MIPS, MACRA, & CJR: Medicare Payment Transformation

Presenter: Thomas Barber, M.D.
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Value = Outcome/Cost

Principals:

- Define Value as a Goal
- There is a need to measure value
- Care should be Organized around the way value is created
- There is a need to measure value
- Define Value as a Goal
Berwick, IHI and the Triple Aim

• 2008 “The Triple Aim: Care, Health, And Cost”: Health Affairs, Vol 27 #3

• 1. Improve the Experience of Care
• 2. Improve the Health of Populations
• 3. Reduce per capita Costs of Health Care

• “we will need new financing and competitive dynamics”
Medicare Payments

• “Large Variations in Medicare Payments for Surgery Highlight Savings Potential from Bundled Payment Programs”, Health Affairs, November 2011, Vol 30 # 11, David Miller, et al

• Medicare episode payments for certain inpatient procedures varied by 49-130 percent

• Post discharge care accounted for a large proportion of variation in payments, as did discretionary physician services

• It can be argued that strong incentives exist for CMS expand or refine its bundled payment policies include spending for home health
Risk and Complexity

- MD Only
- Ancillary Services
- Rotator Cuff
- Knee Pain Evaluation
- Other Specialties
- CJR – total Joint Bundle
- Include Hospital/ASC
- Population Management

Complexity of Management

**What does it do?**

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over **volume**
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in **eligible** alternative payment models (APMs)
What is an Alternative Payment Model (APM)?

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

As defined by MACRA, 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
Advanced APMs meet certain criteria. 

As defined by MACRA, advanced APMs must meet the following criteria:

- The APM requires participants to use **certified EHR technology**.
- The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- The APM either: (1) requires APM Entities to bear more than nominal **financial risk** for monetary losses; OR (2) is a **Medical Home Model expanded** under CMMI authority.
PROPOSED RULE
Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;

**No minimum** number of measures or domain requirements, **except** that an Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

**Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:

- Quality measures that are endorsed by a consensus-based entity; or
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**
APMs:

- **But, tough to meet the thresholds of participation:**
  - 2019 and 2020, EPs must have 25% of Part B payments for covered professional services furnished by APM that meets criteria of eligible alternative payment entity.
  - 2021/2022 50% of Part B payments
  - 2023 onward 75% of Part B payments
### Calculating the Composite Performance Score (CPS) for MIPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>• Each measure 1-10 points compared to historical benchmark (if avail.)&lt;br&gt;• 0 points for a measure that is not reported&lt;br&gt;• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting&lt;br&gt;• Measures are averaged to get a score for the category</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>• Similar to quality</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>• Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target</td>
</tr>
<tr>
<td>Advancing care information</td>
<td>25%</td>
<td>• Base score of 50 points is achieved by reporting at least one use case for each available measure&lt;br&gt;• Up to 10 additional performance points available per measure&lt;br&gt;• Total cap of 100 percentage points available</td>
</tr>
</tbody>
</table>

- **Unified scoring system:**
  1. Converts measures/activities to points
  2. Eligible Clinicians will know in advance what they need to do to achieve top performance
  3. Partial credit available
Summary:

- Selection of 6 measures
- 1 outcome measure and 1 cross-cutting measure, or other high priority measure, OR
- Selection of a specialty-specific measure set
- Key Changes from Current Program (PQRS):
  - Reduced from 9 measures to 6 measures with no domain requirement
  - Measure Applicability Validation (MAV) process is retired
  - Year 1 Weight: 50%
PROPOSED RULE
MIPS: Resource Use Performance Category

Summary:

✓ Assessment under all available resource use measures, as applicable to the clinician
✓ CMS calculates based on claims so there are no reporting requirements for clinicians
✓ Key Changes from Current Program (Value Modifier):
  • Adding 40+ episode specific measures to address specialty concerns
  • Year 1 Weight: 10%
Summary:

- Minimum selection of one CPIA activity (from 90+ proposed activities) with additional scoring for more activities
- Full credit for patient-centered medical home
- Minimum of half credit for APM participation
- Key Changes from Current Program:
  - Not applicable (new category)
  - Year 1 Weight: 15%
Summary:

✓ Scoring based on key measures of health IT interoperability and information exchange.

