

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



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Cathleen Biga, MSN, RN: Disclosures:

- 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



What is the problem.....

Our national healthcare crisis is strongly related to our aging population.



EVERY **8** SECONDS A BOOMER ENTERS MEDICARE

These patients are...

65+

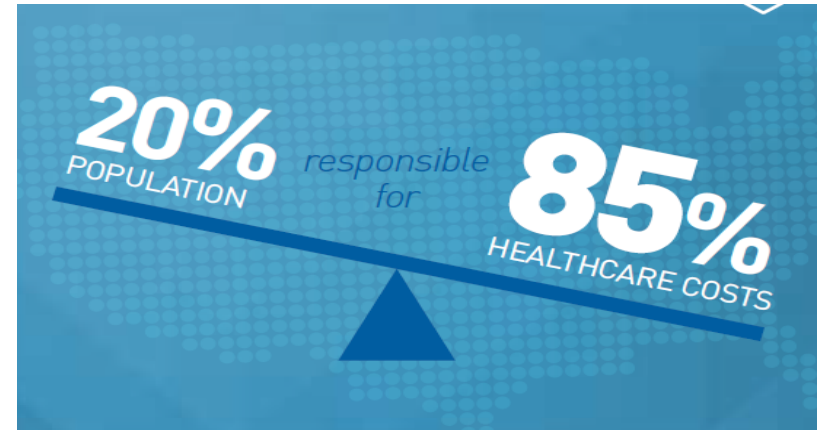


MORE LIKELY
TO PRESENT CHRONIC DISEASES

Which represent a disproportionate healthcare expenditure due to...

45%

ARE NONCOMPLIANT
WITH THEIR CARE PLANS



Where are we....how do we get there

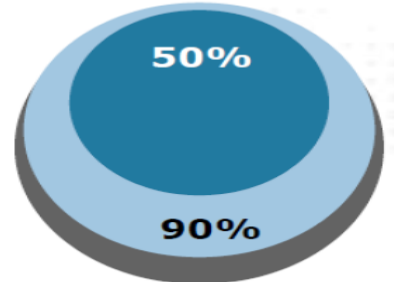
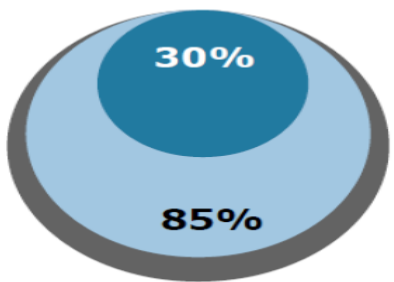
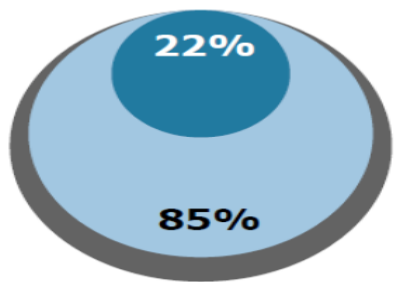
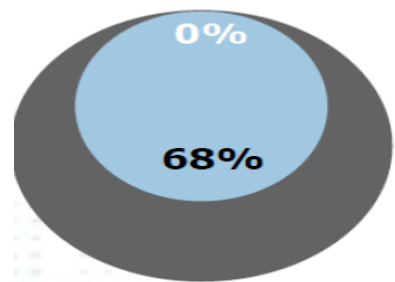
Historical Performance

2011

2014

2016

2018



- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)



