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# Washington Update: Focus on MACRA, but a little BPCI and EPM Too!

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# General Information

# MACRA Crossroads Quality Payment Programs

## MIPS

+/- 4% in 2019

+/-9% in 2022

CMS estimates 687,000-  
746,000 clinicians

## APMs

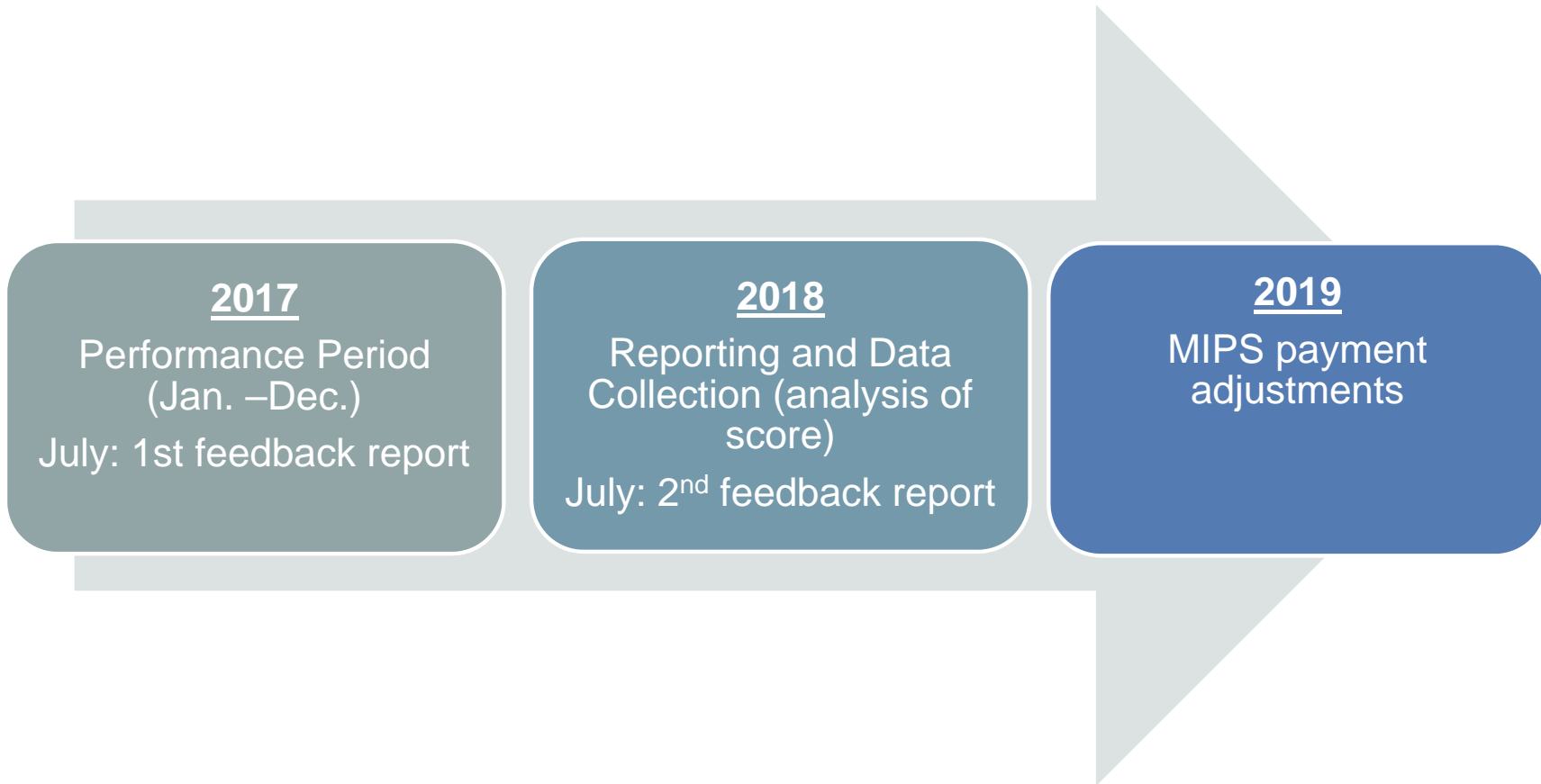
+5% for 2019-2024

CMS estimates 30,658-  
90,000 Eligible Clinicians  
would become QPs

## Overall Themes of Academic Medical Centers

- Will most likely report under MIPS
- Participating or considering participation in alternative payment models; would like to qualify for 5% incentive payment as advanced APM.
- Most report quality measures using GPRO Web Interface
  - Review success with GPRO web interface scoring
  - Review scores for readmission measures and episode measures.
- Concerned about impact of quality scores and payment of complex vulnerable patients treated by AMCs.

# MIPS Timeline



# MACRA CMS Announcement: “Pick Your Pace” 9/9/2016

Eligible Clinicians will have four options:

**“Test”**: As long as Clinicians submit some data to the QPP program, they will avoid a negative payment adjustment.

**Participate for part of year**: Submit data for reduced number of days (on or after January 1, 2017) and qualify for “small” positive payment adjustment.

**Participate for full calendar year**: Submit data for entire year beginning Jan. 1, 2017; qualify for “modest positive payment adjustment.”

**Participate in Advanced APM Model** in 2017 and qualify for 5% incentive payment

## AAMC's Take..

- Need More details from CMS; Should be Included in Final Rule (e.g, what does some data mean?)
- Allows providers who are less prepared to ease into program
- Only impacts reporting requirements for first year
- Will be less money in the MIPS “pool” for performers above threshold
