, and provided services more efficiently
- ACE project: tested bundled payments in early 2000's
  - Cardiac and ortho
  - Ortho widely successful
  - Medicare savings while maintaining quality
- BPCI: CMMI project
- LAN – proposed but not implemented to date
- Ortho Mandated bundle

36

Episodes in 2016

- Component of the s-QRUR -64 episodes
  - Condition episodes
  - Procedural episodes
  - 10 of these will transfer to MIPs cost category
    - Just CABG and Valve made it to the final rule
- LAN –
  - Maternity
  - Ortho bundle
  - CAD bundle with nested procedures
- CMS mandated bundles
  - 4/1/16 – ortho (CJR in 67 Metropolitan Statistical Areas)
  - 7/25/16 – MI/PCI, CABG, expansion of ortho (SHFFT)

37

Why ??? And a bit of the How

- Mandated by MACRA
  - Specific clinical criteria & patient condition groups
- Condition and procedure episodes
- Condition:
  - CMS must consider chronic conditions, current health, and recent hx
- Procedure:
  - CMS considers what precipitated the need
- Includes pt. relationship codes

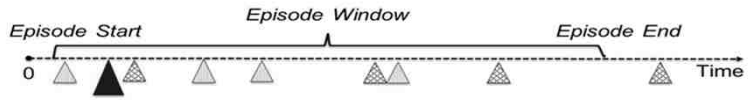
38

Basic episode

▲ **Trigger Event** (Step 1)

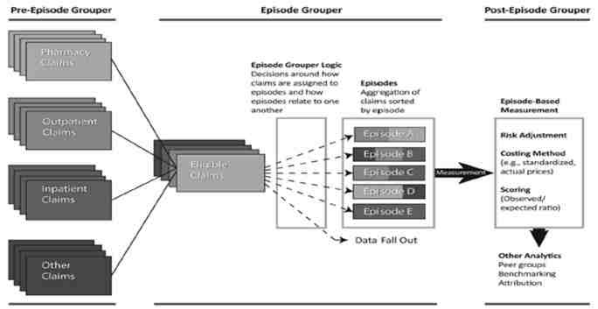
△ **Clinically Relevant Service Grouped to Episode** (Step 2)

△ **Service Not Grouped to Episode**



39

From a service to an episode…..



If a service is associated with more than 1 episode – Full cost is associated with ALL episodes

40

The basics

- Will be mandated in specific Metropolitan Statistical areas – 394 nationally
  - Specific AMI criteria applied
  - 294 MSA's remained
  - 98 MSA's will be "selected" – end of 2016
  - 12 in IL – only 1 excluded
- All Medicare FFS patients
- 2 cardiac bundles – first time condition + procedure/surgery contained within 1 bundle

41

The basics

- MI – includes MI AND MI + PCI
  - Includes both primary AND secondary dx code
  - Outpt MI's not included (nationally this is 6%)
- CABG
- Starts 7/1/17
- Will last for 5 years
- Starts day of admission through 90 days
- Part A and Part B cost included (hospice IS included)
- 1/1/17 thru 12/31/18 – 2/3 local data + 1/3 regional
  - 2019 = yr... 3 = 1/3 local + 2/3 regional
  - 2020-2021 = all regional

42

How Do Bundled Payments Work

Impact of Quality Comparison (CABG)

	Hospital A Highest Quality	Hospital B Acceptable Quality	Hospital C Acceptable Quality
Historical Cost*	$50,000	$50,000	$50,000
CMS Discount	1.5% ($750)	3.0% ($1,500)	3.0% ($1,500)
Quality Adjusted Target Price	$49,250	$48,500	$48,500
Average Total Cost per Patient*	$48,000	$48,000	$50,000
Retrospective Adjustment	$1,250 per patient	$500 per patient	-$1,250 per patient
Volume of Patients	400	400	400
Overall Financial Impact	$500,000	$200,000	-$500,000

*Includes surgery plus all related care provided 90 days after hospital discharge

43

Quality

- Based on 3 yrs. historical data
- Quality score + improvement score
- MI data:
  - 30 day mortality – currently scored at 50% of total
  - Excess days post MI
  - HCAHPS (NQF #0166)
  - There is a voluntary e-measure for mortality
- CABG
  - 30 day mortality – currently at 75%
  - HCAHPS

44

Quality and impact on payment

- If unacceptable quality – not eligible for reconciliation payment
  - And will see a 3% discount
- If acceptable, good, or excellent – eligible for reconciliation payment + an effective discount of 3%, 2%, or 1.5% respectively
  - Better quality = greater financial opportunity

45

Key success factors

- Care coordination
- Team based care
- Best practices
- Reduction in variation of care
- Collaboration between hospitals, physicians, home care, SNF, ECF

46

List of Collaborators

- Physicians and nonphysician practitioners
- Home health agencies
- Skilled nursing facilities
- Long term care hospitals
- Physician group practices
- Inpatient rehabilitation facilities
- Providers of outpatient therapy services
- Hospitals
- Critical access hospitals
- Accountable care organizations (ACO) that participate in the Medicare Shared Savings Program

26

47

Cardiac Episode Payment Models =APM??

Will they qualify?

- Would need to have a financial arrangement
- Criteria ***appears*** to be based on current proposed criteria (20%/25%)
- April, 2018 seems to be the potential start date (upside/downside risk starts)
  - Except for rural, Medicare Dependent, and sole community hospitals not till 2019

48

Re-designing Care delivery

- APP may provide EPM services in home care and waive incident to rules
  - Maximum of 13 visits for AMI or 9 for CABG
  - New codes forthcoming
- APP may supervise and to ITP's for cardiac rehab
- 3-day SNF rule waived in yr.. 2
  - SNF must be 3 stars or higher
  - Beneficiaries can NOT be discharged prematurely
  - Beneficiaries can not be steered

49

Cardiac Rehab Incentive

- Additional program
  - 45 of the 98 randomly selected +
  - 45 selected MSA's that are not part of the EPM
- Cardiac rehab and intensive rehab programs
- $25 per visit from 1-11
- $175 per visit from 12-36
- Can't be included in FSA
- Won't be counted in reconciliation payments
- Can provide transportation
- Use of APP's

50

And so…..

- Ensure coding is accurate
- Understand current quality thresholds
- Understand staged multi-vessel procedures & post MI ICD implants
- Understand impact on transferring hospitals
- Understand your scope/exposure
  - DRG analysis
- Establish data analytics and information sharing
- Reduce variation in care across the System
- Create the infrastructure and expertise to coordinate care transitions and manage post-acute services

51

Just the Basics ***please***

- For the episodes in MIPS/cost
  - Find your s-QRUR
  - Focus your review
- For the CMS Bundles
  - Know your exposure (find the numbers)
  - Prepare to design care pathways
  - Find your current quality benchmarks
  - Identify your collaborators
  - S-QRUR data should be reviewed with hospital data

52

Leading the Charge

- Design consistent care pathways across your hospital – for EVERYONE
- Facilitate communication amongst the team
  - ED, PCP, SNF medical directors, APP's, hospitalists
- Know *your* cost per case – lead the charge in cost reduction that results in exceptional outcomes
- Don't be afraid of re-designing your physician work force

Questions?

54