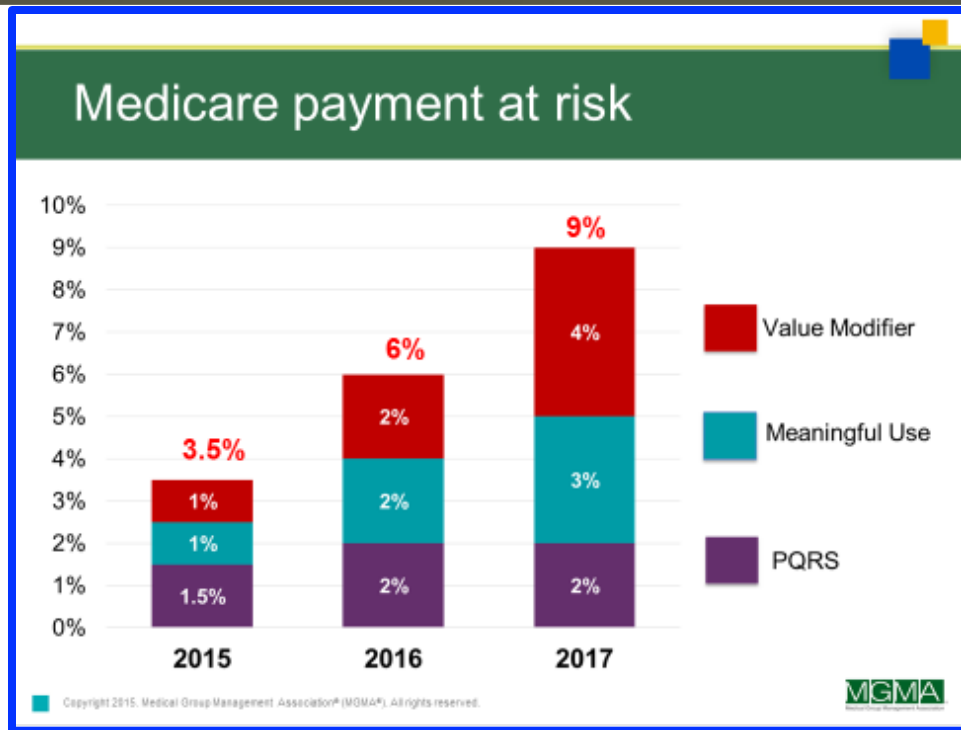
The march to value.....



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%

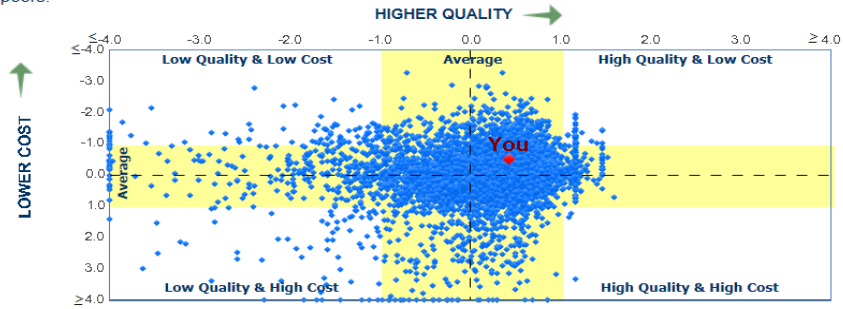


As the world turns.....

2014

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



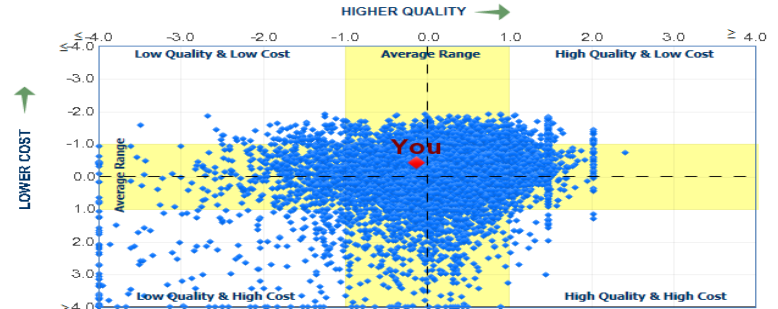
Note: The scatter plot reflects the performance of a representative sample of your peers.

2015

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that 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%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2017 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.



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How did we get to MACRA?

1997

- **Medicare Sustainable Growth Rate (SGR)** implemented as part of the Balanced Budget Control Act of 1997

2002 -
2015

- **17 patches to avert steep cuts to Medicare**
- House of Medicine, including the ACC, works with Congress to craft **MACRA**

March
24, 2015

- H.R. 2 (**Medicare Access and CHIP Reauthorization Act of 2015**) introduced in the House

March
26, 2015

- The House passed H.R. 2 (392-37)

April 14,
2015

- The Senate passed H.R. 2 (92-8)

April 16,
2015

- **MACRA** signed into law by President Barack Obama



The Basics of MACRA

- **Medicare Access and CHIP Reauthorization Act**
- Eliminate SGR
- Effective 1/1/19
- 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