✓ Flexible scoring for all measures to promote care coordination for better patient outcomes

✓ Key Changes from Current Program (EHR Incentive):
  • Dropped “all or nothing” threshold for measurement
  • Removed redundant measures to alleviate reporting burden.
  • Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  • Reduced the number of required public health registries to which clinicians must report
  • Year 1 Weight: 25%
Putting It All Together:

### Fee Schedule

- **2016-2018**: +0.5% each year
- **2019-2021**: No change
- **2022-2024**: +0.25% or 0.75%
- **2026 & on**: +0.25%

### MIPS

Max Adjustment (+/-)

- **2016-2018**: 4
- **2019**: 5
- **2020-2021**: 7
- **2022-2025**: 9

### QP in Advanced APM

+5% bonus (excluded from MIPS)
CJR – Possible APM?
CJR Proposed Rule Key Points

• Hospital Initiator (owner) of Bundle
• Mandatory in 67 markets (1/3rd of all markets in USA)
• Retrospective Payment Design
• Quality Thresholds
• Financial Options/Gainsharing with physicians and “collaborators”
• April 1, 2016 start
Components of the Model

- Triggered by MS-DRG 469 or 470
- Includes hemiarthroplasty for hip fx, Total Ankle Arthroplasty, Primary THR, TKR
- Services in the bundle include hospital services, all physician services, post-acute care, PT.
- **ALL In hospital & post acute expenses (for 90 days)**
If the hospital meets quality thresholds and the total spending is less than the calculated (and discounted) “target price,” the hospital is eligible for a "reconciliation payment" from Medicare. If the total spend is greater than the “target price,” the hospital must repay Medicare.
Mandatory In 67 Markets

• “MSA”: Metropolitan Statistical Area
• 2 stage stratified randomization to determine areas
• Need for inclusion of entire market
• Represents about 1/3 of THA/TKA in the country
Quality Thresholds

- *Hospital* required to report on 2 quality measures:
  - Hosp Level Risk Standardized Complication Rate Following Elective Primary THA and/or TKA
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Pt Reported Outcome Measures

- Voluntary collection of PROMs
- May prove burdensome to measure; estimated about $75/pt to administer
- Cover the cost by reducing year 1 “discount” from 2% to 1.7%
Quality Payments

- 50% Complication Measure
- 40% HCAPS
- 10% Voluntary PRO program

- Overall 0-100 score developed
Quality Payments

• 10% Below Acceptable: No Quality or Target Payments
• 12% Acceptable: No Quality Bonus, yes target payment
• 64% Good 1% quality bonus, yes target payment
• 14% Excellent 1.5% Quality Bonus, yes target payment
How Can Hospitals Manage?

- Cherry Picking or Lemon Dropping
- Individual case management
- Proper systems/processes
  - Registries
  - Managing the entire care continuum
  - Careful co-management by hospital and doctor
Infrastructure Needs

- Quality Measurement
- Care Management
- Contracts & Relationships with SNF & Home Health
- Collaborative Environment
- Cost Monitoring
The Seven Controllable Variables in Patient Outcome in Orthopedic Surgery

- Patient Selection
- Prosthetic Choice
- Procedure Selection
- Technical Expertise
- Compliance With Guidelines
- Hospital/Facility
- Systems/Process

PATIENT outcome
<table>
<thead>
<tr>
<th>HIP</th>
<th>2013 TOTAL HIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals</td>
</tr>
<tr>
<td>&lt;100</td>
<td>106</td>
</tr>
<tr>
<td>Less than 500 but more than 100</td>
<td>137</td>
</tr>
<tr>
<td>Less than 1000 but more than 500</td>
<td>5</td>
</tr>
<tr>
<td>More than 1000</td>
<td>2</td>
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<tr>
<td></td>
<td>250</td>
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<table>
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<tr>
<th>KNEE</th>
<th>2013 TOTAL KNEES</th>
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</thead>
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<tr>
<td></td>
<td>Hospitals</td>
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<tr>
<td>&lt;100</td>
<td>92</td>
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<tr>
<td>Less than 500 but more than 100</td>
<td>148</td>
</tr>
<tr>
<td>Less than 1000 but more than 500</td>
<td>16</td>
</tr>
<tr>
<td>More than 1000</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>259</td>
</tr>
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</table>
# The Best & The Worst