- Range of payment adjustments will rise in subsequent years
- Beneficial to begin reporting as early as feasible to improve performance prior to program taking full effect.

# Physician Options for 2019 (Performance Year 2017)

## Qualifying APM Participant

- Significant participation in APM (25% Medicare payments/patients)
- Eligible for 5% bonuses (2019-2024) paid in a lump sum
- Higher update starting 2026 (.75%)
- Avoid MIPS

## Partial Qualifying APM

- Slightly lower threshold for participation
- No APM incentive payments
- Lower annual updates
- Can avoid MIPS or choose to participate in MIPS; if participate in MIPS are considered to be a MIPS Eligible Clinician and may be subject to payment adjustment
- Starting 2026: 25% update

## MIPS: General or APM

- Eligible Clinicians for first 2 years: physician, PA, NP, CNS, and CRNA
- 3<sup>rd</sup> year onwards: additional Eligible Clinicians may qualify as per the Secretary discretion
- If exceptional performance, eligible for bonus from \$500M pool (2019-2024)
- Starting 2026: .25% update
- Potential payment adjustment



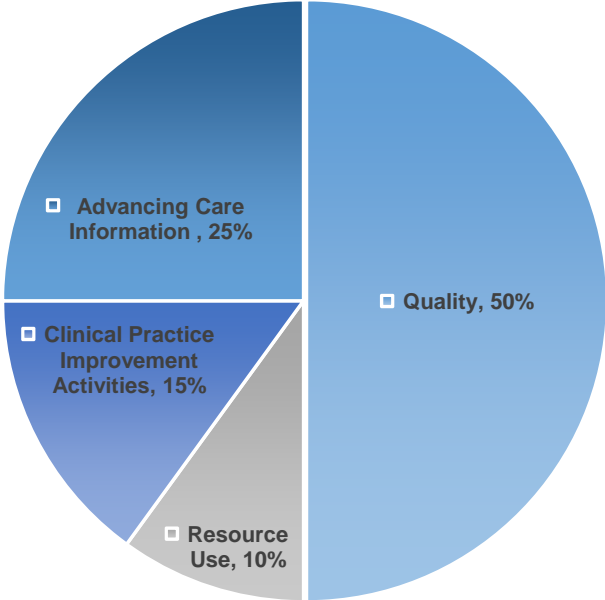
# MIPS

# How to Identify as a Group Under MIPS

MIPS General	MIPS APM
<ul style="list-style-type: none"><li>• Single TIN of 2+ clinicians that have reassigned billing rights to the TIN</li><li>• All MIPS eligible clinicians in group must use same TIN</li></ul>	<ul style="list-style-type: none"><li>• Unique APM identifier for each eligible clinician who is part of APM entity</li><li>• Could include more than 1 TIN as long as the MIPS eligible clinicians identified as participants by unique APM participant identifiers</li><li>• Some eligible clinicians in a TIN can be APM participants and others in same TIN not be participants</li><li>• Must be APM participant on 12/31 of performance period</li></ul>