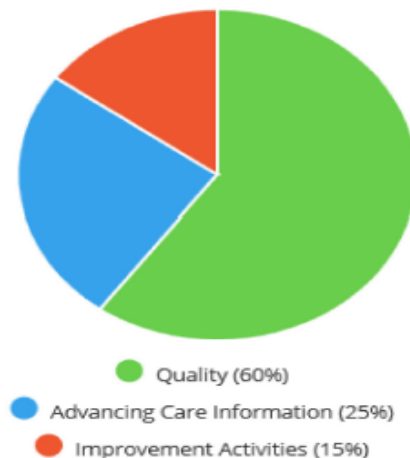
MU requirements: 25 points

- 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
- 40 points



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-QRUP
- 30% by 2021



Changes

- 2017 will be a transition year
- Quality is King
- Cost is collected but not scoredyet
- 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



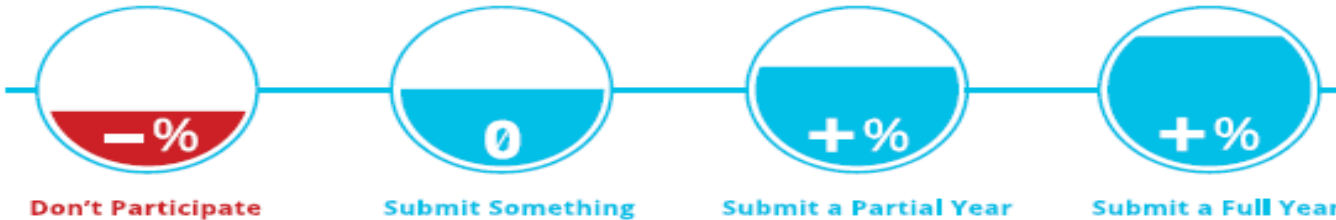
QRUR is out and s-QRUR should be released next week
Stay tuned for the final MACRA rule in early November



Pick your pace:

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



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



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



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.



ACI: 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.



Advancing Care Information – 25%

- ACI aka MU – 131 points
 - Replaces the Medicare EHR program
 - New emphasis on interoperability and information exchange
 - Eliminates the current all or nothing program
 - 'Failure to meet the submission requirements, or measure specifications for any measure in any of the objectives would result in a score of zero for the Advancing Care Information performance category base score
 - Removed eCQM's from requirements
 - There will be a total of 130 points available – base score + performance
 - + 1 bonus point available
 - 100 points will allow you to claim the 25% of this category



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.



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
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Population Management	Participation in CMMI models such as Million Hearts Campaign.	Medium
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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
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Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms.	Medium
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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