## Key Benchmarks

### Quality

<table>
<thead>
<tr>
<th></th>
<th>Worst</th>
<th>Average</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Risk Standardized Complication Rate</td>
<td>7.1%</td>
<td>3.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>10%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Infections</td>
<td>1.5%</td>
<td>0.5%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Revisions @ 5 years</td>
<td>7%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Mortality</td>
<td>1.0%</td>
<td>0.4%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

### Resource Use

<table>
<thead>
<tr>
<th></th>
<th>Worst</th>
<th>Average</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay</td>
<td>4.5</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>% Discharged to SNF</td>
<td>40%</td>
<td>25%</td>
<td>7%</td>
</tr>
<tr>
<td>LOS in SNF</td>
<td>30</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Prosthetic Cost</td>
<td>$5,500.00</td>
<td>$3,500.00</td>
<td>$2,100.00</td>
</tr>
</tbody>
</table>
More Implications

- Must have an infrastructure to gather quality data
- Must meet meaningful use
- Must be able to work cooperatively with other stakeholders
- Need to lead the process in order to maximize revenue
The Future

- Movement from 20% of Medicare Payments being “value based” to 80% by 2018
- Medicare has identified 53 “bundles” being readied to roll out over the next few years
### TABLE 64: MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY PRACTICE SIZE*

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Eligible Clinicians</th>
<th>Physician Fee Schedule Allowed Charges ($ Mil)</th>
<th>Percent Eligible Clinicians with Negative Adjustment</th>
<th>Percent Eligible Clinicians with Positive Adjustment</th>
<th>Eligible Clinicians with no Adjustment</th>
<th>Aggregate Impact Negative Payment Adjustment ($ Mil)</th>
<th>Aggregate Impact Positive Adjustment ($ Mil)</th>
<th>Aggregate Positive Adjustment, excluding exceptional Performance Payment ($ Mil)</th>
<th>Aggregate Positive Adjustment, exceptional Performance Payment only ($ Mil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>$12,458</td>
<td>87.0%</td>
<td>12.9%</td>
<td>103</td>
<td>-$300</td>
<td>$105</td>
<td>$65</td>
<td>$40</td>
</tr>
<tr>
<td>2-9 eligible clinicians</td>
<td>123,695</td>
<td>$18,697</td>
<td>69.9%</td>
<td>29.8%</td>
<td>257</td>
<td>-$279</td>
<td>$295</td>
<td>$182</td>
<td>$113</td>
</tr>
<tr>
<td>10-24 eligible clinicians</td>
<td>81,207</td>
<td>$9,934</td>
<td>59.4%</td>
<td>40.3%</td>
<td>257</td>
<td>-$101</td>
<td>$164</td>
<td>$103</td>
<td>$61</td>
</tr>
<tr>
<td>25-99 eligible clinicians</td>
<td>147,976</td>
<td>$12,868</td>
<td>44.9%</td>
<td>54.5%</td>
<td>873</td>
<td>-$95</td>
<td>$230</td>
<td>$147</td>
<td>$84</td>
</tr>
<tr>
<td>100 or more eligible clinicians</td>
<td>305,676</td>
<td>$18,648</td>
<td>18.3%</td>
<td>81.3%</td>
<td>1,005</td>
<td>-$57</td>
<td>$539</td>
<td>$336</td>
<td>$203</td>
</tr>
<tr>
<td>Overall</td>
<td>761,342</td>
<td>$72,606</td>
<td>45.5%</td>
<td>54.1%</td>
<td>2,527</td>
<td>-$833</td>
<td>$1,333</td>
<td>$833</td>
<td>$500</td>
</tr>
</tbody>
</table>

*2014 data used to estimate 2017 performance. Payments estimated using 2014 dollars.
Summary

• Bundled payments are here to stay
• The types of procedures covered will increase over time
• Significant infrastructure changes are necessary in the hospitals and office practices to adapt to this change
• There will be greater risk
Key Areas of Concern

- Risk Adjustment - Including Socioeconomic
- Small Practice Issues
- Infrastructure Needs
- Possible success strategies
- Inability to contract on in hospital issues
- Measure Development
- QCDR function
- Medicare Data