# Composite Performance Score: Four Categories

- Four Categories Under MIPS:**
- 1. Quality**
  - 2. Resource Use**
  - 3. Clinical Practice Improvement Activities**
  - 4. Advancing Care Information (previously Meaningful Use Program)**



# MIPS Performance Categories/Weights

Performance Category	MIPS General*			MIPS APM
	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	
Quality	50%	45%	30%	Varies depending on APM
Resource Use	10%	15%	30%	
CPIA	15%	15%	15%	
ACI	25%	25%	25%	

**\*For MIPS General weights will be adjusted for certain factors, such as non-patient facing clinicians**

# MIPS APMs and Scoring

## Eligible Clinicians considered part of APM Entity

- Must be on APM participation list on December 31 of MIPS performance year
- If not on list, must report under standard MIPS methods (group or individual)

## Criteria for MIPS APM

- APM Entities participate in APM under agreement with CMS
- APM Entities include eligible clinicians on participation list
- APM bases payment incentives on performance on cost/utilization and quality measures

## Examples

- Shared savings program (all tracks)
- Next Generation ACO
- CPC Plus
- Oncology Care

# Advanced APMs

# CMS List of Advanced APMs: Examples

APM	Advanced APM
Medicare Shared Savings Program-Track 1	No
Medicare Shared Savings Program-Track 2	Yes
Medicare Shared Savings Program-Track 3	Yes
Oncology Care Model two-sided risk	Yes
Oncology Care Model one-sided risk	No
BPCI	(No-Maybe with program change)
Comprehensive Primary Care Initiative	Yes
Next Generation ACO	Yes
Comprehensive Care for Joint Replacement	Yes (Track 1 - CEHRT) No (Track 2 – No CEHRT)
CABG/AMI Bundle	Yes (Track 1) No (Track 2)

## Medicare Threshold Requirements for Qualifying and Partially Qualifying APMs

- To be classified as “qualifying APM participant” or “partial qualifying APM participant,” have to meet or exceed certain thresholds related to APM entities
- Thresholds determined by payments for services in APM but **MA revenue does not count in 2019-2020.**
- Threshold can be set using patients or services

Years	Min Thresholds for APM Participant (Payment)		Min Thresholds for APM Participant (Patient)	
	Qualifying	Partially Qualifying	Qualifying	Partially Qualifying
<b>2019-2020</b>	25%	20%	20%	10%
<b>2021-2022</b>	50%	40%	35%	25%
<b>2023 and beyond</b>	75%	50%	50%	35%

*The thresholds are based on Medicare FFS revenue and patients ONLY. FFS & All-Payer combination begins in 2021 and have separate requirements.*



## Advanced APM Determination

- Initial set of Advanced APM determination related no later than January 1, 2017
  - **Won't know if you meet threshold until 2018**
- For new APMs announced after 1/1/2017, will be determination in conjunction with another proposed rule for Request for Applications
- List of Advanced APMs updated at least annually

## QP Determinations

- QP determination is made at group level; applies to all individual eligible clinicians who are part of Advanced APM entity
- If eligible clinicians in one or more Advanced APM entities that meet the threshold, the eligible clinician becomes a QP
  - Incentive payment proportioned among TINS
- If none of clinician's Advanced APMs meet the threshold, then go to MIPS APM requirements