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



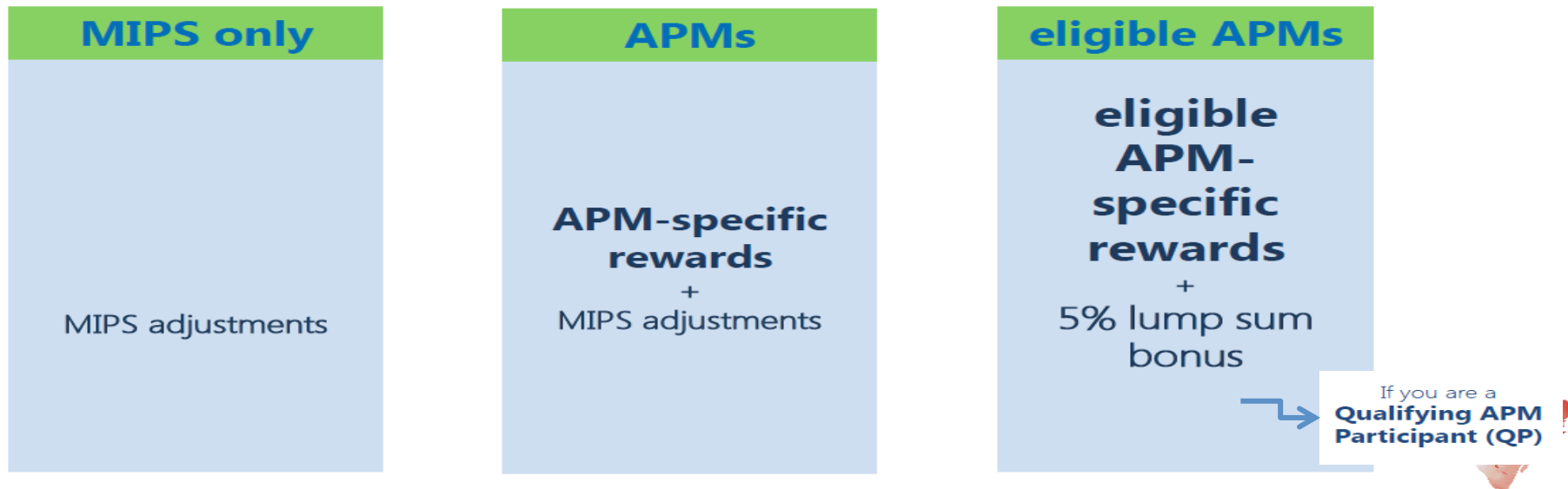
APMs

- 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



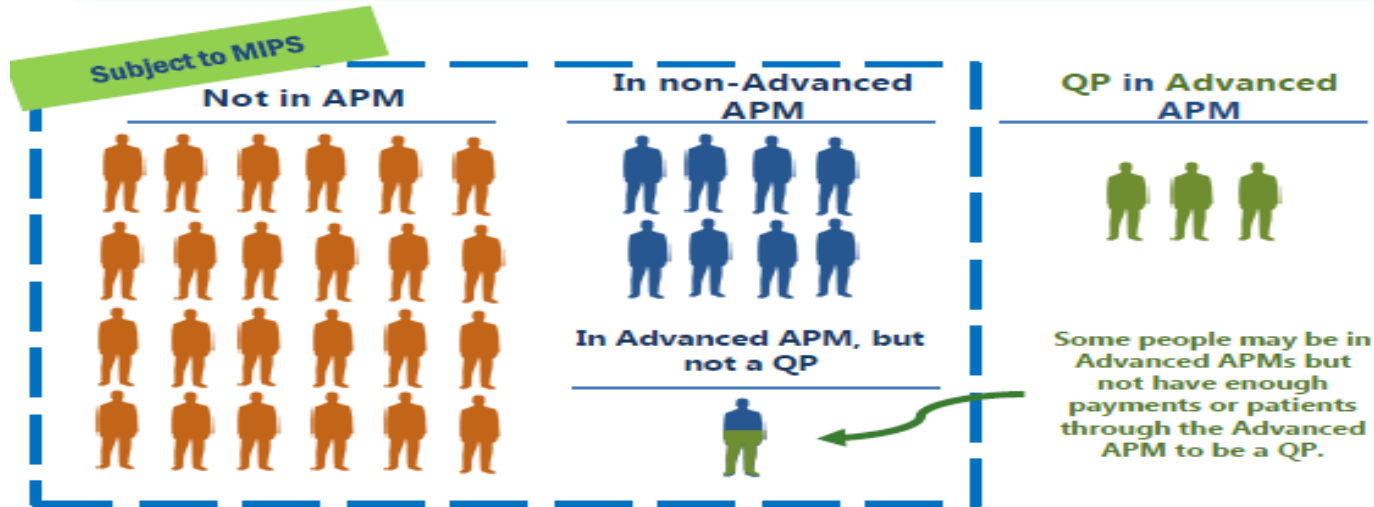
There are really 3 “Buckets”

- 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.



Qualifying ACO AND Qualifying Provider

Note: Most clinicians will be subject to MIPS.



Are You MACRA Ready?

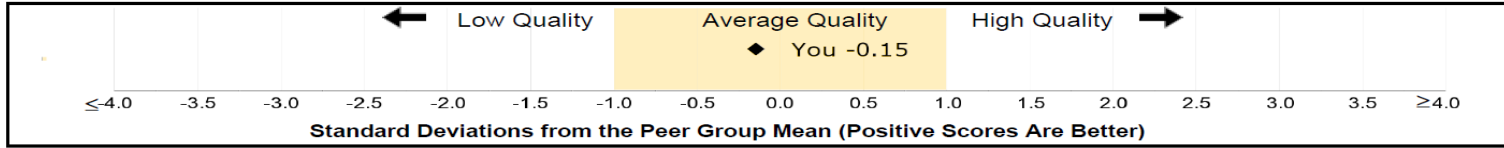
- Organizational focus
- Physician led process
- Currently successful in
 - PQRS
 - MU
 - VM – QRUR and s-QRUR
- You have found your data
- You know your numbers
- Reducing variability in care delivery – MUST happen
- Understanding cost
- Understanding episodes of care
- Care coordination is an organizational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



PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: Average

Exhibit 2. Your TIN's Quality Composite Score

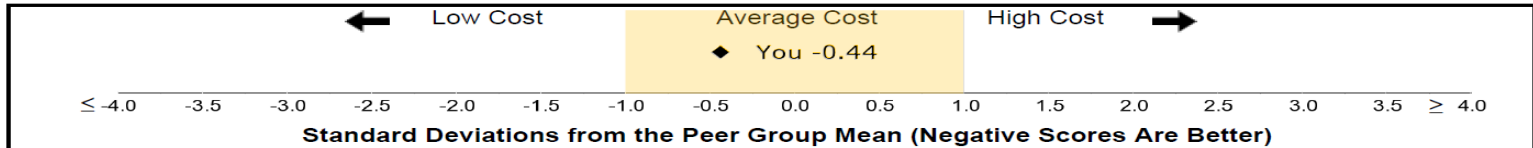


Your TIN's Quality Composite Score (Exhibit 2) indicates that your TIN's overall performance on quality measures is -0.15 standard deviation from the mean for your TIN's peer group. Because your TIN's Quality Composite Score is less than one standard deviation from the mean, your TIN's quality performance is classified as Average Quality under quality-tiering.

PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Average

Exhibit 4. Your TIN's Cost Composite Score



Your TIN's Cost Composite Score (Exhibit 4) indicates that your TIN's overall performance on cost measures is -0.44 standard deviation from the mean for your TIN's peer group. Because your TIN's Cost Composite Score is less than one standard deviation from the mean, your TIN's cost performance is classified as Average Cost under quality-tiering.

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

◆ You -0.50

Standard deviations from the mean (positive scores are better)

Measure Identification Number(s)	Measure Name	Number of Eligible Cases	Your TIN			All TINs in Peer Group	
			Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	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
118 (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

2014 Supplemental QRUR: Episodes of Care

Performance Period: 01/01/2014 - 12/31/2014

The 2014 Supplemental Quality and Resource Use Reports (QRURs) provide information to medical group practices and solo practices on their resource utilization for the management of episodes of care ("episodes") for their Medicare fee-for-service (FFS) patients. The 2014 Supplemental QRURs are for informational purposes only and provide actionable and transparent information on resource use to assist medical group practices and solo practices, as identified by their Medicare-enrolled tax identification number (TIN), in improving their practice efficiency. This report is limited to 26 major episode types and an additional 38 episode subtypes, resulting in 64 total reported episodes. The 64 reported episodes can be classified into condition episodes and procedural episodes and include the following:

Condition Episodes

1. Acute Myocardial Infarction (AMI) (All)
2. AMI without PCI/CABG

Procedural Episodes

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



Anatomy of an Episode

- Structured payment around a patients TOTAL experience of care
 - Quality – outcome
 - Cost
 - Experience
- Pre and post hospital
 - Often 3 days pre and 90 days post
- Better coordination of care
- Ultimately better patient outcome



Episodes of care - historical

- ACE project: tested bundled payments in early 2000's
 - Cardiac and ortho
 - Ortho widely successful
 - Medicare savings while maintaining quality
- 1990's Bundled payments CABG
 - Successful in reducing cost, improved quality, and provided services more efficiently
- BPCI: CMMI project
- Ortho Mandated bundle



Episodes in 2016

- Component of the s-QRUR -64 episodes
 - Condition episodes
 - Procedural episodes
 - 40 of these will transfer to MIPs cost category
- 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)

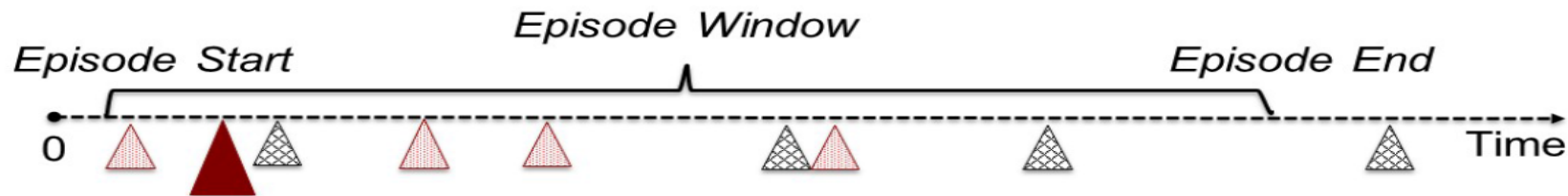


Basic episode

 **Trigger Event (Step 1)**

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

 **Service Not Grouped to Episode**



So....do we run.....or



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



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
- Part A and Part B cost included (plus hospice)
- 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



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



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



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?





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