# APM Scenarios

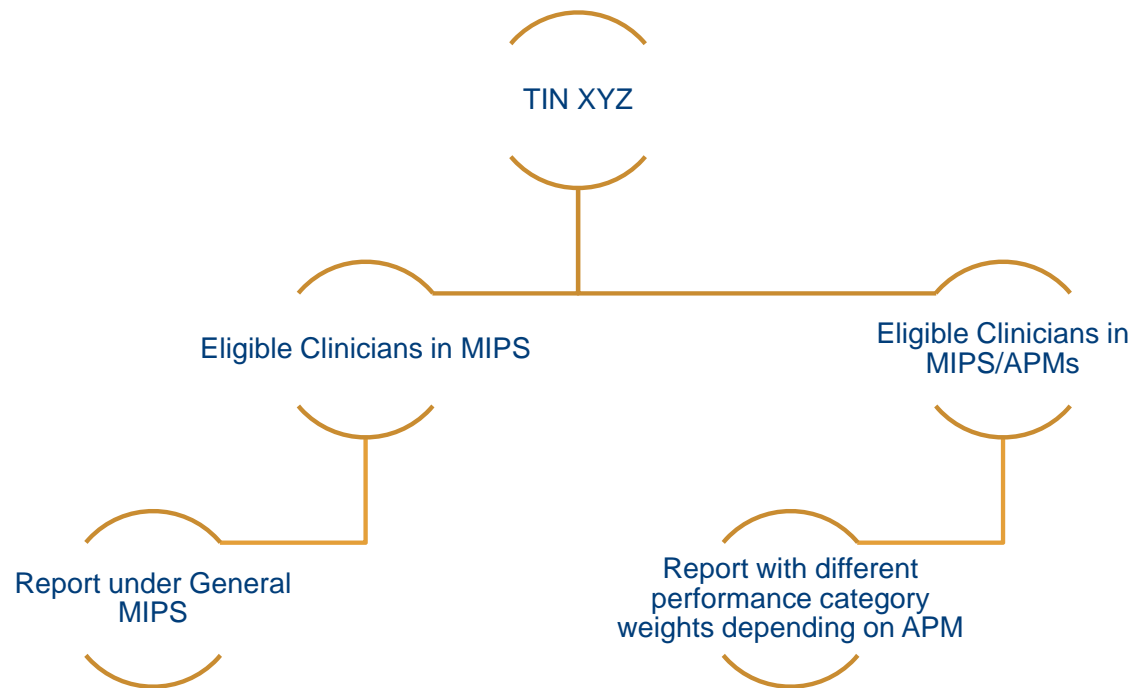
## **If you don't meet Advanced APM Threshold . . .**

. . . .you may qualify for reporting as a MIPS APM

- Weighting of performance categories differs by APM

# Case Example

**REMEMBER**—it is possible that parts of your TIN may be in different programs!



# Overview of Physician Group Practice

## TIN Structure

- **TIN 1: Next Generation Participant (primary care physicians); remainder of physicians in group practice**
  - **Payment Track Option: APMs or MIPS/APM for primary care participants; MIPS for remainder of physicians in group**
- **TIN 2: MSSP ACO Participant (Track 3) /Oncology Care Model (Track 2) (oncologists in model)**
  - **Payment Track Option: APMs or MIPS/APM**

# TIN # 1: Next Generation Participants (APM or MIPS APM)



# MIPS APM Scoring for Eligible Clinicians in Next Generation --Proposed

MIPS Performance Category	Data Submission Requirement	Performance Score	Weight
Quality	Submit quality measures to CMS web Interface for participating eligible clinicians	MIPS quality performance category requirements and benchmarks will be used to develop ACO MIPS quality score.	50%
Resource Use	MIPS eligible clinicians not assessed	Not applicable	0%
CPIA	All MIPS eligible clinicians in the APM entity group submit <u>individual</u> level data.	All ACO eligible clinicians will receive one half of the possible points at a minimum. If eligible clinician is in a PCMH, will receive the highest possible score. All MIPS eligible clinician scores will be aggregated and averaged to one ACO score.	20%
Advancing Care Information	All MIPS eligible clinician's in APM Entity group submit individual level data.	All of MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	30%



## TIN 1: Physicians in Group Practice Scored under General MIPS

Performance Category	MIPS General*		
	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)
Quality	50%	45%	30%
Resource Use	10%	15%	30%
CPIA	15%	15%	15%
ACI	25%	25%	25%

**\*For MIPS General weights will be adjusted for certain factors, such as non-patient facing clinicians**

## TIN #2: MSSP ACO Participant (Track 3 )



# MIPS/APM Scoring for Eligible Clinicians in Shared Savings Program - Proposed

MIPS Performance Category	Data Submission Requirement	Performance Score	Weight
Quality	Submit quality measures to CMS web Interface for participating eligible clinicians	MIPS quality performance category requirements and benchmarks will be used to determine category at ACO level	50%
Resource Use	MIPS eligible clinicians not assessed	Not applicable	0%
CPIA	All MIPS eligible clinicians submit according to the MIPS requirements and have performance assessed as a group through billing TINs associated with ACO	All ACO participant group billing TINs will receive one half of the possible points at a minimum. IF the TIN is a PCMH, it will receive the highest possible score. All ACO participant TIN scores for MIPS eligible clinicians in APM entity group will be aggregated, weighted and average to one score	20%
Advancing Care Information	All MIPS eligible clinician's submit according to MIPS requires and performance assessed as a group through their billing TINs associated with the ACO	All of ACO participant group billing scores aggregated, as a weighted to score to yield one group score	30%

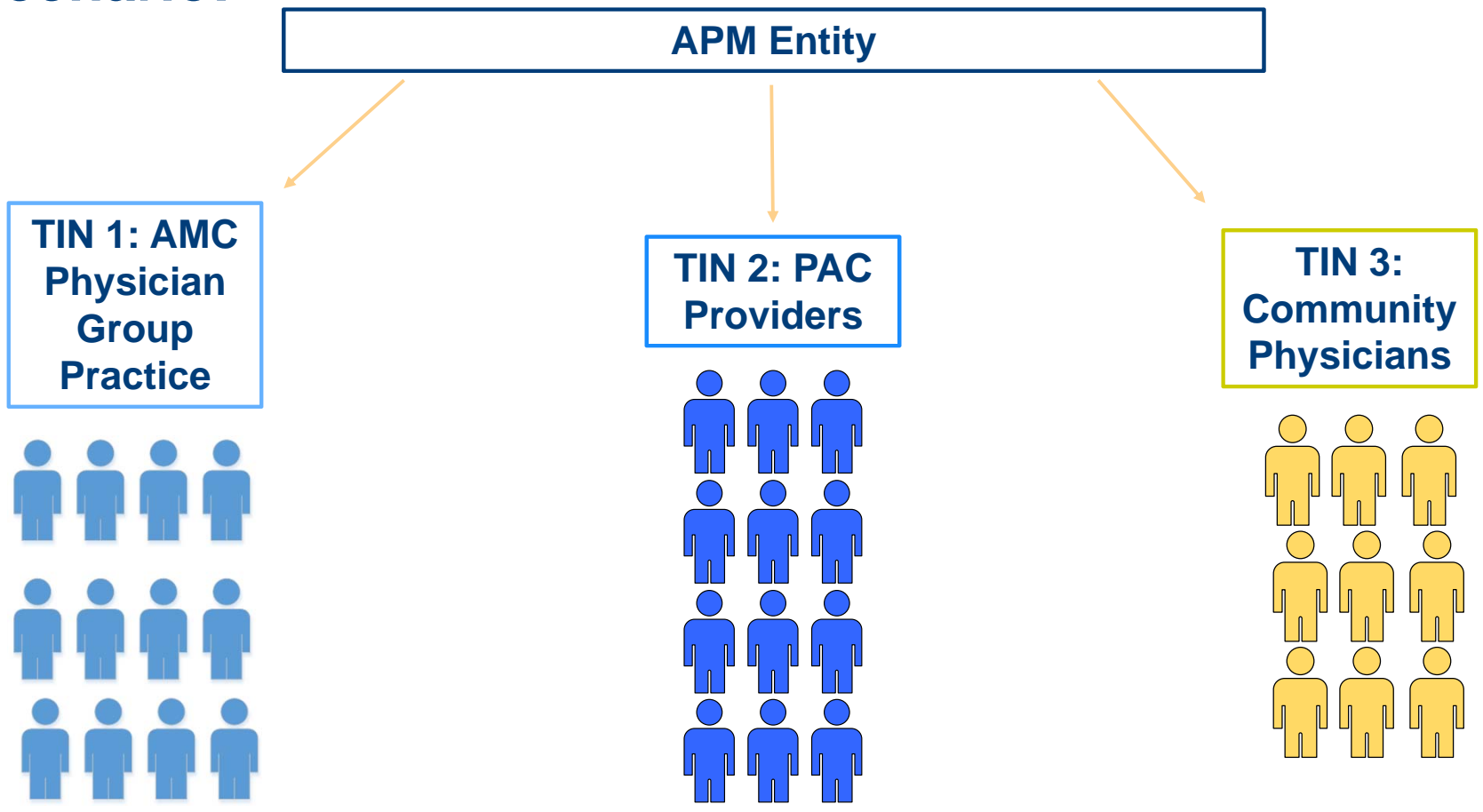
## TIN #2: Oncology Care Model (Track 2) Oncologists



## MIPS APM Scoring Other (Oncology Care Model)

MIPS Performance Category	Data Submission Requirement	Performance Score	Weight
Quality	The APM Entity group would not be assessed on quality in first performance period. APM submits quality measures as required by APM.	N/A	0%
Resource Use	MIPS eligible clinician	Not applicable	0%
CPIA	All MIPS eligible clinicians in the APM entity group submit individual level data.	All ACO eligible clinicians will receive one half of the possible points at a minimum. If eligible clinician is in a PCMH, will receive the highest possible score. All MIPS eligible clinician scores will be aggregated and averaged to one ACO score.	25%
Advancing Care Information	All MIPS eligible clinician's in APM Entity group submit individual level data.	All of MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	75%

# Case Scenario:



## Thoughts and Considerations

- How frequently can physicians be added to the list of participants in APM?
- How has the TIN performed in the past under quality using the GPRO web Interface?
- How has the ACO performed on quality measures? Identify practices to improve performance scores.
- What other physician groups TINs participate in the APM? Is it possible to collaborate with the other groups to improve quality and performance scores?
- How will the APM leadership coordinate the activities of the TINs to improve performance scores?
- Will the APM meet the thresholds for qualified participants in advanced APMs?

## Next Steps for MACRA

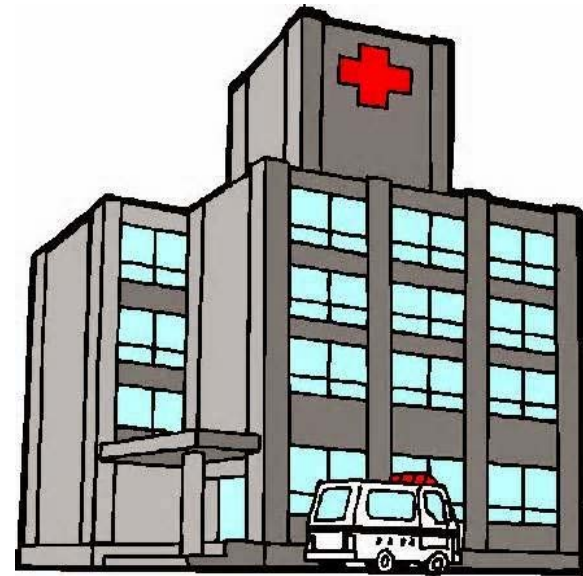




# BPCI Year 2 Evaluation

## BPCI Evaluation: Year 2

- Participants: larger, operate in more affluent urban areas, have higher episode costs; commitment from leadership and financial investment in consultants or other resources
- Model 2 most popular



- Average Model 2 participant in 5 clinical episodes
  - 74%: major joint replacement of lower extremity
  - 35%: CHF
  - 26%: COPD
  - 20%: pneumonia
- Average standardized payment decline \$864 for ortho surgery episodes
  - Reduced use of PAC
  - Patients in participating hospitals indicated greater improvement in 2 mobility measures

# EPM Proposed Rule

# Episode Payment Models (EPMs): The Basics

**Start Date** *(mandatory)*

**JULY 1, 2017**

**Timeframe**

**5 PERFORMANCE  
YEARS**

**Savings**

**CONTINGENT ON  
COST & QUALITY**

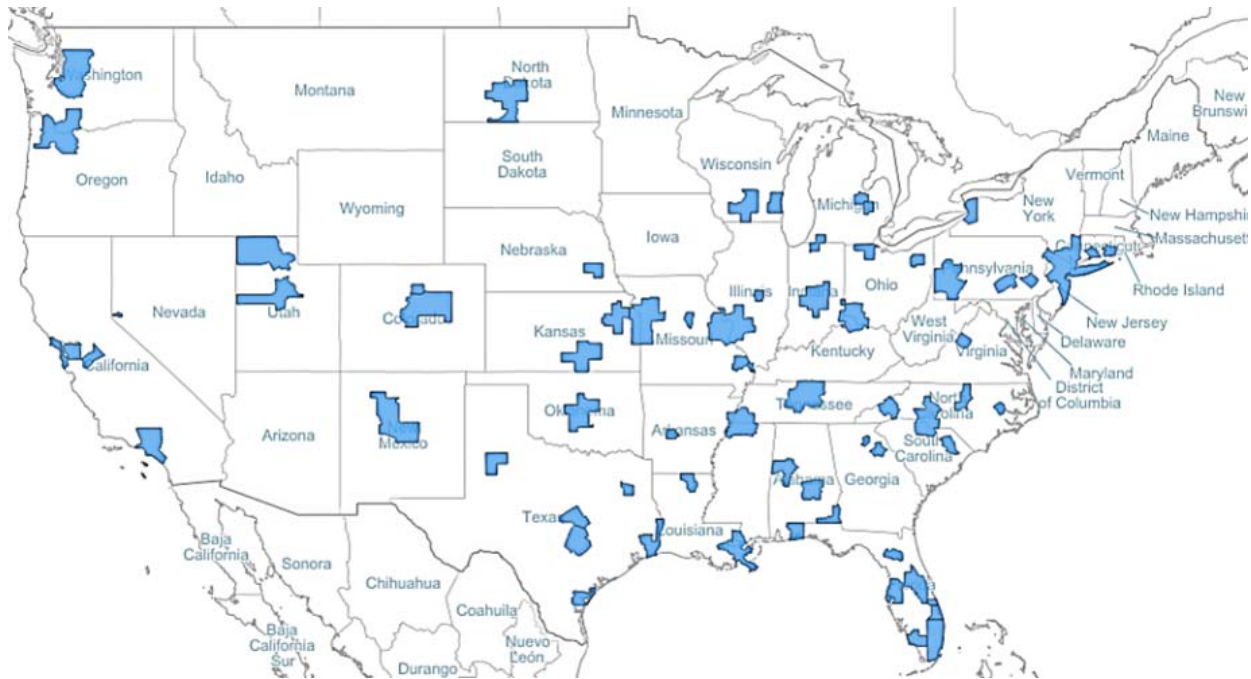
## **3 EPISODES**

- Surgical hip/femur fracture treatment (SHFFT)
- Acute myocardial infarction (AMI)
- Coronary artery bypass graft (CABG)



# EPM Participants: SHFFT

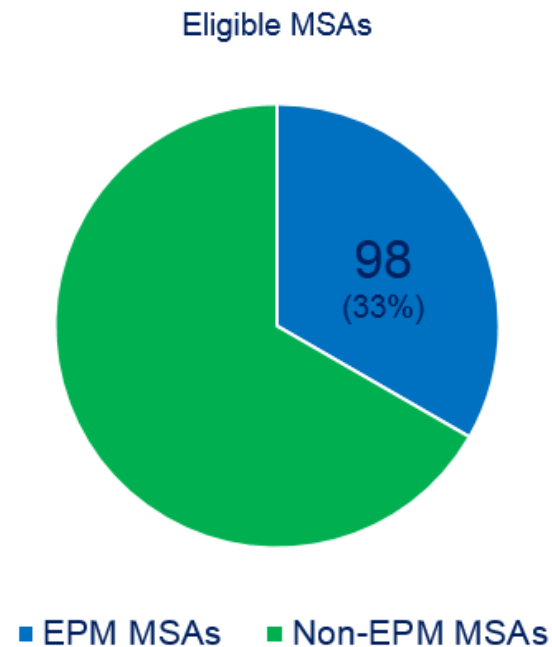
67 CJR MSAs



- <https://innovation.cms.gov/initiatives/CJR>

## EPM Participants: AMI & CABG

- AMI and CABG EPMs to be implemented in the same randomly selected MSAs.
- MSAs excluded from selection based on:
  - ✓ Volume of AMIs
  - ✓ Volume of BPCI AMIs
- **294** eligible MSAs remain
- **98** will be randomly selected for participation



# EPM Payment Methodology

## Standard Methodology

Hospitalization



90 days



Average Episode Medicare Payments Across a 3 Year Baseline

## EPM Methodology

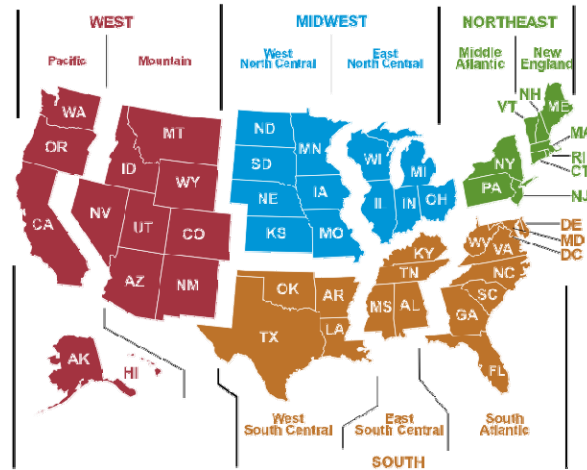
### Makes adjustments for:

- ✓ Chained anchor hospitalizations (transfers)
- ✓ CABG readmissions
- ✓ AMI diagnosis
- ✓ MS-DRG w/ MCC



# Regional Pricing

Target Price Components	Performance Year				
	1	2	3	4	5
Hospital-Specific Data	2/3		1/3	0%	
Regional Data	1/3		2/3	100%	
Baseline Period	CY 2013 - 2015		CY 2015 - 2017		CY 2017 - 2019



# Risk Mitigation: Cap on Total Losses

	Performance Year				
	1	2	3	4	5
<b>Cap on Losses</b> (% of target amount)	0% (No Risk)	5%	10%	20%	

## Example

Episode Volume	Target Price	Target Amount	Cap on Losses		
			PY 2	PY3	PY 4
100	\$20,000	\$2,000,000	\$100,000	\$200,000	\$400,000

Target Amount	Actual FFS Payments	Medicare Losses	Actual Amount Owed to CMS		
			PY 2	PY3	PY 4
\$2,000,000	\$2,150,000	\$150,000	\$100,000	\$150,000	\$150,000
\$2,000,000	\$2,350,000	\$350,000	\$100,000	\$200,000	\$350,000

# EPM Quality Overview

- Three separate EPM quality models
  - AMI, CABG, and Surgical hip/femur fracture treatment (SHFFT)
- Quality performance → National Percentile
  - 30<sup>th</sup> percentile – minimum performance to receive points for each quality measure
  - Points are awarded based on percentile
  - Length of reporting period:
    - AMI and CABG mortality, AMI excess days, and hip/knee complications – 3 years
    - HCAHPS – 1 year
    - Voluntary measures – varies by performance year

**Performance + Improvement + Voluntary Points = Quality Composite Score**

# Quality Measure Composite Scoring

AMI Quality Measures	Weight	Max Available Points
Hospital AMI 30-day Mortality	50%	10
Excess Days in Acute Care After Hospitalization (EDAC)	20%	4
Voluntary Hybrid AMI Mortality	10%	2 if submitted successfully
HCAHPS	20%	4

CABG Quality Measures	Weight	Max Available Points
Hospital CABG 30-day Mortality	75%	15
HCAHPS	25%	5

SHFFT Quality Measures	Weight	Max Available Points
Hip/Knee Complications	50%	10
HCAHPS	40%	8
THA/TKA Voluntary PRO	10%	2 if submitted successfully